

# Response to HCR 77 of the 2016 Regular Legislative Session

*Evaluation of Accountable Care Organization Model*

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**Louisiana Department of Health**

*Bureau of Health Services Financing*

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## Preface

The Louisiana Department of Health’s (henceforth “LDH”) submits this report on *Accountable Care Organizations* (henceforth “ACOs”) and the experience of state Medicaid programs with ACOs throughout the country.

Many state Medicaid programs are choosing to engage payers, providers, and physicians in Medicaid-run ACOs, in order to maximize care quality and minimize healthcare expenditure. There are currently ten states (Colorado, Illinois, Maine, Minnesota, New Jersey, New York, Oregon, Utah, Rhode Island, and Vermont) that have implemented Medicaid ACO programs, and six more states that are “actively pursuing” ACO models of delivery (Alabama, Connecticut, Maryland, Massachusetts, North Carolina, and Washington).<sup>1</sup>

## What is an ACO?

As defined by the Centers for Medicare and Medicaid Services, an ACO is a group of doctors, hospitals, and other healthcare providers who come together voluntarily to give high-quality coordinated care to their patients. Successful care coordination ensures that patients receive the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.<sup>2</sup>

Payers hold providers financially accountable through differently structured payment mechanisms, ensuring that value of care is incentivized more than volume of care delivered. According to the Center for Health Care Strategies, Inc., this accountability is achieved through three key activities:

- 1) Implementing a value-based payment structure;
- 2) Measuring quality improvement; and
- 3) Collecting and analyzing data.<sup>2</sup>

While there are other forms of delivery and payment mechanisms that address the value battle, such as patient-centered medical homes and bundled payments, ACOs are distinctly different because they more strongly prevent over utilization (the other models are still partly or majorly incentivized to produce volume over value).

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<sup>1</sup> Center for Health Care Strategies, Inc. (September 2016). *Medicaid Accountable Care Organizations: State Update* [Fact Sheet]. Retrieved from: <http://www.chcs.org/media/ACO-Fact-Sheet-9-21-16.pdf>

<sup>2</sup> Accountable Care Organizations (ACOs). (2016, January 1). Retrieved October 27, 2016, from <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html>

The Accountable Care Organization Learning Network names four defining features of ACOs that tackle downfalls of other delivery/payment models:<sup>3</sup>

Underlying Causes of Poor Performance	Principles of Accountable Care
Lack of clarity about aims, and about whose perspectives are most relevant.	Clear aims: better overall health through higher-quality care and lower costs with a focus on patients.
Providers are fragmented and unable to coordinate care well; providers accept responsibility only for what they directly control.	Establish provider organizations accountable for achieving better results for all of their patients at a lower cost.
Payment system drives fragmentation, rewards unnecessary care, and penalizes care coordination and overall efficiency.	Align financial, regulatory, and professional incentives with the aims of better health through higher-quality care, lower costs.
Inadequate information to support provider and patient confidence about the value of reforms.	Valid, meaningful performance measures that support provider accountability for aims and support informed and confident patient care choices.

ACOs have common features between all models:

- ACOs must focus on bettering the overall health of the population they serve. This is achieved through better-coordinated care as well as population health initiatives.
- ACOs must have a stated legal structure with a governing board that is responsible for measuring and improving quality of care.
- Primary care must be the main focus of ACO care delivery. This ensures maximum impact of care at the patient level.
- The population under an ACO’s umbrella of care must be substantially large, as to ensure an adequately sized population for quality benchmarking.
- ACOs must implement “meaningful and identifiable” reforms in patient engagement and care delivery, to demonstrate a significant effort to improve quality and value of patient care.
- ACOs must incentivize a realistically achievable shared savings mechanism for their providers to combat volume-driven care delivery.

ACOs must measure and report quality metrics that are readily accessible to its patients and governing board.<sup>3</sup>

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<sup>3</sup>Fisher, E., & McClellan, M. (2011, January). ACO Toolkit. *Accountable Care Organization Learning Network*, 7-15. Retrieved October 27, 2016, from <https://xteam.brookings.edu/bdacoln/Documents/ACO Toolkit January 2011.pdf>.

## Value-Based Payments

To establish a financial incentive for providers to deliver value instead of volume within Medicaid ACO programs, states typically use one of the following models:

**Shared Savings Arrangement** - Providers participating in an ACO have an opportunity to share in savings if their attributed population uses a less costly set of health care resources than a predetermined baseline (the “upside”). In some cases, providers transition over time to share the risk of providing costlier services (the “downside”), whereby they would have to pay the state back a percentage of costs if they exceed baseline numbers.

**Global Budget Model** - ACOs receive a capitated per-patient payment to provide services and accept full financial risk for the health of their patient population.

To determine how patient costs are measured under either model, states define the type of services offered under ACOs (in addition to physical health services, some Medicaid ACO models include behavioral health, long-term services and supports, pharmaceuticals, and even social services) and calculate the predicted total cost of care of these services, either on a per-patient or population-wide basis.<sup>2</sup>

## Quality Metrics and Improvements

Quality metrics are used to track whether Medicaid ACOs improve patient outcomes and to ensure that providers are not withholding health services to retain savings. States typically require ACOs to measure health outcomes, report process metrics that focus on service delivery, and record patient experience metrics to determine an ACO’s quality performance. These measurements are compared to quality benchmarks, which could be based on either the ACO’s prior performance, the performance of other ACOs, or statewide averages of other health care providers’ performance.

Quality metrics are tied to payment, and providers typically will not receive a portion of shared savings if they do not meet or exceed their quality benchmarks.<sup>4</sup>

## Data Analysis and Health Information Technology

Timely and accurate data collection and analysis are essential to a Medicaid ACO’s operation, since data allows ACOs to track patient utilization and costs, and target patients for care management interventions and programs. States implementing ACOs must establish and maintain their own data infrastructure to adequately support ACOs and determine which entity will “own” — i.e., store and analyze — ACO data. States may consider helping providers with financial resources to facilitate the implementation of health information technology that supports ACO data management needs.

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<sup>4</sup> Center for Health Care Strategies, Inc. (September 2016). *Medicaid Accountable Care Organizations: State Update* [Fact Sheet]. Retrieved from: <http://www.chcs.org/media/ACO-Fact-Sheet-9-21-16.pdf>

## Successes of Medicaid ACOs

While Medicaid ACOs are still a relatively new phenomenon, some state programs have shown promising results:

- **Colorado's** *Regional Care Collaborative Organizations* (RCCOs) have reported \$77 million in net savings for Colorado Medicaid. RCCOs have demonstrated lower rates of emergency department (ED) visits, high-cost imaging, and hospital readmissions for adult patients who have been enrolled in the program for more than six months.
- **Minnesota** attributed \$76.3 million in savings to its Integrated Health Partnerships program within its first two years. All nine IHPs achieved shared savings, exceeded their quality targets, and collectively reduced inpatient and ED utilization among patients served during the program's second year.
- **Oregon** reported that ED visits for patients served by its Coordinated Care Organizations decreased 23 percent, admissions for short-term complications from diabetes dropped 32 percent, and admissions related to asthma and chronic obstructive pulmonary disease decreased 68 percent. In FY 2015, all CCOs showed improvement in quality measure performance, and 15 of the 16 earned 100 percent of their potential quality pool bonuses. These improvements have allowed the state to stay well within its two percent annual growth target.
- **Vermont** reported \$14.6 million in savings due to its Vermont Medicaid Shared Savings Program (VMSSP) in the program's first year. Both of the state's Medicaid ACOs achieved significant savings and exceeded their quality benchmarks to receive shared savings distributions.

These early efforts demonstrate the value of connecting providers' reimbursement to patient health outcomes and cost savings rather than the volume of services, as in the traditional fee-for-service model. Although the model is still evolving, Medicaid ACOs offer significant potential for positive change at the provider level to support a healthier population at lower cost.

The following table from the Center for Health Care Strategies, Inc. (next page) includes 11 programs from the 10 states that have implemented Medicaid ACOs and provides basic information about how the programs are designed, including their payment models, approaches to quality measurement, and the scope of services included in the total cost of care.<sup>5</sup>

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<sup>5</sup> Fisher, E., & McClellan, M. (2011, January). ACO Toolkit. *Accountable Care Organization Learning Network*, 7-15. Retrieved October 27, 2016, from [https://xteam.brookings.edu/bdacoln/Documents/ACO Toolkit January 2011.pdf](https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf).

## Conclusion

LDH anticipates that ACO models in Medicaid can improve quality while reducing costs. Medicaid ACOs have been successful in other states, producing savings while improving quality. By holding providers financially accountable, they are incentivized to provide top-quality care.

Additional attachments for review and consideration in this report include the following:

1. **Attachment A:** Request for Information (RFI) for Provider-Led Accountable Care Organizations
2. **Attachment B:** Findings Summary: Request for Information: Provider-Led Accountable Care Organizations
3. **Attachment C:** RFI Responses
  - LSU Health Sciences Center New Orleans
  - Medicaid ACO Exploratory Committee of the Louisiana Primary Care Association
  - Res-Care, Inc.
  - AmeriHealth Caritas – Redacted
  - Gateway Health
  - Blue Cross Blue Shield of Louisiana
  - Franciscan Missionaries of Our Lady Health System and LCMC Health (Jointly)
  - Aetna
  - Amerigroup
  - Louisiana Healthcare Connections
  - UnitedHealthcare
  - 504HealthNet
  - GlaxoSmithKline
  - Louisiana Public Health Institute
  - Planned Parenthood Gulf Coast
4. **Attachment D:** Center for Healthcare Strategies, Inc. Program Design Considerations for Medicaid Accountable Care Organizations

State	Program Name	Governance Structure	Scope of Service	Payment Model	Quality Measurement
Colorado	Accountable Care Collaborative	Care coordination management entity (geographic)	<ul style="list-style-type: none"> <li>Physical health</li> </ul>	Care coordination payment and pay-for-performance	Three quality measures tied to payment
Illinois	Accountable Care Entities	Provider-led	<ul style="list-style-type: none"> <li>Physical health</li> <li>Behavioral health</li> </ul>	Care coordination payment transitioning to shared savings and then capitation over three years	29 quality measures, four tied to payment
Maine	Accountable Communities Initiative	Provider-led	<ul style="list-style-type: none"> <li>Physical health</li> <li>Behavioral health</li> <li>Long-term services/supports (optional)</li> <li>Dental (optional)</li> </ul>	Shared savings using two tracks: (1) upside only; and (2) upside/downside	17 quality measures, including 14 core measures and three elective measures; all tied to payment
Minnesota	Integrated Health Partnerships	Provider-led, with two tracks: (1) Integrated - larger systems that provide inpatient and outpatient care; (2) Virtual - smaller systems not formally integrated with a hospital	<ul style="list-style-type: none"> <li>Physical health</li> <li>Behavioral health</li> <li>Pharmacy</li> </ul>	Shared savings using two tracks: (1) virtual - upside only; and (2) integrated - upside/downside	32 quality measures scored as nine aggregate measures; all measures are reported in year-one, then increasingly tied to payment
New Jersey	Medicaid Accountable Care Organization Pilot	Community-led (geographic)	<ul style="list-style-type: none"> <li>Physical health</li> </ul>	ACOs and MCOs negotiate an upside only shared savings agreement <sup>6</sup>	27 quality measures, 21 mandatory measures and six voluntary measures; all tied to payment
New York	Accountable Care Organizations	Provider-led	<ul style="list-style-type: none"> <li>Physical health</li> </ul>	Shared savings or shared savings/risk contracts are negotiated between ACOs and MCOs	ACO must propose a quality management and improvement program (which includes quality metrics) to the state for approval
Oregon	Coordinated Care Organizations	Payer-led (geographic)	<ul style="list-style-type: none"> <li>Physical health</li> <li>Behavioral health</li> <li>Dental</li> </ul>	Global budget capped at two percent growth rate. Quality pool bonus available via four percent withhold	33 quality measures, 17 tied to quality pool payment
Rhode Island	Accountable Entities (AE) Pilot	Provider-based entities contracting with MCOs under shared savings arrangements specified by the state Two AE tracks: (1) All populations; and (2) SPMI/SMI only	<ul style="list-style-type: none"> <li>Physical health</li> <li>All Medicaid services that are covered by Executive Office of Health and Human Services' (EOHHS) contracts with MCOs</li> <li>Does not include services reimbursed by EOHHS fee-for-service programs</li> </ul>	Negotiated by the two parties in the arrangement (AE and MCO), reviewed and approved by the state. Must be: (1) total cost of care based; (2) include attributed lives in accordance with state guidance; and (3) be shared savings only	Negotiated by the parties in accordance with state guidelines; reviewed and approved by the state
Utah	Accountable Care Organizations	Payer-led	<ul style="list-style-type: none"> <li>Physical health</li> </ul>	Capitated payment	25 quality measures, not tied to payment
Vermont	Vermont Medicaid Shared Savings Program	Provider-led	<ul style="list-style-type: none"> <li>Physical health</li> <li>Long-term services/supports (optional)</li> <li>Behavioral health (optional)</li> <li>Pharmacy (optional)</li> </ul>	Shared savings using two tracks: (1) upside only; and (2) upside/downside	Core set of 28 measures, eight tied to payment
Vermont	Next Generation Accountable Care Organization	Provider-led	<ul style="list-style-type: none"> <li>Physical health</li> <li>Behavioral health</li> </ul>	Prospective capitation plus quality withhold, with full risk (no savings/losses cap)	Quality withhold (3%-5% over time) tied to performance on six measures

<sup>6</sup> Center for Health Care Strategies, Inc. (September 2016). *Medicaid Accountable Care Organizations: State Update* [Fact Sheet]. Retrieved from: <http://www.chcs.org/media/ACO-Fact-Sheet-9-21-16.pdf>

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HEALTH**

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**MEDICAL VENDOR ADMINISTRATION**

**Office of the Medicaid Director**

**Request for Information for**

**Provider-Led Accountable Care Organizations**

**Release Date: November 4, 2016**

**Responses Due: ~~December 9, 2016~~ January 31, 2017**

LOUISIANA DEPARTMENT OF HEALTH  
REQUEST FOR INFORMATION  
Provider-Led Accountable Care Organizations

11/4/2016

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## Section I. Overview

As part of its efforts to modernize payment mechanisms for Louisiana's Medicaid program and its delivery system features, to shift from paying for *volume* to paying for *value* and to improve health care quality and outcomes, the Louisiana Department of Health (LDH) is seeking comment on the possibility of inviting provider-led managed care plans to participate in the Healthy Louisiana Medicaid managed care program as Accountable Care Organizations (ACOs). As defined by the Centers for Medicare and Medicaid Services, an ACO is a group of doctors, hospitals, and other healthcare providers who come together voluntarily to give high-quality coordinated care to their patients. Successful care coordination ensures that patients receive the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.<sup>1</sup> Following the lead of successful ACO programs in other states, LDH is optimistic that an ACO model would improve quality for Medicaid patients while bettering the state's financial stability by combatting rising healthcare costs.

ACOs would contract directly with the state as a provider led managed care plan to manage the care of a population of Medicaid recipients in exchange for a fixed per-member per-month rate. LDH intends to re-procure its current Medicaid managed care contracts and is examining ACOs in addition to, rather than as replacements for, traditional MCOs.

LDH is in the process of developing requirements related to ACOs, but expects that ACOs would be:

- A) Organizations or groups of organizations for which each member organization is a hospital as defined by La. R.S. 40:2102; a federally-qualified health center (FQHC) as defined by La. R.S. 40:1185.3(2); or a rural health clinic (RHC) as defined by La. R.S. 40:1185.3(3);
- B) Capable of providing for the case management and primary and secondary care needs of no fewer than 10,000 Medicaid beneficiaries annually;
- C) Owned, governed, and led by Louisiana health care providers; and
- D) Sufficiently capitalized and structurally prepared to assume both insurance and performance risk associated with the provision of full Medicaid benefits to a population of recipients.

LDH anticipates a potential need for some or all ACOs to contract with third party health care providers to ensure full care coverage and third party administrators (TPAs) for claims processing services.

While this RFI does not bind the state to procuring for provider-led plans, LDH is highly interested in the ACO approach and is working to procure capable, high-quality ACO contractors as part of its Medicaid managed care procurement process in SFY 2019. Through this Request for Information (RFI), LDH is seeking community input on the development of requirements for the provider led ACOs. Vendors should refer to the response format in this document for clarification of the nature of information sought by LDH.

For the purposes of this RFI, the provisions of the Louisiana Public Records Act (La. R.S. 44.1 *et. seq.*) will be in effect. Pursuant to this Act, all proceedings, records, contracts, and other public documents relating to this RFI shall be open to public inspection. Proposers are reminded that, while trade secrets

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<sup>1</sup> Accountable Care Organizations (ACOs). (2016, January 1). Retrieved October 27, 2016, from <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html>

and other proprietary information submitted in conjunction with this RFI may not be subject to public disclosure, protections must be claimed by the proposer at the time of submission of its Technical Proposal. Proposers should refer to the Louisiana Public Records Act for further clarification.

## Section II. Background

In the America's Health Rankings 2015 Annual Report, Louisiana ranked last in the country in overall health.

- 50th in health behavior (e.g., physical inactivity, obesity, % of adult population that smokes)
- 50th in community and environmental factors (e.g. children in poverty, infectious disease)
- 50th in clinical care (e.g., % of live births that are low birth weight, preventable hospitalizations)
- 50th in outcomes (e.g., infant mortality, premature death, cardiovascular deaths)

To promote better health, LDH seeks to shift its payment system from volume to value and its delivery system from a focus on disease to a focus on population health.

LDH's vision is to pay for value by promoting the Triple Aim:

- Improved patient experience of care
- Improved population health
- Spending resources wisely

ACOs have common features between all models:

- ACOs must focus on bettering the overall health of the population they serve. This is achieved through better-coordinated care as well as population health initiatives.
- ACOs must have a stated legal structure with a governing board that is responsible for measuring and improving quality of care.
- Primary care must be the main focus of ACO care delivery. This ensures maximum impact of care at the patient level.
- The population under an ACO's umbrella of care must be substantially large, as to ensure an adequately sized population for quality benchmarking.
- ACOs must implement "meaningful and identifiable" reforms in patient engagement and care delivery, to demonstrate a significant effort to improve quality and value of patient care.
- ACOs must incentivize a realistically achievable shared savings mechanism for their providers to combat volume-driven care delivery.
- ACOs must measure and report quality metrics that are readily accessible to its patients and governing board.<sup>2</sup>

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<sup>2</sup> Fisher, E., & McClellan, M. (2011, January). ACO Toolkit. *Accountable Care Organization Learning Network*, 7-15. Retrieved October 27, 2016, from [https://xteam.brookings.edu/bdacoln/Documents/ACO Toolkit January 2011.pdf](https://xteam.brookings.edu/bdacoln/Documents/ACO%20Toolkit%20January%202011.pdf)

Because of these common features, the ACO initiative is envisioned as potentially helping the state advance its value based payment goals by vesting providers who are ready and interested with responsibility and accountability for care management and total cost of care. LDH's goal in this initiative is to imbue providers with the flexibility necessary to appropriately and rationally deliver services according to patient needs by sharing both the financial benefits of delivering appropriate care and the burdens of inefficient care.

The ACO initiative is but one of multiple reform options under consideration by LDH in the development of a Transformation Roadmap to build on major reforms over the past five years, including the launch of Medicaid managed care, privatization of the state charity hospital system, and Medicaid expansion through which Louisiana has extended coverage to more than 325,000 residents. The Roadmap will be informed by a robust stakeholder engagement process currently in progress, including but not limited to this RFI.

### **Section III. Questions for Respondents**

Please use the attached form to answer the following questions. Respondents are not required to answer all questions.

#### ***A. ACO Requirements***

LDH envisions establishing requirements for provider led ACOs that mirror requirements for the Medicaid managed care organizations currently participating in the Healthy Louisiana Managed Care Program. LDH seeks the following information related to requirements for ACOs.

1. Are there any exceptions or modifications to [current requirements](#) that LDH should consider to encourage ACO participation (e.g., special licensure and solvency requirements)?<sup>3</sup>
2. What governance principles and/or requirements should LDH consider implementing to ensure that ACOs are governed and led by Louisiana providers?
3. Are there any interim steps or technical assistance that LDH could provide to promote providers' ability to develop ACOs over time?
4. Are there any other unique requirements that LDH should consider applying to ACOs?

#### ***B. ACO Functions***

ACOs would be expected to provide all functions of a traditional MCO, including but not limited to: claims adjudication and payment, marketing, member services, provider network development, credentialing, prior authorization, care management, data analytics and quality reporting. ACOs would also be expected to offer the same set of benefits to enrollees as that offered by current MCOs.<sup>4</sup> LDH seeks the following information related to key ACO functions.

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<sup>3</sup> Managed Care Contract Requirements listed in Request for Proposals linked here:  
<http://www.ldh.la.gov/assets/docs/contracts/BayouHealthPrepaidFINAL72814.pdf>

<sup>4</sup> For more information on Louisiana's covered benefits, please see:  
[http://dhh.louisiana.gov/assets/docs/Making\\_Medicaid\\_Better/Medicaid\\_Services\\_Chart.pdf](http://dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/Medicaid_Services_Chart.pdf)

1. Should ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan?
2. Are there any key functions that LDH should not permit the provider led ACO to delegate to another entity?
3. Are there certain functions that LDH should consider standardizing or centralizing to facilitate ACO development and to ease provider administrative burden?
  - a. Should these functions be standardized across ACOs and MCOs?

### ***C. ACO Populations***

LDH envisions that ACOs, like the state's traditional MCOs, would serve all Medicaid members who are eligible for enrollment in Healthy Louisiana. LDH seeks the following information related to populations to be served by ACOs.

1. Should LDH permit ACOs to serve specific regions, rather than enrolling Medicaid members statewide?
  - a. Would ACOs be able to develop statewide networks?
2. If LDH were to permit ACOs to serve specific regions, would the ACOs have large enough enrollment to support the infrastructure needed for ACO functions and to take on financial risk?
3. How should populations defined or limited for ACO enrollment, if at all?

### ***D. Selection of ACOs***

LDH would likely procure ACOs as part of its standard MCO procurement process. LDH seeks the following information related to ACO selection.

1. What are the most important characteristics and qualifications for LDH to consider in selecting ACOs?

### ***E. Other Strategies***

As described above, LDH is seeking to implement strategies that promote and encourage provider accountability for care management and the total cost of care for Medicaid enrollees.

1. Are there other managed care contracting or payment models that LDH can implement to achieve its goals?
  - a. For example, should LDH encourage or require MCOs to contract with ACOs or implement other alternative payment arrangements with providers?

## **Section IV. Statement of Interest (For Potential ACO Respondents Only)**

1. Please describe your interest in becoming an ACO.
2. Please describe the Medicaid population(s) you currently serve.
3. Please describe the services you currently provide to these populations.

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4. Would your ACO be able to enroll and serve all Healthy Louisiana populations statewide? If not, please describe the region(s) of the state you would be able to serve.
5. Would your ACO be able to enroll and serve all Healthy Louisiana eligibility groups? If not, please describe the population your ACO would serve.
6. Does your organization currently participate in any risk arrangements or contracts with Medicaid, Medicare or commercial payors? If so, please describe these (e.g., the type of arrangement, the payor—Medicaid, Medicare or commercial, etc.).
7. Does your organization currently participate in or own an Accountable Care Organization (ACO)?
8. Does your organization currently have capacity in the following areas needed to serve as an ACO?
  - Marketing
  - Claims adjudication and payment
  - Network development
  - Provider services
  - Member services
  - Prior authorization
  - Patient outreach and education
  - Care management
  - Data analytics
  - Quality measurement and reporting
9. What capacity would your organization need to obtain to serve as an ACO?
10. How might your organization obtain needed capacity?
11. When would your organization be ready to respond to an LDH procurement for ACOs?

## Section V. RFI Submission Instructions

Responders are encouraged to propose efficient options for providing solutions that enable Louisiana Medicaid to reach its goals, including recommending what resources will be required. Responders are encouraged to be as detailed as possible and encouraged to suggest and comment on any other related issues not specially outlined herein.

Responses are due by **5:00 p.m. CT on ~~Friday, December 9, 2016~~ Tuesday, January 31, 2017.** Responses should be delivered via email. Responses should be limited to twenty 8 ½ x 11 pages and identified as **ACO RFI Response** on the electronic subject line. Proposers interested in participating in this RFI should send an electronic copy of their response to the email address below:

Louisiana Department of Health, Bureau of Health Services Financing  
Frank Opelka  
[Frank.opelka@la.gov](mailto:Frank.opelka@la.gov)

Medicaid Program Manager

## **Section VI. Additional Information – Purpose, Disclaimer, Ownership, and Confidentiality**

This RFI is issued as a means of technical discovery and information gathering. It is for planning purposes only, and should not be construed as a solicitation for services or a request for proposals (RFP), nor should it be construed as an obligation on the part of the state to purchase services. This RFI is not a means of pre-qualifying vendors for any subsequently issued RFP related to this RFI. RFI responses are non-binding on the state or respondent.

### **Liabilities of Agency**

This RFI is only a request for information about potential products/services and no contractual obligation on behalf of LDH or BHSF whatsoever shall arise from the RFI process.

This RFI does not commit the LDH or BHSF to pay any cost incurred in the preparation or submission of any response to the RFI.

### **Confidentiality and RFI Ownership**

All responses to the RFI will become the property of LDH and will not be returned.

The designation of certain information as trade secrets and/or privileged, confidential, or proprietary information shall only apply to the technical portions of your response to this Request for Information. Any response to this request marked as copyrighted or marked as privileged, confidential, or proprietary **in its entirety** is subject to rejection without further consideration or recourse based on the professional opinions of LDH legal staff.

Respondents should bear in mind that while trade secrets and other proprietary information submitted in conjunction with this RFI may not be subject to public disclosure, ***the submitting party must claim protections at the time of submission.*** The following guidelines provide accurate instructions to mark adequately certain information as privileged, confidential, or proprietary.

- The respondent must clearly designate the part of the response that contains a trade secret and/or privileged or confidential proprietary information as “confidential” in order to claim protection, if any, from disclosure. The respondent shall mark the cover sheet of the response with the following legend, specifying the section(s) of the response sought to be restricted in accordance with the conditions of the legend:  
*“The data contained in pages \_\_\_\_\_ of this response have been submitted in confidence and contain trade secrets and/or privileged or confidential information, and such data shall only be disclosed for evaluation purposes. This restriction does not limit the state of Louisiana’s right to use or disclose data obtained from any source, including the proposer, without restrictions.”*

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- Further, to protect such data, respondents should identify and mark each page containing such data as “CONFIDENTIAL.” A watermark or footnote delineating each page containing such data as “confidential” will satisfy this requirement.

Respondents must be prepared to defend the reasons why material should be held as confidential. If another respondent or entity seeks to review copies of a respondent’s confidential data, LDH will notify the owner of the asserted data of the request. If the owner of the asserted data does not want the information disclosed, it must take legal action as necessary to restrain LDH from releasing information LDH believes to be public record.

If the response contains confidential information, the respondent should submit a redacted copy of the response. Without the submission of a redacted copy, LDH may consider the entire response to be public record. When submitting the redacted copy, it should be clearly marked on the cover as a “REDACTED COPY.” The redacted copy should also state which sections or information have been removed.

## Attachment: Response Form

### RESPONDENT INFORMATION

First Name:

Last Name

Title:

Organization:

Address:

Contact Phone:

Contact Email:

Responding as an Individual: (Y/N)

Responding on Behalf of Organization: (Y/N)

Check all that describe your organization:

Hospital or Hospital System

Clinical System

Advocacy Organization

Health Plan

Physician

Non-physician Health Care Provider

Other – Please Describe: \_\_\_\_\_

**RESPONSES**

**Section III.**

***A. ACO Requirements***

- Question 1.
- Question 2.
- Question 3.
- Question 4.

***B. ACO Functions***

- Question 1.
- Question 2.
- Question 3.
- (a)

***C. ACO Populations***

- Question 1.
- (a)
- Question 2.

***D. Selection of ACOs***

- Question 1.
- Question 2.
- Question 3.

***E. Other Strategies***

- Question 1.
- (a)

**Section IV. Statement of Interest (if applicable)**

- Question 1.
- Question 2.
- Question 3.
- Question 4.
- Question 5.
- Question 6.
- Question 7.
- Question 8.
- Question 9.
- Question 10.

## ATTACHMENT B

### **Findings Summary: Request for Information: Provider-Led Accountable Care Organizations**

#### *Executive Summary*

On May 31, 2016, the Louisiana Legislature passed House Concurrent Resolution 77 by Representative Jack Montoucet (HCR 77), urging and requesting the Louisiana Department of Health (LDH) to evaluate and report on prospective models for improving care management in the then “Bayou Health” managed Medicaid program in advance of the next Medicaid managed care request for proposals (RFP). HCR 77 specifically requested that LDH examine the feasibility and advisability of implementing an accountable care organization (ACO) model within the managed care program, defining an ACO as a “group of physicians, hospitals, and other healthcare providers who come together voluntarily to deliver coordinated, high-quality care to their patients.” As a result of HCR 77, LDH’s internal desire to explore alternative payment models to incentivize cost-effective, high-quality care, and feedback from external stakeholders, on November 4, 2016 LDH released a Request for Information (RFI) for Provider-Led ACOs (ACO RFI). This report synthesizes stakeholder feedback since and resulting from that ACO RFI.

Fifteen stakeholders provided formal responses to the ACO RFI, including six (6) providers, seven (7) health plans, one (1) health care supplies manufacturer, and one (1) health policy institute. Overall responses showed a willingness to participate in value-based payment (VBP) models of varying degrees of sophistication, ranging from simple pay-for-performance arrangements to shared savings agreements to full-risk ACOs. No provider, however, expressed an imminent readiness to operate a full-risk ACO and providers were generally more supportive of a regional ACO model with downstream potential to shift toward a statewide model. Health plan respondents, on the other hand, generally urged caution in adopting a regional approach, noting the strong risk of urban-rural industry fragmentation; complexity of maintaining managed care organization (MCO) network adequacy and efficient provider rates alongside regional ACO; and the need for ACO-MCO parity in financial, compositional, and licensure standards. Health plans did note that the possibility of developing a regional ACO within an MCO could ameliorate many of these issues.

A number of issues drew broad consensus, building a foundation for LDH’s VBP/ACO strategy. Respondents generally encouraged local ownership requirements with a board composition of providers, population management, and financial experts. There was agreement that ACOs should be permitted to contract with an MCO for third-party administrative services, with plans generally supporting making such services mandatory. Consensus also heavily emphasized the need for a statewide source of health care data and information exchange and for provider-facing care quality feedback. Respondents also supported a mandatory minimum ACO capacity for 10,000 beneficiaries and a showing of both solvency and sufficient capitalization to support the level of risk involved, although plans again generally suggested the additional requirement that ACOs demonstrate financial stability on par with a Medicaid managed care organization and, potentially, even become a licensed health maintenance organization (HMO).

On balance, responses favored a ramped-up approach to ACOs and VBP, generally. Respondents favored either regional pilots or a strong MCO-based VBP push with a long-run goal of building capacity for providers to manage risk, whether through a provider-led health plan or otherwise.

## **Section I. ACO Requirements**

The first set of questions asked respondents to describe necessary or beneficial ACO requirements. Key response themes were the need for financial solvency requirements, consensus around a 10,000 patient minimum, provider-focused governance, and a strong need for LDH to invest in health information technology (HIT) and health information exchange (HIE) infrastructure. In addition to these responses, there was also strong agreement among plans that solvency, credentialing, and operating requirements of ACOs should mirror those of MCOs.

- 1. Are there any exceptions or modifications to current requirements that LDH should consider to encourage ACO participation (e.g. special licensure and solvency requirements)?*

Seven of the nine respondents that answered this question noted the need for basic financial requirements, and most recommended that these requirements mirror those of the MCOs. Five of the nine respondents and all but one of the plans recommended that overall ACO requirements should be effectively identical to that of the MCOs. One plan advised a more flexible approach to permit unconventional ACO models, but did recommend that ACOs be required to maintain an insurer's license.

- 2. What governance principles and/or requirements should LDH consider implementing to ensure that ACOs are governed and led by Louisiana providers?*

Respondents generally suggested that either ownership or board composition or both be at least 50 percent practicing providers. One respondent suggested requiring as much as 75 percent of the board be primary care providers (PCPs) and 80 percent of ownership be physicians, with a preference for 100 percent. On the other hand, another responded counseled avoiding strict board composition standards, noting that ACOs need the flexibility to develop a strong mix of multidisciplinary expertise to effectively guide policy. Consensus held that governance should be by local, active members of the health care industry. Several respondents also strongly recommended including a patient representative in the governance composition requirements.

- 3. Are there any interim steps or technical assistance that LDH could provide to promote providers' ability to develop ACOs over time?*

The overwhelming response to this question was that LDH needs to help providers build HIE and HIT infrastructure. Every respondent with ACO experience noted that successful ACOs *must* have access to both patient records and to a continuous stream of quality metrics to permit them to monitor and improve care delivery before measurement turns into payment. Respondents strongly suggested focusing on a robust information exchange platform that permits analytics, whether a traditional HIE or otherwise.

A large number of respondents – primarily health plan respondents – suggested emphasizing less sophisticated VBP strategies as an interim strategy for preparing providers to assume full risk in an ACO setting. In general, this suggestion was to include specific VBP targets within the MCO arrangements and permit the MCOs to meet providers where they are and bring each provider along at a pace at which it is comfortable. Many MCOs – not all of which serve the Louisiana Medicaid market – noted that ACOs are high-risk ventures for providers and few, if any, have the necessary infrastructure for the care coordination and risk management necessary to succeed in a full-risk setting. MCOs also emphasized how critical early ACO success is for the model to reach sustainability.

One respondent recommended LDH consider procuring an experienced vendor to administer the overall ACO program. This vendor would assist ACOs develop the capacity necessary to successfully manage a population, provide claims data and analytics, oversee performance, evaluate the overall operation of the model, develop necessary infrastructure, and managed the system.

*4. Are there any unique requirements that LDH should consider applying to ACOs?*

Responses to this question were highly variable. Plans generally agreed that ACOs should align with MCOs. A few noted that ACOs should be held to the same fee floors and access requirements as MCOs. Provider responses generally emphasized robust access across the entire spectrum of needs, a population-specific approach to care, and a strong desire for a single formulary.

## **Section II. ACO Functions**

Questions in this section had a high degree of consensus around a very narrow set of core principles and recommendations. Providers and plans agreed that ACOs should be allowed to contract for third-party administrator (TPA) services, and plans generally felt that this should be mandatory. Few nondelegable duties were identified and those that were tended to be central to operation of a care management entity. There was broad consensus that provider credentialing and data exchange should be centralized. There was also broad consensus that functions should be standardized across ACOs and MCOs.

*1. Should ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan?*

Every respondent answered this question in the affirmative or did not respond. Several plans recommended that LDH make this requirement mandatory. One health plan noted that this relationship needs to be built properly to avoid conflicts of interest where the MCO has a financial interest in the ACO. It suggested implementing Florida Medicaid's disqualification language to prevent such issues.

*2. Are there any key functions that LDH should not permit the provider-led ACO to delegate to another entity?*

Care management, network development, quality measurement, and board management were all noted. Responses generally favored latitude for functions that were not critical to the identity of the ACO.

- 3. Are there any functions that LDH should consider standardizing or centralizing to facilitate ACO development and to ease provider administrative burden?*

Provider credentialing and data exchange and analytics had strong consensus. Multiple providers also suggested a statewide, single formulary.

- 4. Should these functions be standardized across ACOs and MCOs?*

With little variation, responses simply offered support for this goal.

### **Section III. ACO Populations**

Responses split between groups supporting regional ACOs and groups supporting statewide ACOs in this section. Broadly, providers supported regional ACOs serving a subset of the Medicaid population, while plans supported a statewide ACO standing alongside the existing MCOs. A few plans also noted the potential for a regional ACO operating within a statewide MCO.

- 1. Should LDH permit ACOs to serve specific regions, rather than enrolling Medicaid members statewide?*

One of the major provider respondents noted that a regional approach fits closely with providers' current structure and would permit later growth into a statewide ACO. This provider also suggested the possibility of the state examining a statewide ACO serving a narrow class of beneficiaries.

Health plans generally cautioned against the regional approach, raising several fundamental issues. If the ACO provides regional coverage, LDH would need to ensure that providers within that ACO continue to serve non-ACO Medicaid clients to maintain access. Furthermore, such non-ACO clientele would need to be served at reasonable rates to ensure the ACO does not use its position to increase price for either the MCOs or LDH. Additionally, because ACO-ready providers are heavily concentrated in urban areas, shifting to a regional model runs significant risk of creating a two-tiered system of coverage, where urban recipients are covered by ACOs and rural recipients receive care through MCOs with increasingly rural networks. Concerns about the effect of a regional ACO on the structure of the overall environment were pervasive and were not limited to Louisiana Medicaid participants.

- 2. If LDH were to permit ACOs to serve specific regions, would the ACO have large enough enrollment to support the infrastructure needed for functions and take on financial risk?*

A few plans noted concerns with this issue, but there was not a broad consensus.

- 3. How should populations be defined or limited for ACO enrollment, if at all?*

Several respondents recommended omitting the waiver populations at first. One respondent requested LDH consider the inclusion of the LTSS population and providers in this model, generally.

#### **Section IV. Selection of ACOs**

- 1. What are the most important characteristics and qualifications for LDH to consider in selecting ACOs?*

Respondents emphasized several previous answers related to qualifications. Ability to ensure access and experience with case management were often emphasized.

#### **Section V. Other Strategies**

- 1. Are there other managed care contracting or payment models that LDH can implement to achieve its goals?*

Respondents suggested a number of significant VBP measures, including bundled payments for specialty care, gainsharing with an end-goal of capitation, minimum (percentage-based) thresholds for VBP in MCO contracts, global payments, and health homes.

One respondent suggested focusing on high return-on-investment care targeted at women of reproductive age.

#### **Section VI. Statement of Interest**

Three providers responded to portions of the statement of interest questions. One of these responses was submitted confidentially. LSUHSC-New Orleans expressed interest in participating in an ACO, although it did not specifically discuss the potential to create or managed such an ACO. Res-Care responded as a potential LTSS-focused ACO provider member. Res-Care provides residential, pharmacy, and home care services to several hundred Louisiana Medicaid recipients.

#### **Section VI. Statement of Interest – REDACTED**

Attachment C

LOUISIANA DEPARTMENT OF HEALTH  
REQUEST FOR INFORMATION  
Provider-Led Accountable Care Organizations

11/4/2016

**Attachment: Response Form**

**RESPONDENT INFORMATION**

First Name: **Chris**  
Last Name: **Vidrine**  
Title: **Director of External Affairs**  
Organization: **LSU Health Sciences Center New Orleans**  
Address: **433 Bolivar St., New Orleans, LA 70112**  
Contact Phone: **504-568-8976**  
Contact Email: [cvidr1@lsuhsc.edu](mailto:cvidr1@lsuhsc.edu)

Responding as an Individual: (Y/N)

**N**

Responding on Behalf of Organization: (Y/N)

**Y (LSU Health Sciences Center New Orleans)**

Check all that describe your organization:

- Hospital or Hospital System
- Clinical System
- Advocacy Organization
- Health Plan
- Physician
- Non-physician Health Care Provider
- Other - Please Describe:

**Health Care University (Medical, Dental, Nursing  
Allied Health, Public Health, Graduate Studies)**

## **RESPONSES**

### **Section III.**

#### **A. ACO Requirements**

**1. Are there any exceptions or modifications to current requirements that LDH should consider to encourage ACO participation (e.g., special licensure and solvency requirements)?**

Answer: The requirements should include provisions that ensure that health care training institutions are able to participate such that future health care inter-professionals have been exposed to and have participated in progressive models of primary care / coordinated care. This might include additional payments to support faculty involved in teaching in an appropriate setting.

**2. What governance principles and/or requirements should LDH consider implementing to ensure that ACOs are governed and led by Louisiana providers?**

Answer: The governance should require a high percentage of Louisiana primary care physicians to be members of the governing board.

**3. Are there any interim steps or technical assistance that LDH could provide to promote providers' ability to develop ACOs over time?**

Answer: It is advised that interim steps be taken in the move towards an ACO. Initially, the Fee For Service (FFS) model could remain prevalent. Over the course of a transition period, the programs would adapt progressive payment models, similar to those seen implemented by Medicare, to encourage value-based care:

- Pay for "transition of care" codes at a higher rate, encouraging patients to get care early when discharged in an effort to reduce hospital readmissions.
- Pay for telephonic care management similar codes used by Medicare for chronic care management. Some patients can be assisted without bringing them in for office visits, opening up access to patients who need to be seen in a face-to-face setting.
- Incentivize patients and providers to do wellness exams to address preventive health, immunizations, screenings, tobacco cessation, and advance directives.
- Pay for electronic consults between specialists and primary care physicians, thus reducing wait times for specialists and freeing up their access slots for the most serious patients.
- Include a Per Member Per Month (PMPM) fee that would allow the primary care team to pay for outreach to patients in the population.

**4. Are there any other unique requirements that LDH should consider applying to ACOs?**

Answer: LDH may consider an ACO model that encompasses sharing a percentage of revenue dollars to support loan forgiveness for health care professionals who elect to practice primary care in areas of need or accept a faculty position in primary care. This program could be tied in with the existing LSU Health New Orleans Rural Scholars Track ([https://www.medschool.lsuhschool.edu/family\\_medicine/rural\\_scholars.aspx](https://www.medschool.lsuhschool.edu/family_medicine/rural_scholars.aspx)) or federal programs associated with Health Professional Shortage Areas (HPSAs).

**B. ACO Functions**

**1. Should ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan?**

Answer: An ACO could participate with a health plan but consideration should be given to assure that providers, especially primary care providers, play a majority rule in the governance.

**2. Are there any key functions that LDH should not permit the provider led ACO to delegate to another entity?**

Answer: LDH should not permit provider led ACO delegate policies regarding care processes to another entity.

**3. Are there certain functions that LDH should consider standardizing or centralizing to facilitate ACO development and to ease provider administrative burden?**

**a. Should these functions be standardized across ACOs and MCOs?**

Answer: The majority of performance measures, such as HEDIS, should be standardized as much as possible, leaving flexibility in a few measures to account for certain populations which may be more highly represented.

**C. ACO Populations**

**1. Should LDH permit ACOs to serve specific regions, rather than enrolling Medicaid members statewide?**

**a. Would ACOs be able to develop statewide networks?**

Answer: Regional Medicaid Networks, if they have enough patients and are able to provide all the services (hospital, office, home health, nursing home, etc.) may make sense for patients. A huge network might be tempted to offer services in regions that are too distant to be practical for patients from outlying regions.

- 2. If LDH were to permit ACOs to serve specific regions, would the ACOs have large enough enrollment to support the infrastructure needed for ACO functions and to take on financial risk?**

Answer: This obviously depends on the overall health of the region. LSUHSC New Orleans would recommend inclusion of a primary care patient risk score. These data will help create generalizations about region populations and will allow for better estimation of financial exposure and overall population risk.

Massachusetts is currently approved on a CMS 1115 demonstration to transform their Medicaid model from pure Fee-For-Service (FFS) to accountable care, an effort they are calling MassHealth Restructuring. From reading their 1115 waiver submittal to CMS, the state is using the University of Massachusetts Medical School's Center for Health Policy and Research to conduct data collection and evaluation.

<http://www.mass.gov/eohhs/gov/commissions-and-initiatives/healthcare-reform/masshealth-innovations/1115-waiver-proposal-information.html>

LSUHSC New Orleans would recommend a similar approach in support of this ACO effort. A joint effort between LDH and LSU Health Sciences Center (Schools of Medicine, Allied Health, and Public Health specifically) could bring a very powerful set of skills to addressing health care modernization in Louisiana while leveraging the robust and diverse health care workforce associated with LSU Health Sciences Center.

- 3. How should populations defined or limited for ACO enrollment, if at all?**

Answer: It would be ideal to understand severity of risk of the populations served so that costs can be measured against risk.

#### ***D. Selection of ACOs***

- 1. What are the most important characteristics and qualifications for LDH to consider in selecting ACOs?**

Answer: The state needs to be sure the ACOs include a component that includes trainees so that future providers understand how to work together in integrated networks and work efficiently.

#### ***E. Other Strategies***

- 1. Are there other managed care contracting or payment models that LDH can implement to achieve its goals?**
  - a. For example, should LDH encourage or require MCOs to contract with ACOs or implement other alternative payment arrangements with providers?**

Answer: As mentioned in A. 3. above, adapt progressive payment models similar to Medicare to encourage value-based care:

- Pay for “transition of care” codes at a higher rate, encouraging patients to get care early when discharged in an effort to reduce hospital readmissions.
- Pay for telephonic care management similar codes used by Medicare for chronic care management. Some patients can be assisted without bringing them in for office visits, opening up access to patients who need to be seen in a face-to-face setting.
- Incentivize patients and providers to do wellness exams to address preventive health, immunizations, screenings, tobacco cessation, and advance directives.
- Pay for electronic consults between specialists and primary care physicians, thus reducing wait times for specialists and freeing up their access slots for the most serious patients.
- Include a Per Member Per Month (PMPM) fee that would allow the primary care team to pay for outreach to patients in the population.
- Eventually look to program-wide shared savings.

#### **Section IV. Statement of Interest (if applicable)**

##### **1. Please describe your interest in becoming an ACO.**

Answer: LSU Health Sciences Center New Orleans is interested in partnering, either with LDH or with a to-be-formed ACO, to provide support services in primary care, specialty care, and other health care support services (nursing, behavioral health, dentistry, etc.). It is strongly suggested that Louisiana’s health care universities be heavily involved in any ACO, as they provide a readily available and skilled workforce. Additionally, ACO support of both Undergraduate Medical Education and Graduate Medical Education helps provide for a sustainable and predictable source of Louisiana trained and experienced health care workers.

##### **2. Please describe the Medicaid population(s) you currently serve.**

Answer: LSU Health Sciences Center New Orleans currently supports a large percentage of the south Louisiana Medicaid population through clinical practices such as the LSU Healthcare Network. Additionally, LSUHSC physicians and health care support personnel work at all safety net hospitals in the south Louisiana region.

##### **3. Please describe the services you currently provide to these populations.**

Answer: Primary clinical care, specialty clinical care, staffing and admitting throughout south Louisiana’s safety net hospitals, auxiliary services (labs, imaging, etc.), behavioral health, telemedicine services, community outreach, public health services and studies, dental services, immunizations, geriatric health care, and infectious disease outreach.

4. **Would your ACO be able to enroll and serve all Healthy Louisiana populations statewide? If not, please describe the region(s) of the state you would be able to serve.**

Answer: Not Applicable.

5. **Would your ACO be able to enroll and serve all Healthy Louisiana eligibility groups? If not, please describe the population your ACO would serve.**

Answer: Not Applicable.

6. **Does your organization currently participate in any risk arrangements or contracts with Medicaid, Medicare or commercial payors? If so, please describe these (e.g., the type of arrangement, the payor—Medicaid, Medicare or commercial, etc.).**

Answer: LSUHSC and its faculty practice have a variety of standard contracts with Medicaid, Medicare, and commercial payors. Additionally, there is a risk based contract in place for Medicare Advantage patients with People's Health.

7. **Does your organization currently participate in or own an Accountable Care Organization (ACO)?**

Answer: No.

8. **Does your organization currently have capacity in the following areas needed to serve as an ACO?**

- Marketing
- Claims adjudication and payment
- Network development
- Provider services
- Member services
- Prior authorization
- Patient outreach and education
- Care management
- Data analytics
- Quality measurement and reporting

9. **What capacity would your organization need to obtain to serve as an ACO?**

Answer: Not Applicable.

10. **How might your organization obtain needed capacity?**

Answer: Not Applicable.

11. **When would your organization be ready to respond to an LDH procurement for ACOs?**

Answer: LSUHSC estimates that establishing the initial relationships, partnerships, and financial agreements needed to create ACO groups will be time consuming. As much as

feasible, it is recommended that sufficient response time (4-6 months) be given for any ACO procurements. This may also be accomplished through the use of Pre-RFP notices to help establish expectations and allow ACO partnerships the opportunity to coalesce.

***Louisiana Department of Health Request for Information for Provider-Led  
Accountable Care Organizations***

*Submitted on behalf of the Medicaid ACO Exploratory Committee of the Louisiana  
Primary Care Association*

December 9, 2016

For nearly 50 years, U.S. health centers have delivered comprehensive, high-quality preventive and primary health care to patients regardless of their ability to pay, becoming one of the largest safety net systems in the country. Louisiana health centers have been no exception. Louisiana health centers provide care to many of the most underserved members of their communities through 215 service delivery sites. In addition to providing quality care, Louisiana health centers generated positive economic impacts, including jobs, tax revenues and savings to the health care system.

In 2015, Louisiana's 34 grantees served 344,364 patients who had 1,228,845 visits and 100% of FQHCs have adopted Electronic Medical Records. Community health centers provide high quality, cost-effective, patient-centered care to vulnerable populations. Health centers serve 1 in 7 Medicaid beneficiaries, almost 1 in 3 individuals in poverty, and 1 in 5 low-income, uninsured persons. Nationally, two-thirds of health center patients are members of racial or ethnic minorities, which places health centers at the center of the national effort to reduce racial disparities in health care.

Recent studies show that, on average, each patient receiving care at a health center saved the health care system 24%, annually. As health centers expand, their expenditures and corresponding economic impact also grow. In 2014 alone, Louisiana health centers contributed about \$318.2 million dollars to the Louisiana economy.

A recent National Association of Health Centers (NAHC) study on impacts of FQHCs in Medicaid program shows:

- 22% fewer specialty care visits
- 33% lower spending on specialty care
- 25% fewer inpatient admissions
- 27% lower spending on inpatient care
- 24 % lower total spending.

In addition, we are proud to share with you that the Centers for Medicare & Medicaid Services (CMS) has most recently approved our application for participation in the Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organization (ACO) to begin in January 2017. In addition to the functions our

organizations already perform, with the Medicare ACO we will have strengthened and built the following capabilities and infrastructure:

- Claims data integration
- Utilization management and risk stratification
- Care management infrastructure including population management software, care coordinators, care planning tools and resources
- Patient outreach, marketing and member services
- Centralized clinical care guidelines and resources
- Data reporting and performance management
- Data analysis for performance management and quality improvement efforts
- Network development
- Claims adjudication and payment.

In a Medicaid ACO model, we would intend to use shared savings to reinvest in the ACO's infrastructure and to create financial incentives for its ACO providers to strengthen evidence-based guidelines and care coordination processes recommended by its Clinical Committee and adopted by its Board of Managers. These evidence-based guidelines and care coordination processes will be designed to achieve the goals of the Triple Aim of improving care, reducing cost, and improving the patient experience.

The Participant Health Centers will pool resources to focus on strengthening their EHR reporting initiative which is currently a Bureau of Primary Care funded Health Center Controlled Network program within the Louisiana Primary Care Association. Further, resources would be required and used to enhance quality improvement activities under the direction of a Clinical Committee. We would invest in turning paid claims data into usable information and network-wide cost and quality improvement strategies. We are confident that such a partnership between the state and FQHCs will be successful in producing shared savings.

Contracted funds paid to the Health Centers will be used to pay for local care coordinators within the Health Centers to work with high cost, high-risk patients. Further, it will support the cost of redesigned care processes to support improved health and utilization amongst the attributed Medicaid population.

Investment in infrastructure costs will help the ACO create the programs it needs to generate savings. Our program would actively encourage participation in the design and implementation of these programs. This creates clear incentives for each Health Center to achieve the goals of the ACO and a Shared Savings Program. ACO members would use its best efforts to actively support the development, implementation, operation, and continual improvement of the ACO Program.

It is the intent of the parties that the ACO Program will be an active and ongoing program, the purpose of which will be to evaluate and modify practice patterns of, and create a high degree of interdependence and cooperation among the ACO Program participants in order to improve the quality and efficiency of health care in the community. This would require an open dialogue between LDH and FQHCs to best build a data-driven evolving program which continues to build upon past successes and continues to make evidence based decisions.

Some essential functions of an ACO may include:

- work collaboratively with other ACO Program participants to propose and refine evidence-based clinical protocols and standardized order sets to guide the delivery of quality care to Enrollees
- work cooperatively with other ACO Program participants to monitor practice patterns of the ACO Program Professionals to assure adherence to the ACO Program's clinical protocols and quality standards in the provision of services to Enrollees
- support the implementation of the ACO Program requirements, including the clinical protocols and standardized order sets adopted by ACO by participating in the submission, review and analysis of data pertaining to the Member's performance under measures of quality, cost and efficiency as established from time to time by ACO
- participate in the time and work effort reporting system that ACO may establish and implement to track time spent performing the tasks and functions related to participation in the ACO Program
- cooperate with and participate in Utilization Management/Quality Improvement/and Risk Management Plans, including providing information necessary to implement such plans
- adopt the information technology capabilities that ACO establishes for ACO Program participants to the extent reasonably practicable for Member.

Our health centers are already have mandated quality measures in place to be NCQA or JCAHO certified with extended hours supporting greater continuity of care. We are already the medical home for hundreds of thousands of Louisiana patients and managing our own ACO model would allow us the flexibility to focus on specific metrics for cost savings such as smoking and diabetes with lower administrative burden. An

ACO would permit greater pooling of resources statewide between all participating centers and other healthcare providers which would allow for increased access to care for all of our patients.

In short, FQHC's are perfectly positioned to provide high-quality low-cost managed care to Louisiana's statewide Medicaid population. An ACO model with FQHC's at the helm would result in real managed care, not just managed dollars and this program would keep Louisiana tax dollars in Louisiana with Louisiana based providers. Unlike a traditional for profit organization, the ACO would seek to make less money/profits as the years progress and health outcomes continue to improve and savings ("profits") are reinvested into enhanced healthcare infrastructure.

If LDH is interested in pursuing an alternative model of delivery of care to the state's Medicaid population with the FQHC's we would propose doing so through a negotiation process in concert with our Medicaid ACO exploratory committee in order to form a model best tailored for the state of Louisiana. Our exploratory committee is comprised of four FQHC leaders chosen from LPCA membership from all corners of the state and we would be ready and willing to begin this process immediately.

Sincerely,

Gary M. Wiltz, M.D.

LOUISIANA DEPARTMENT OF HEALTH  
RFI FOR PROVIDER-LED ACCOUNTABLE CARE ORGANIZATIONS

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LOUISIANA DEPARTMENT OF HEALTH  
REQUEST FOR INFORMATION  
Provider-Led Accountable Care Organizations

11/4/2016

**Attachment: Response Form**

**RESPONDENT INFORMATION**

First Name: Troy  
Last Name: Robb  
Title: President, Residential Services - West Region  
Organization: Res-Care, Inc.  
Address: 9901 Linn Station Road, Louisville, KY 40223  
Contact Phone: 502-394-2376  
Contact Email: trobb@rescare.com

Responding as an Individual: (Y/)

Responding on Behalf of Organization: (/N)

Check all that describe your organization:

- Hospital or Hospital System
- Clinical System
- Advocacy Organization
- Health Plan
- Physician
- Non-physician Health Care Provider
- Other – Please Describe: Long-term services and supports provider for the aging population and individuals with intellectual, developmental, mental, and physical disabilities

## EXECUTIVE SUMMARY

Res-Care, Inc. (ResCare) is a national provider of residential and support services to people with intellectual and developmental disabilities (IDD) and is a leading provider of home care, pharmacy services, and workforce solutions. We offer a broad range of managed long-term services and supports nationwide, including Intermediate Care Facilities, waiver homes, foster and host homes, in-home and other community based supports, home care, specialized pharmacy services, workforce options, and technology-based solutions. Our company's 45,000 employees serve more than 1.2 million people each year at thousands of locations in the U.S. and Canada. Through this national footprint, ResCare has gained considerable experience in the design of person-centered care plans and solutions, care coordination, administrative management, service innovation, and understanding the needs of the individuals and families we serve.

ResCare is pleased to submit comments on the Louisiana Department of Health's Request for Information for Provider-Led Accountable Care Organizations. We have more than 25 years of experience serving individuals with IDD in Louisiana through 91 Intermediate Care Facilities and waiver homes. We also provide home care services to 146 Louisianans, including children, the elderly, and individuals with IDD.

As a long-term services and supports provider, ResCare fully supports this provider-led ACO model as the next step in a systems transformation aimed at improving cost efficiency, expanding services to more individuals in need, and enhancing overall quality of life outcomes.

We recommend that LDH adopt a coordinated, continuum of care approach to address the varying and complex needs of high-cost, high-need populations. We view the provider-led ACO model as an opportunity to build creative solutions to the most pressing concerns for the elderly and individuals with intellectual, developmental, mental, and physical disabilities.

Cost efficiency can be achieved through a focus on the following ACO priorities. Our experience serving individuals that depend on Medicaid-funded long-term services and supports informs these elements.

- **Flexible model** — Maintain a flexible service model designed to match the service provided with the specific needs of the client. Ensure recipients have access to the right care, at the right time, in the right setting with the confidence that the services are provided with consistently high quality leading to optimal outcomes.
- **Whole-person care** — Effectively manage the continuum of care needed for individuals across a broad range of physical health, behavioral health, long-term services and supports, and other ancillary services.
- **Partner integration** — Leverage a network of high quality providers who deliver measurable outcomes and results for the person served in the most cost-effective manner possible. Expand the network to include all provider types linked to individual needs.
- **Innovative technology** — Strategic use of technology that improves administrative efficiency, delivers transparency, improves data sharing and coordination of services, and tracks and measures outcomes. In addition, integrate solutions such as remote monitoring and telecare technology as an additional level of cost-effective support.

With our extensive history of service and our commitment as a tenured provider of services to Louisiana's Medicaid recipients, ResCare believes it can contribute to the development of the

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provider-led ACO model. While ResCare's recommendations are based upon more than 40 years of experience serving persons with IDD and those needing in-home care, we believe many components of our recommendations can be extended across a broader range of Medicaid services. We look forward to LDH's progress with this RFI and the opportunity to contribute as a member of the ACO provider network.

## **SECTION III. RESPONSES**

### ***A. ACO Requirements***

**1. Are there any exceptions or modifications to current requirements that LDH should consider to encourage ACO participation? (e.g., special licensure and solvency requirements)?**

LDH should ensure that long-term services and supports (LTSS) licenses and certifications are eligible providers in the ACO network (e.g., ICF, home and community-based, and other certifications).

In addition, we believe LDH should examine the process for licensing, credentialing, monitoring, and certifying service providers. The current system is fragmented and has many entities involved in various aspects of the process. As a result, the use of existing rules and regulations perpetuates a system of separate silos of overly prescriptive services that limits innovation, efficiency, and flexibility. Therefore, a new licensure category should also be considered that accurately reflects this new integrated service model.

**2. What governance principles and/or requirements should LDH consider implementing to ensure that ACOs are governed and led by Louisiana providers?**

No response.

**3. Are there any interim steps or technical assistance that LDH could provide to promote providers' ability to develop ACOs over time?**

To counteract the current siloed model, technical assistance should be provided to create, implement, and troubleshoot use of an integrated Electronic Health Record (EHR) database for shared information on individual care and costs. All partners across the spectrum of Medicaid-funded programs and services will access the whole person through this integrated EHR system. This system should enable faster and easier program access, improve coordination of service delivery, and ensure timely and accurate claims processing and payment for services provided.

**4. Are there any other unique requirements that LDH should consider applying to ACOs?**

No response.

### ***B. ACO Functions***

**1. Should ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan?**

Yes.

**2. Are there any key functions that LDH should not permit the provider led ACO to delegate to another entity?**

No, our understanding of the ACO model is that the provider group within the ACO's network should be competent enough to provide all necessary functions.

**3. Are there certain functions that LDH should consider standardizing or centralizing to facilitate ACO development and to ease provider administrative burden?**

We view standardization as a main driver for the ACO model. One of the keys to help manage costs is to ensure that the information system is integrated across the entire range of Medicaid-funded services. Just as service silos must be replaced with person-centered, integrated care,

information silos must be replaced with integrated systems. We recommend a standard EHR database to maintain an integrated record that consolidates information about an individual's progress and facilitates Interdisciplinary Team decision-making. This database will improve the ability to measure, report, and share outcomes and information with service providers and agencies.

In addition, standardized intake, assessment, and performance measures are all critical to support whole-person care and the quality goals of the ACO model. For example, without standardized processes and procedures, there is inevitable variability in needs assessments and insufficient connection between needs and resources identified in individual support plans. In turn, this disconnect can contribute to poor outcomes as well as rising support service and healthcare costs. Standardization facilitates quality person-centered planning through improved individual support plans and an enhanced focus on individual outcomes.

**a. Should these functions be standardized across ACOs and MCOs?**

No response.

**C. ACO Populations**

**1. Should LDH permit ACOs to serve specific regions, rather than enrolling Medicaid members statewide?**

**a. Would ACOs be able to develop statewide networks?**

ResCare values a flexible ACO model and supports flexibility for LTSS providers to serve regionally. One of the greatest service delivery challenges in Louisiana is service to rural areas. ResCare is at the forefront of technological solutions that increase access to quality care for rural residents. For example, in our California residential programs, individuals are able to receive behavior services, medical supports, and our state-of-the-art telecare service (Rest Assured®) via video technology in the home.

Our substantial footprint in Southern Louisiana provides an excellent position for provision of LTSS as an ACO network provider. In addition, we maintain an unparalleled ability to expand quickly as an organization. ResCare is a national leader in transitioning individuals to community-based settings; in systems transformation projects aimed at reducing costs, enhancing capacity and access to services, and improving quality of life outcomes; and in developing service models that meet emergent needs.

**2. If LDH were to permit ACOs to serve specific regions, would the ACOs have large enough enrollment to support the infrastructure needed for ACO functions to take on financial risk?**

No response.

**3. How should populations be defined or limited for ACO enrollment, if at all?**

ResCare supports identifying specialty populations for LTSS for individuals with IDD, physical disabilities, and the elderly.

If LDH is considering a pilot program for the provider-led ACO model, we advise that an opt-in approach not be used. Our recommendation would be for LDH to identify a specific pilot population for participation.

#### ***D. Selection of ACOs***

##### **1. What are the most important characteristics and qualifications for LDH to consider in selecting ACOs?**

As a result of our extensive experience and knowledge of managed care, we value the following characteristics in an ACO:

- Commitment to enhancing overall quality of life outcomes
- Flexibility
- Capacity
- Technology
- Network of collaborative partnerships for whole-person care

#### ***E. Other Strategies***

##### **1. Are there other managed care contracting or payment models that LDH can implement to achieve its goals?**

###### **a. For example, should LDH encourage or require MCOs to contract with ACOs or implement other alternative payment arrangements with providers?**

No response.

#### **SECTION IV. STATEMENT OF INTEREST (IF APPLICABLE)**

##### **1. Please describe your interest in becoming an ACO.**

ResCare is interested in participating in the ACO network. We are experts in specialty populations, and we support Accountable Care Organizations' place in providing that care.

##### **2. Please describe the Medicaid population(s) you currently serve.**

Nationally, ResCare serves individuals with intellectual, developmental, mental, and physical disabilities, individuals with traumatic brain injuries, as well as the aging population. In Louisiana, we support 588 individuals through residential services, 146 through home care, 760 through Pharmacy Alternatives, and recipients of Temporary Assistance for Needy Families through our workforce services.

##### **3. Please describe the services you currently provide to these populations.**

ResCare provides the following services to Medicaid populations:

Residential: We support people in waiver homes, ICF settings, foster or companion care settings, supported living arrangements, and vocational/day habilitation programs. Our staff provides people with personalized services, including training for activities of daily living, behavior supports, social skills development, community integration, job placement services, and nursing care.

Pharmacy: Pharmacy Alternatives, LLC is a pharmacy focused on serving individuals with IDD who are receiving support and services from ResCare or other private providers, including in long-term care facilities, residential youth facilities, group homes, and other congregate settings.

Home Care: We offer quality in-home care, including professional nursing, personal care, homemaking, home health, companionship, respite, remote/telecare, therapy, traumatic brain injury care, catastrophic care, and many other health services in homes, hospitals, rehabilitation

centers, long-term assisted living care facilities, and other places of residence. Additionally, our Safe Discharge program improves the transition of a patient from the hospital to their home or other care facility. The program provides a trained professional to manage the transition process, to remain with the client throughout discharge, and to re-establish the client in their home environment.

We also have access to signature programs within ResCare that provide specialized supports and expertise to strengthen and augment service delivery. For example, a few opportunities for synergies within ResCare include:

- ResCare Rest Assured<sup>®</sup> provides telecare systems that can improve cost efficiency, safety, monitoring, and training. Our web-based, remote support system utilizes wireless technology, a secure broadband Internet connection, and a state-of-the-art response center staffed with trained care providers to offer a variety of in-home services from passive sensor-only monitoring to periodic health and safety check-ins to full, live and interactive support. ResCare was the first organization to work with CMS to get a telecare system documented as an approved service.
- ResCare Behavior Services helps providers support challenging behavioral and mental health needs through clinicians trained in a variety of evidence-based practices.
- Our Pharmacy Alternatives line of business more fully integrates pharmacy services into the person's therapeutic milieu. This can help to improve personal outcomes by ensuring more consistent, timely, and personalized prescription oversight and delivery.

**4. Would your ACO be able to enroll and serve all Healthy Louisiana populations statewide? If not, please describe the region(s) of the state you would be able to serve.**

No response.

**5. Would your ACO be able to enroll and serve all Healthy Louisiana eligibility groups? If not, please describe the population your ACO would serve.**

No response.

**6. Does your organization currently participate in any risk arrangements or contracts with Medicaid, Medicare or commercial payors? If so, please describe these (e.g., the type of arrangement, the payor – Medicaid, Medicare or commercial, etc.).**

No response.

**7. Does your organization currently participate in or own an Accountable Care Organization (ACO)?**

We have been working with other providers, including nursing facilities, home health providers, community mental health centers, etc. toward developing an LTSS ACO entity in another state and have recently added an MCO to this partnership.

**8. Does your organization currently have the capacity in the following areas needed to serve as an ACO:**

As a member of the ACO provider network, ResCare has capacity and expertise in the following areas:

- Marketing

- Claims adjudication and payment
- Network development
- Provider services
- Member services
- Prior authorization
- Patient outreach and education
- Care management
- Data analytics
- Quality measurement and reporting

### **Data Analytics**

One example of ResCare’s data analytics capacity is our QuickMAR system for Medication Administration Records. QuickMAR allows us to collect – and analyze – data every day, about every medication pass to each of our persons served. The system’s sophisticated analytics produce an array of real-time information about the care and the medications received by the people we support. QuickMAR reports allow ResCare leadership to spot trends and continuously improve our medication administration and treatment processes.

### **Quality Measurement and Reporting**

We believe robust quality management systems will reduce costs and improve outcomes. ResCare’s Best In Class<sup>®</sup> system of performance measurement and continuous improvement ensures the consistent delivery of high quality services — whether those services relate to the operation of a group home for persons with IDD or providing in-home care services to children, individuals with disabilities, and the elderly.

In addition, our Rest Assured<sup>®</sup> telecare system offers 24/7 recorded video of common living areas in the home that may be reviewed at any time by authorized personnel. This feature can be used as a quality assurance tool to ensure staff interactions and active treatments are appropriate, and as a data collection tool for positive behavioral programming.

Every ACO provider should be required to have in place a comprehensive performance measurement and quality system that can be audited and certified by independent certification bodies.

### **9. What capacity would your organization need to obtain to serve as an ACO?**

ResCare is excited about the opportunity to serve as a piece of the ACO network. Our capacity includes a broad array of high-quality, person-centered services; national LTSS expertise; proven administrative capabilities; quality assurance best practices; and collaborative experience working with state stakeholders on systems transformation.

### **10. How might your organization obtain needed capacity?**

We will obtain needed capacity through company resources or partnership agreements.

### **11. When would your organization be ready to respond to an LDH procurement for ACOs?**

ResCare would be able to respond as an ACO network provider at the state’s direction. We look forward to and would be ready to respond whenever the LDH procurement is released.

**REDACTED COPY**

December 9, 2016

SUBMITTED VIA E-MAIL

Louisiana Department of Health, Bureau of Health Services Financing  
628 N. 4th Street  
Baton Rouge, LA 70802  
Attention: Frank Opelka, Medicaid Program Manager

RE: ACO RFI Response — Provider-Led Accountable Care Organizations

Dear Mr. Opelka,

AmeriHealth Caritas Louisiana is pleased to provide this response to the above-referenced Request for Information issued by the Louisiana Department of Health on November 4, 2016. For five years, we have been serving Medicaid populations in Louisiana through our managed care organization. We currently serve more than 200,000 members across the state.

This RFI response includes recommendations and observations based on the 30 years of experience the AmeriHealth Caritas Family of Companies, our health plan's local expertise, as well as our knowledge and support for state and federal innovations and modernizations that are improving access and the quality of care for our members. Health care is not just a business to us — it is an opportunity to serve the least advantaged and make a difference in their lives. As Louisiana citizens, we share LDH's commitment to improving state health outcomes.

AmeriHealth Caritas Louisiana delivers the highest-quality health care through a culture that prioritizes delivering the right care at the right time and place, and in accordance with member's rights and cultural preferences. We are committed to serving our members wherever they are and whatever their circumstances may be. We develop strong relationships within the communities we serve, partnering with excellence-driven organizations and providers to help our members achieve the best possible health outcomes through an integrated, cost-effective approach that coordinates physical health, behavioral health, pharmacy, community care, long-term care, and social services. Our organization is committed to leveraging our clinical and business expertise to provide seamless, quality health care experiences for our members.

We look forward to the opportunity to further discuss our capabilities and to demonstrate how care is truly the heart of our work. Please feel free to contact me with any additional questions or comments regarding this response, at [KViator@amerihealthcaritasla.com](mailto:KViator@amerihealthcaritasla.com) or 225-300-9238.

Sincerely,



Kyle C. Viator  
Market President  
AmeriHealth Caritas Louisiana

## Cover Sheet

### Section VI. Additional Information — Purpose, Disclaimer, Ownership, and Confidentiality

*The data contained in the pages of this response as identified below have been submitted in confidence and contain trade secrets and/or privileged or confidential information, and such data shall only be disclosed for evaluation purposes. This restriction does not limit the state of Louisiana’s right to use or disclose data obtained from any source, including the proposer, without restrictions.*

Page #	Description of Redacted Text	Reason
7, 9	Details about member or provider incentives that are not publicly known or that have not been finalized.	This information constitutes or reveals confidential details about business initiatives that are not publicly available. This is confidential, proprietary, and/or trade secret information and not subject to disclosure under La. R.S. §44:3.2.
7, 9	Metrics related to enrollment, disenrollment, or participation of health plan members in health plan activities that are not publicly known.	This information constitutes or reveals confidential details about business initiatives that are not publicly available. This is confidential and/or proprietary information and not subject to disclosure under La. R.S. §44:3.2.
7–8	Business processes/diagrams that are not publicly known or that have not been finalized.	This information constitutes or reveals confidential details about business initiatives that are not publicly available. This is confidential, proprietary, and/or trade secret information and not subject to disclosure under La. R.S. §44:3.2.
9	Details about initiatives that are not publicly known or that have not been finalized.	This information constitutes or reveals confidential details about business initiatives that are not publicly available. This is confidential, proprietary, and/or trade secret information and not subject to disclosure under La. R.S. §44:3.2.
9	Details about partnerships or subcontracts that are not publicly known or that have not been finalized.	This information constitutes or reveals confidential details about business initiatives that are not publicly available. This is confidential, proprietary, and/or trade secret information and not subject to disclosure under La. R.S. §44:3.2.
9, 10	Metrics or results related to health plan provider networking activities.	This information constitutes or reveals confidential details about provider networking activities that are not publicly available. This is confidential and/or proprietary information and not subject to disclosure under La. R.S. §44:3.2.

## Attachment: Response Form

### RESPONDENT INFORMATION

First Name: Kyle  
Last Name Viator  
Title: Market President  
Organization: AmeriHealth Caritas Louisiana  
Address: P.O. Box 83580, Baton Rouge, LA 70884  
Contact Phone: 225-300-9238  
Contact Email: KViator@amerihealthcaritasla.com

Responding as an Individual: (Y/N)  
Responding on Behalf of Organization: (Y/N)

Check all that describe your organization:

- Hospital or Hospital System
- Clinical System
- Advocacy Organization
- Health Plan
- Physician
- Non-physician Health Care Provider
- Other – Please Describe: \_\_\_\_\_

LOUISIANA DEPARTMENT OF HEALTH  
REQUEST FOR INFORMATION  
Provider-Led Accountable Care Organizations

11/4/2016

**RESPONSES**

**Section III.**

***A. ACO Requirements***

- Question 1. A response has been provided.
- Question 2. A response has been provided.
- Question 3. A response has been provided.
- Question 4. A response has been provided.

***B. ACO Functions***

- Question 1. A response has not been provided.
- Question 2. A response has been provided.
- Question 3. A response has been provided.
- (a) A response has been provided.

***C. ACO Populations***

- Question 1. A response has been provided.
- (a) A response has been provided.
- Question 2. A response has been provided.
- Question 3. A response has been provided.

***D. Selection of ACOs***

- Question 1. A response has been provided.
- Question 2. No question provided.
- Question 3. No question provided.

***E. Other Strategies***

- Question 1. A response has been provided.
- (a) A response has been provided.

**Section IV. Statement of Interest (if applicable)**

- Question 1. Not applicable.
- Question 2. Not applicable.
- Question 3. Not applicable.
- Question 4. Not applicable.
- Question 5. Not applicable.
- Question 6. Not applicable.
- Question 7. Not applicable.
- Question 8. Not applicable.
- Question 9. Not applicable.
- Question 10. Not applicable.

## Responses to RFI for Provider-Led Accountable Care Organizations

### A. ACO Requirements

*LDH envisions establishing requirements for provider led ACOs that mirror requirements for the Medicaid managed care organizations currently participating in the Healthy Louisiana Managed Care Program. LDH seeks the following information related to requirements for ACOs.*

*Question 1. Are there any exceptions or modifications to current requirements that LDH should consider to encourage ACO participation (e.g., special licensure and solvency requirements)?*

AmeriHealth Caritas Louisiana agrees with the need to establish requirements for provider-led ACOs that mirror the requirements applied to Medicaid managed care organizations currently participating in the Healthy Louisiana Managed Care Program. Doing so will ensure that all parties meet the same provider network, service level, financial solvency, and fiduciary reserve requirements listed in the Scope of Work section (2.0) of our existing managed care contract ([RFP# 305PUR-DHHRFP-BH-MCO-2014-MVA](#)), including but not limited to solvency standards; bond requirements; and medical loss ratio (MLR) standards. We do not recommend any exceptions or modifications.

*Question 2. What governance principles and/or requirements should LDH consider implementing to ensure that ACOs are governed and led by Louisiana providers?*

As a Louisiana MCO, AmeriHealth Caritas Louisiana fully supports requirements that ACOs are governed and led by Louisiana providers. We do not have any recommendations for governance principles or requirements at this time.

*Question 3. Are there any interim steps or technical assistance that LDH could provide to promote providers' ability to develop ACOs over time?*

Medicaid managed care organizations (MCOs) have many years of experience helping providers transform practices into more accountable models. AmeriHealth Caritas Louisiana recommends that LDH require MCOs to encourage engagement with providers to transform care delivery by first transitioning providers into value-based payment models. This approach will allow LDH to take advantage of MCOs' experience in partnering with Louisiana providers as providers look to transition to become effective ACOs.

AmeriHealth Caritas Louisiana currently maximizes the MCO/provider partnership by combining the existing strengths of our MCO in risk management, data management and analytics, innovative payment options, predictive modeling, and integrated care and case management with provider

strengths, namely clinical expertise and established relationships with patients. This model capitalizes on the robust staffing and technology infrastructure our MCO has built to meet operational requirements. Our provider partners leverage our statewide infrastructure and capabilities while focusing on coordinating care for their patients. Duplicating this infrastructure could become costly and redundant for providers and confusing for members.

Louisiana MCOs should collaborate with providers to establish network infrastructure, clinical integration across the continuum, and partnerships with local organizations to link patients to community resources. Providers can effectively facilitate point of care coordination activities, drive improved clinical outcomes, and ensure that their patients are treated in the most appropriate care setting.

*Question 4. Are there any other unique requirements that LDH should consider applying to ACOs?*

No. LDH should require ACOs to adhere to the requirements in the Scope of Work section (2.0) of the existing managed care contract ([RFP# 305PUR-DHHRFP-BH-MCO-2014-MVA](#)). Any modifications to these requirements may jeopardize member rights and institute an unequal playing field between MCOs and ACOs.

## B. ACO Functions

*ACOs would be expected to provide all functions of a traditional MCO, including but not limited to: claims adjudication and payment, marketing, member services, provider network development, credentialing, prior authorization, care management, data analytics and quality reporting. ACOs would also be expected to offer the same set of benefits to enrollees as that offered by current MCOs. LDH seeks the following information related to key ACO functions.*

*Question 1. Should ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan?*

AmeriHealth Caritas Louisiana does not have feedback in response to this question.

*Question 2. Are there any key functions that LDH should not permit the provider-led ACO to delegate to another entity?*

We believe that provider-led ACOs should not be permitted to delegate provider network development, care management, or medical management services. These are core functions that any entity accountable for population-based risk must govern and oversee. We strongly encourage LDH to hold ACOs to the same requirements as Medicaid MCOs regarding all functions, including delegation and oversight, to ensure that Medicaid beneficiaries receive a consistent level of care and service, regardless of payer.

*Question 3. Are there certain functions that LDH should consider standardizing or centralizing to facilitate ACO development and to ease provider administrative burden?*

AmeriHealth Caritas Louisiana believes that certain functions under the current Healthy Louisiana Managed Care Program could be standardized or centralized, in collaboration with the provider community, to ease provider administrative burden.

Another function we would recommend centralizing is clinical data exchange through a health information exchange (HIE) and provider electronic health records (EHR), which would ease provider administrative burden while driving quality improvement and value by improving the collection and reporting of quality performance data. We envision a system in which MCOs and providers collaborate to develop a centralized data infrastructure that supports the exchange of electronic clinical data. This would alleviate provider burden for those who dedicate significant administrative resources to collect and report clinical quality data for value-based payment and quality improvement initiatives. It would also lessen the MCO burden, as they do manual medical record chart reviews to collect data for quality reporting purposes. By creating a centralized infrastructure, data can flow through a HIE between providers and MCOs to improve health outcomes, drive provider accountability, reduce unnecessary utilization, and lower costs.

*(a) Should these functions be standardized across ACOs and MCOs?*

All functions should be standardized across ACOs and MCOs to ensure consistent requirements and to collectively minimize administrative burden for all parties, including LDH.

## **C. ACO Populations**

*LDH envisions that ACOs, like the state's traditional MCOs, would serve all Medicaid members who are eligible for enrollment in Healthy Louisiana. LDH seeks the following information related to populations to be served by ACOs.*

*Question 1. Should LDH permit ACOs to serve specific regions, rather than enrolling Medicaid members statewide?*

AmeriHealth Caritas Louisiana recommends that LDH not permit ACOs to serve specific regions as this may result in selective enrollment and inconsistent requirements across payers. We recommend that ACOs should be required to enroll Medicaid members statewide. This directive aligns with current MCO requirements and ensures a level playing field and consistent requirements for MCO and ACO participants in the Healthy Louisiana Managed Care Program.

*(a) Would ACOs be able to develop statewide networks?*

ACOs would function as provider-led health plans and should develop comprehensive statewide networks to best serve the needs and rights of their patients and protect taxpayer dollars. Therefore, ACOs and MCOs should have consistent requirements for provider network development to maintain network adequacy and accessibility.

*Question 2. If LDH were to permit ACOs to serve specific regions, would the ACOs have large enough enrollment to support the infrastructure needed for ACO functions and to take on financial risk?*

We do not believe that ACOs should serve specific regions, as this may result in selective enrollment. If an ACO cannot scale its functional capabilities to operate statewide, it should not be allowed to enter into a contract with the state to take on all-inclusive risk. In these instances, the ACO may be better served to take on partial risk, as a provider, for the specific population it serves under a value-based risk contract with a MCO.

*Question 3. How should populations be defined or limited for ACO enrollment, if at all?*

We do not recommend that populations be defined or limited for ACO enrollment, as inconsistent requirements for ACOs and MCOs could contribute to adverse selection situations where one type of entity is managing care for higher-risk populations. ACOs should be subject to and capable of meeting all of the same requirements that are applicable to MCOs.

## ***D. Selection of ACOs***

*LDH would likely procure ACOs as part of its standard MCO procurement process. LDH seeks the following information related to ACO selection.*

*Question 1. What are the most important characteristics and qualifications for LDH to consider in selecting ACOs?*

The characteristics and qualifications that LDH uses in its standard MCO procurement process should be the same for the selection of ACOs to ensure that both entities demonstrate their ability to withstand risk and deliver capabilities to manage the Healthy Louisiana population. We support the selection of evolving value-based models that foster collaboration between MCOs and providers to achieve the Triple Aim: 1) improve the patient experience of care; 2) improve the health of populations; 3) and reduce the per capita cost of health care).

Several core characteristics that demonstrate improved outcomes have emerged based on the experiences of public payers, private payers, and provider-led ACOs. AmeriHealth Caritas Louisiana recommends that LDH consider the following core capabilities when selecting entities to serve the Healthy Louisiana population:

- **Effective care management inclusive of collaboration between providers and community supports** — Collaboration between providers and community supports is essential to successfully engage patients in their care and effectively develop care plans that help individuals achieve their health care goals. Building on evidence-based best practices that ensure the integration of behavioral health, ACOs should demonstrate their ability to offer enhanced care management, which goes beyond provider-based care management to ensure that patients receive ongoing care coordination and support within their communities, such as addressing barriers to care and social determinants of health through services and supports like community-based care.
- **Data sharing and analysis** — Data integration and intelligence are critical success factors. Provider-led ACOs should demonstrate the ability to implement an effective platform for capturing and analyzing data in order to proactively identify and stratify individuals by risk severity. Sophisticated data analytics capabilities, such as predictive modeling, are particularly beneficial and enable data mining to better identify individuals for targeted interventions and implement population-based health initiatives, which ultimately improve the performance and cost-effectiveness of the Healthy Louisiana program.
- **Provider-level financial accountability through value-based payment incentives** — As the health care delivery system moves away from pay-for-volume to pay-for-value, provider-led ACOs must accept full risk to manage their entire patient population. Models include a range of options such as episode-based/bundled payments, comprehensive care payments, partial or total capitation, global payments, and percent of premium or medical loss ratio (MLR). The provider-led entity must demonstrate the ability to take risk both short-term and long-term. The ACO must also create downstream, value-based incentives for participating physicians, hospitals, and other practitioners. Successful value-based payment programs involve not just changing the payment method, but also setting the right payment amount and aligning incentives to achieve state and federal goals.
- **Robust quality measurement** — ACOs must demonstrate the capacity to collect and report data on a robust set of performance metrics, including quality, utilization, and cost, as well as indicators of process improvements and patient engagement for ongoing assessment. In addition, they should be held accountable for driving performance improvement similar to those which are subject to penalties through LDH's MCO quality-based performance metrics. Furthermore, ACOs should be required to participate in LDH's quality performance improvement projects (PIPs) to ensure that all quality measurement activities are harmonized across all entities. These requirements and quality measurement activities will ensure all Healthy Louisiana participants are served by entities held to the same quality standards.

Although some ACOs have achieved success in particular areas and in particular markets, there is no clear evidence that suggests ACOs have the capability to provide sustainable models that equal the effectiveness of a MCO. We encourage LDH to consider whether the establishment of a provider-led ACO infrastructure would improve health outcomes or lead to redundancies and inefficiencies in the delivery system and greater administrative burden for LDH. We believe there are opportunities for ongoing partnership between MCOs and providers to jointly develop ACO-like models that could be more effective in delivering core capabilities while driving meaningful quality improvement and significant value.

## E. Other Strategies

*As described above, LDH is seeking to implement strategies that promote and encourage provider accountability for care management and the total cost of care for Medicaid enrollees.*

*Question 1. Are there other managed care contracting or payment models that LDH can implement to achieve its goals?*

### Strategies LDH Can Implement to Achieve its Goals

Through the reprocurement process, LDH can implement new strategies and requirements for MCOs that promote increased provider accountability for care management and the total cost of care for Medicaid enrollees. AmeriHealth Caritas Louisiana has identified specific priorities that focus on improved health, better outcomes, and lower per-capita health care costs. To achieve these goals, we have developed a pathway for our provider partners, enabling them to transition into value-based payment models, including partial and full-risk arrangements. We are currently working with providers in Louisiana to implement new payment models. Our value-based provider programs ensure that performance measures are incorporated and that our provider partners are equipped with the necessary data to succeed in these arrangements. Providers recognize the importance of these evidence-based measures and appreciate the opportunity to improve quality, increase efficiency, and earn financial rewards. Building from our experience, we recommend the following strategies:

#### MCO-supported Transformation Assistance

LDH can require value-based contracts and MCO-supported practice transformation assistance to support provider care management functions. AmeriHealth Caritas Louisiana recognizes that the practice transformation necessary to deliver comprehensive primary care requires time, resources, and expertise that have not always been readily available to some providers. We are committed to collaborating with provider organizations to assist with practice transformation, including but not limited to embedding plan staffing resources in provider offices, in order to expand access to the value-based accountable care delivery model.

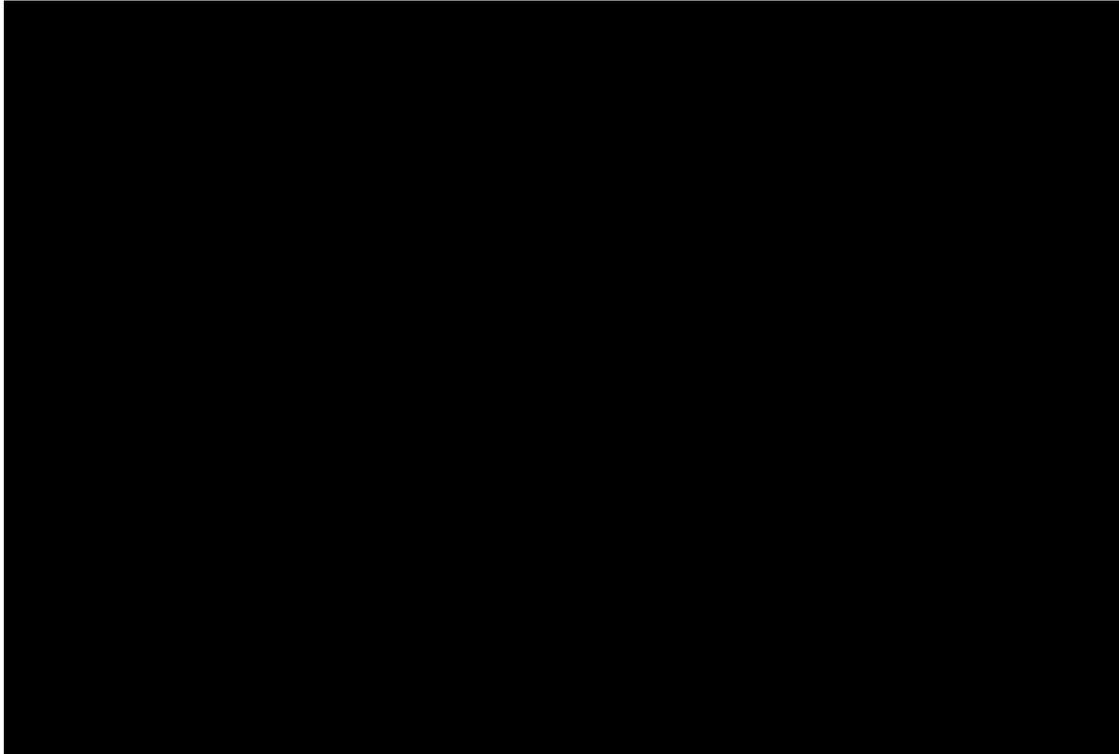
AmeriHealth Caritas Louisiana currently provides support for practice transformations to help providers transition to a more comprehensive level of primary care, especially for their patients identified as higher risk. Our support focuses on key medical home attributes and functions, including but not limited to: (1) access and continuity; (2) care management and care coordination; (3) patient and caregiver engagement; (4) data-driven strategies for intervention and outreach; and (5) planned care and population health.

#### MCO-administered Alternative Payment Models

As the health care industry transitions from traditional fee-for-service to value-based reimbursement models, providers and health plans will need to find new ways to work together to coordinate and

integrate care, improve patient outcomes, and share the risk associated with managing vulnerable populations. We recommend that LDH require MCOs to demonstrate a viable path for providers moving into value-based alternative payment models (APM). **Exhibit 1** illustrates the [REDACTED]

[REDACTED]

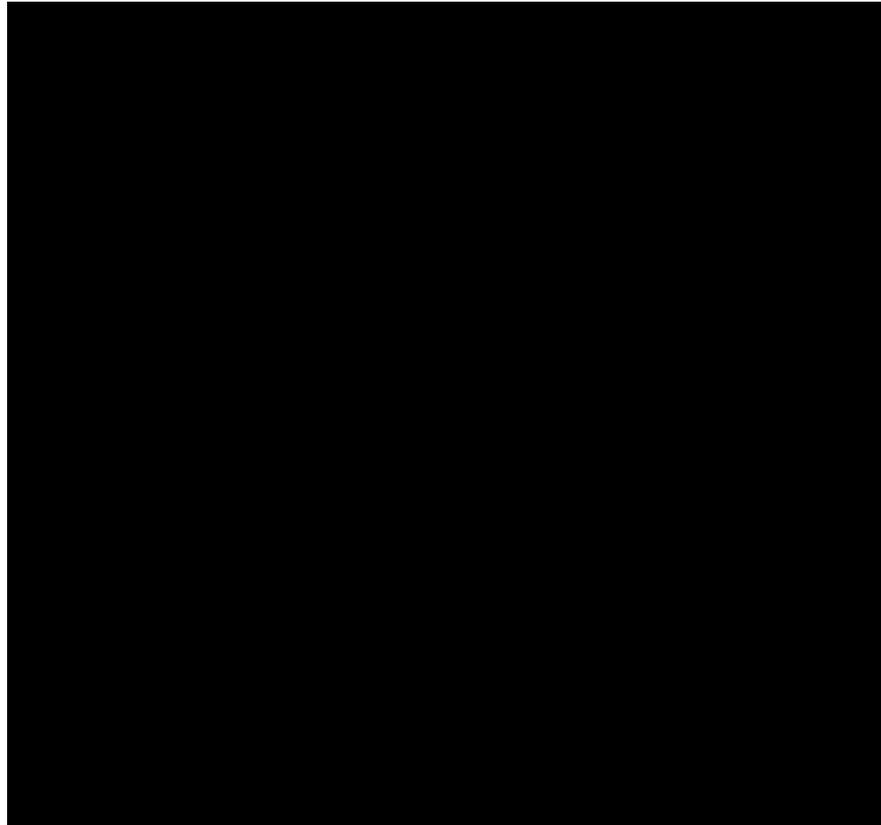


**Exhibit 1:** [REDACTED]

## Overview of AmeriHealth Caritas' Value-based Experience

AmeriHealth Caritas' successful approach to value-based contracting is centered on collaboration with providers: we share best practices and tools, as well as foster provider accountability and learning opportunities, to support transformation and performance improvement initiatives. To accomplish this, AmeriHealth Caritas has developed an infrastructure capable of supporting value-based payment systems, including [REDACTED] and [REDACTED] and [REDACTED], and [REDACTED].

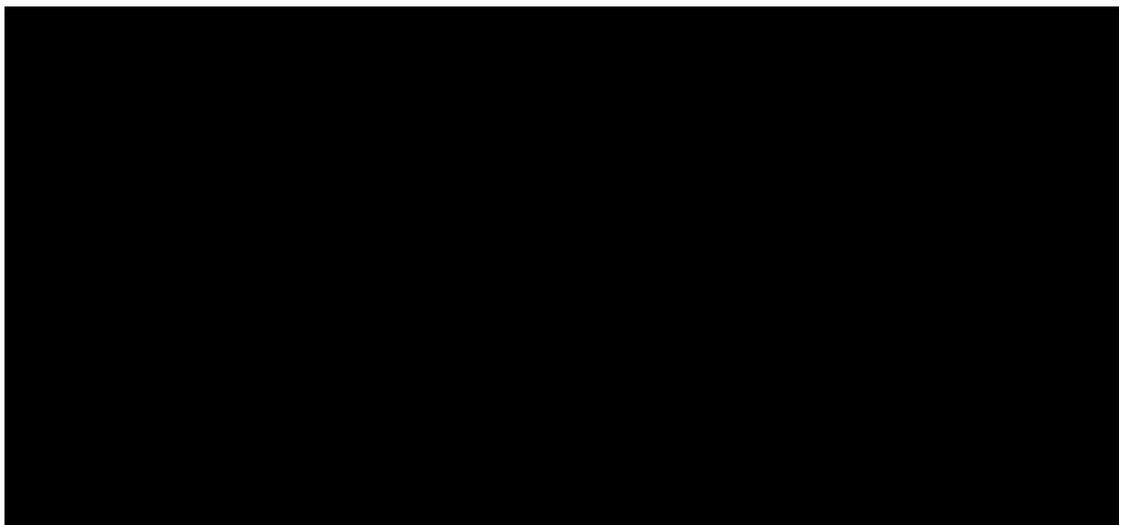
AmeriHealth Caritas has rewarded providers for quality-based performance for over 10 years. Our programs were initially developed as pay-for-performance programs, and in 2009, AmeriHealth Caritas launched our PerformPlus® suite of value-based incentive programs for participating primary care practitioners, specialist physicians, hospitals, integrated delivery systems, and federally-qualified health centers (FQHCs). Currently, more than [REDACTED] of AmeriHealth Caritas members in Louisiana are impacted by a value-based model of care. **Exhibit 2** highlights all of our PerformPlus® programs:



**Exhibit 2: PerformPlus suite of value-based initiatives**

### PerformPlus® Programs

Our PerformPlus® programs offer flexible contracting arrangements that enable providers to partner with us at "core," "premium," and "elite" levels of risk tolerance and move along the continuum of alternative payment models:



**Exhibit 3: AmeriHealth Caritas offers a variety of PerformPlus models**

**Core programs** (Category 2 in Exhibit 1), such as our [REDACTED] and our [REDACTED], focus on [REDACTED] and [REDACTED] for [REDACTED] and [REDACTED].

**Premium programs** (Category 2C and Category 3A in Exhibit 1) target [REDACTED] and [REDACTED] to [REDACTED] with a [REDACTED]. Premium programs include our [REDACTED] and [REDACTED] for [REDACTED].

**Elite programs** (Category 3 and Category 4 in Exhibit 1) include [REDACTED] such as [REDACTED] and [REDACTED]. Reporting and measurement within our current value-based portfolio will be enhanced with the addition of [REDACTED] for [REDACTED], and others.

AmeriHealth Caritas' approach is designed to transform existing value-based payment arrangements into robust risk-based arrangements over time. Our clinical support team provides services critical to the success of risk-based initiatives, enabling positive patient outcomes and shared success.

To further support our provider partners, we offer a **PerformPlus® dashboard** that provides near real-time population-level data in a secure, easy-to-use format for all value-based key performance indicators, with self-service drilldown reporting capabilities to the facility, provider, and member levels. The dashboards also help providers identify frequent emergency department utilizers, readmissions, HEDIS results, care gaps, clinical risk, and other member-centric data to foster collaboration and meaningful member outreach.

### **PerformPlus® Programs Launched in Louisiana**

In 2014, AmeriHealth Caritas Louisiana launched the Quality Enhancement Program (QEP), a unique reimbursement system for participating primary care practitioners. Currently, over [REDACTED] primary group practices qualify, serving more than [REDACTED] Louisiana members. In 2015, we launched a Perinatal Quality Enhancement Program (PQEP) for practitioners who provide obstetric care. The QEP & PQEP reward practices based on their [REDACTED] and are designed to provide financial incentives beyond a practice's base compensation. Incentive payments are [REDACTED] payments.

In 2016, AmeriHealth Caritas Louisiana began working with targeted provider partners to transition them to the next level of value-based models that include shared savings and are designed to [REDACTED]. We currently have value-based agreements with [REDACTED] providers and pending agreements with an additional [REDACTED] providers. Results from our initial shared savings program with CHRISTUS Health System, which was initiated in 2014, show a reduction in potentially preventable admissions, improved compliance with postpartum visits, and a reduction in emergency department utilization.

*(a) For example, should LDH encourage or require MCOs to contract with ACOs or implement other alternative payment arrangements with providers?*

State Medicaid programs have a tremendous opportunity to encourage the adoption of value-based payment models and advance delivery system and payment reform. State governments can lead the charge working with Medicaid MCOs to develop innovative performance programs to drive the implementation of quality and outcome based programs. One approach is to require MCOs to have a certain percentage of medical revenue in a value-based payment arrangement. In the Pennsylvania Health Choices program, the state requires this percent to grow each year with benchmarks set at 7.5 percent, 15 percent, and 30 percent by 2019. AmeriHealth Caritas has exceeded the benchmark set for year 2 by achieving a current rate of █████ percent. The South Carolina Department of Health and Human Services requires a percent of all payments for medical care be spent on a value-oriented contract with benchmarks set at 5 percent, 12 percent, and 20 percent by the end of 2017. Select Health, AmeriHealth Caritas' South Carolina health plan, is performing better than the year 2 benchmark with a current rate of █████ percent.

AmeriHealth Caritas Louisiana believes that provider partnerships are successful when there are strong synergies that allow each partner to do what they do best. To maximize partnerships between MCOs and providers, AmeriHealth Caritas Louisiana strongly supports strategies that combine our existing strengths in risk management, data management and analytics, innovative payment options, predictive modeling, and integrated care and case management with provider resources. Provider partners can focus on their areas of strength and will be responsible for coordinating on-site care activities, improving clinical outcomes, and ensuring that patients are treated in the most appropriate setting. In ACO arrangements, providers would also be responsible for network infrastructure, clinical integration across the continuum of care, and partnerships with local organizations to link patients to community resources. In addition, MCO relationships with ACOs should be driven by a collaborative desire to drive better outcomes and lower costs; these relationships should be encouraged by LDH, but not be mandated or required.

Furthermore, we support strategies to move hospital-based payments from per diem to diagnosis-related groups as an important step to assist the advancement of quality and value-based reimbursement models.

## Response Form

### RESPONDENT INFORMATION

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Responding as an Individual: N  
Responding on Behalf of Organization: Y

Check all that describe your organization:

- Hospital or Hospital System
- Clinical System
- Advocacy Organization
- Health Plan
- Physician
- Non-physician Health Care Provider
- Other – Please Describe: \_\_\_\_\_

## **RESPONSES**

### **Section III.**

#### **A. ACO Requirements**

**Question 1. Are there any exceptions or modifications to current requirements that LDH should consider to encourage ACO participation (e.g., special licensure and solvency requirements)?**

No response.

**Question 2. What governance principles and/or requirements should LDH consider implementing to ensure that ACOs are governed and led by Louisiana providers?**

Gateway Health was founded in 1992 by charitable organizations to serve Medicaid recipients using a community-based approach and we continue to operate as a true partner with providers, stakeholders, and community organizations. As a local provider-led, non-profit organization, we recognize the value of contracting with organizations that are governed and led by Louisiana providers. Based on our experience in working closely with provider organizations to manage Medicaid programs, Gateway Health recommends that LDH consider the following requirements:

- Further define ACO ownership (provided in Section I of the RFI) as being an organization in which Louisiana providers have at least 50 percent ownership. This threshold will help ensure that LDH's goals of having a true provider-led ACO are achieved.
- Establish parameters for the ACO that include clear expectations for provider participation in organization governance, leadership and policy development.
- Require potential bidders to demonstrate how they will meet these requirements and incorporate their response as part of their contractual obligations.
- Develop metrics and reports to demonstrate ongoing compliance with this requirement.

Gateway Health supports LDH's goal to leverage ACO expertise to manage and deliver services to Medicaid members.

**Question 3. Are there any interim steps or technical assistance that LDH could provide to promote providers' ability to develop ACOs over time?**

In our experience, as providers are focused on delivering member care, they have not developed the infrastructure to coordinate member care and benefits across providers and systems, analyze and report on quality metrics for the system of care, and complete administrative functions such as claims payment. For example, we know that working with providers to facilitate real-time data-sharing related to specific events such as inpatient admissions and emergency department visits is crucial for making sure members have access

to the right services at the right time, and in the right place. To help ensure the success of ACOs we recommend that LDH provide a consistent technology platform, historical member utilization data, processes for regulating member assignment, and alternative payment models that encourage and reward system transformation.

### **Technology Platform**

Gateway Health believes that technology innovations are key to enabling a high level of coordination of care for members. System-wide implementation of a Health Information Network (HIN) to facilitate the exchange of data in real-time at the point of service. An HIN can offer numerous benefits to all system stakeholders, including improved clinical decision-making, reduced administrative burden, and improved outcomes/decreased costs as a result of preventing duplicate or unnecessary care. Providing for a standard technology platform across all ACOs and MCOs enables HIN participation and provides for data interoperability as well as data exchange near real time, event driven, between hospitals and specialists.

By implementing the infrastructure that supports data sharing with providers near real time, ACOs will be better equipped to proactively treat members—especially high-risk members. A standardized technology platform allows for ACOs and MCOs to weave data into their workflows, incentivize providers to use that data to treat members effectively, and track progress monthly. However, access to the data is only one part. Using the data at the point of care is the next critical step to make this approach successful and bend the cost curve.

We recommend that LDH model the Washington State Emergency Department Information Exchange system: the Emergency Department Information Exchange (EDIE), a software tool for proactively notifying EDs when high-utilization or special needs members register. The information includes those members' prior ED visit history, primary care provider information, and associated care plans. The Washington State Health Care Authority reports that use of EDIE by hospital EDs has helped save the state a projected \$31 million annually.<sup>1</sup>

### **Member Clinical and Utilization Data**

Access to historical clinical and member utilization data as well as data from services provided by other systems is vital for delivering high quality member care. ACOs will need this data for all members, especially those who have been identified as having high needs/risk levels and those who have been diagnosed with specific combinations of illnesses and conditions. This information is critical for identifying members in need of additional support to access appropriate services and learn self-management. LDH should also provide summary-level statistics for facility admissions as well as detailed listings of inpatient admissions and admissions to a psychiatric hospital or residential treatment center for the prior 12 months.

### **Regulation of Member Assignment**

To allow ACOs to build up financial sustainability, Gateway Health recommends LDH regulate member mix and assignment (i.e., children and non-disabled adults vs. more complex members). We further recommend the state establish a quality measure whereby those ACOs who meet a specific threshold are eligible to obtain additional auto assignment

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<sup>1</sup> <http://www.healthcare-informatics.com/blogs/david-raths/improving-emergency-department-information-flow-pacific-northwest>

of members.

### **Alternative Payment Models**

Using alternative payment methods such as a value-based payment (VBP) model or developing a Delivery System Reform Incentive Payment Program<sup>2</sup> model will further support LDH's Triple Aim. Gateway Health is pleased to report that our percentage of the medical portion of the capitation and maternity revenue spending that is applied to VBP strategies is more than 30%.

We encourage the State to adopt a payment model that supports the traditional face-to-face contact with members, including collaborative care coordination; increased telephonic and email communication with other providers, members, and family members; and improved access to innovative and user-friendly technology. Because increased time, effort, and money is often required for providers to embrace integration as well as manage and navigate the needs of members with both physical and behavioral health conditions, the payment model must reflect the added value of developing a sound infrastructure.

To further support ACOs, setting clear and complete contractual expectations, policies and procedures and regulatory standards with specific quality measures is critical for successful program implementation.

### **Question 4. Are there any other unique requirements that LDH should consider applying to ACOs?**

To address the needs of Louisiana's Medicaid system, our response focuses on the following key components, all of which are designed to achieve the Triple Aim of high quality, improved outcomes, and lower costs. We recommend that LDH consider applying the following requirements to ACOs serving Louisiana:

- Accountability for outcomes and quality
- Adopting innovative technology solutions
- Developing a diverse provider network

### **Accountability for Outcomes and Quality**

Gateway Health believes the State should hold ACOs accountable for improving member outcomes. We are supportive of the State adopting quality of life outcomes that are standardized and consistently applied and audited through oversight. The goal of the service delivery system should be to enhance members' lives, and incentives should be aligned accordingly. To that end, we recommend that LDH employ contract requirements to hold ACOs accountable for use and application of data at the point of care, integration of physical and behavioral health, automation of processes (e.g., claims payment), and data transparency (e.g., sharing the right level of info based on acuity level). Medicaid programs in states like Arizona, New Mexico, and Ohio include contract language about risk pool incentives to ensure measurement of data and actions that directly relate to achieving the state's program goals. By including these measurements in the contract and tying incentives to them, the

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<sup>2</sup> DSRIP initiatives are part of broader Section 1115 Waiver programs and provide states with significant funding that can be used to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries

states are assured that their contractors are performing to expectation.

### **Adopting Technology Solutions to Share Actionable Data across Providers and Systems**

ACOs should demonstrate their commitment and ability to work with and encourage providers to adopt and meaningfully use electronic health records. Technology adoption and use can vary widely across providers; thus, ACOs must be able to deliver information in a way that providers can use while also promoting the benefits that health information technology can offer, including better care coordination, prevention, wellness, and improved quality. Gateway Health's over-arching data sharing strategy is to *meet our providers where they are* to align our data sharing methodology with providers' ability to accept and use data. Our strategy leverages our advanced data delivery system that meets the provider's level of practice maturity.

Gateway Health offers our providers access to the wealth of data we have about our members. Our provider data-sharing strategy for the VBP arrangements leverages both data and analytics and fosters improved outcomes and reduced cost. The data shared gives the providers the actionable information and insight needed to better manage risk and identify members with chronic conditions, those who are non-compliant with their treatment regimens, and those in need of specialty care or additional interventions.

### **Developing a Diverse and Comprehensive Provider Network**

LDH should develop and have in place clearly defined policies to ensure adequate network capacity that is appropriate to the specific geographic areas and populations covered by the program. These policies should help to ensure access to (1) community-based providers that offer essential local services; (2) ancillary providers that extend services, service locations and enrollee preferences; and (3) non-traditional providers to accommodate cultural needs and accessibility. In addition to geographically-appropriate standards for access to services, network adequacy standards should address provider certification requirements and training and technical assistance for providers. Successful models bring creative, localized solutions focused on achieving member outcomes. ACOs must be able to demonstrate the ability to address the needs of diverse communities, including but not limited to, the Hispanic population, American Indian Tribes, and members who reside in border areas and rural regions of the state.

Gateway Health focuses on developing a provider network that reflects the characteristics of the local communities we serve. We are creative in our contracting and program development to address the specific cultural, linguistic, psychosocial and healthcare needs of members. For example, we contract with providers to deliver programs specific to local needs such as high risk pregnancies, opiate addiction, and high emergency room utilization. Each of these programs was developed in collaboration with local providers, community organizations and the State. We are poised to work directly with the State of Louisiana and local communities to develop programs that meet their specific needs.

## B. ACO Functions

### **Question 1. Should ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan?**

Gateway Health recommends that LDH permit ACOs to enter into a TPA or joint venture with a health plan that has specific experience in managing Medicaid programs. Experienced MCOs have developed the resources, tools, and systems to support key functions that ACOs and providers typically do not already have and would be costly to develop. For example, as an MCO with over two decades of experience, we have worked alongside state partners, providers, and communities to provide comprehensive care to members, including children, families, adults, and those diagnosed with chronic diseases. Some of the capabilities and infrastructure available through the MCOs that are necessary components of an effective service delivery system include:

- **Processes that support system-wide improvement and accreditation.** Gateway Health was the first Medicaid MCO in the nation to achieve an Excellent rating from NCQA and has maintained that rating for 16 of the last 19 years. In managing one of the largest D-SNP programs in the country, Gateway Health has maintained a 3.5 star quality score and offers the experience needed to develop programs that can help keep Louisiana members in their communities while both improving outcomes and reducing costs.
- **Managing pharmacy benefits.** MCOs are well-versed in administering pharmacy benefits while controlling costs and improving member care. They create programs such as Medication Therapy Management that include coordinating care, enhancing communication between providers, and controlling polypharmacy. MTM programs are important for supporting members who use multiple pharmacies or doctors, fill multiple medications, or have multiple chronic disease states to provide support and education. Additionally, they often result in improved quality scores, increased member engagement, and reduced costs. For 2017, our D-SNP received a five star rating in member experience with the drug plan.
- **Advanced analytics.** MCOs, such as Gateway Health, offer advanced analytic capabilities to better serve members and seamlessly coordinate care by allowing providers and staff to have the latest information on benefits, pharmacy, authorizations, eligibility and enrollment, claims, utilization, providers, health risk profiles/stratification, and care gaps. For example, our MIS has the capability to manage large volumes of data and exchange data real-time with subcontractors and supports the dissemination of real-time, actionable data to providers. To provide effective care at the point of service, Louisiana providers need data transparency—for example, near time-real information about admissions, discharges and transfers—to share the right level of information based on the member’s acuity level. Bringing data transparency to the last mile of care with actionable data enables providers to focus on giving members the care they need at the right time and in the right setting.

- **Innovative technology solutions.** In our experience, MCOs have the bandwidth and resources to leverage the latest technology to improve system efficiency and member care. For example, Gateway Health has developed innovative technologies that enable providers to proactively identify gaps in services that may indicate potential access to care issues.
- **Clinical programs that improve population health.** By leveraging national best practices with local community input, MCOs have the expertise to implement initiatives that minimize hospitalizations, inappropriate ED visits, and residential treatment while increasing community tenure. Louisiana’s population includes individuals who have complex needs and who require the right mix of providers who have the specialized experience to serve them, helping them achieve their goals, maintain their independence, and thrive in the setting of their choice. Reducing health disparities and improving members’ health through prevention, education, and screenings requires a tailored approach. In placing members first, we honor the cultural needs of each community. For example, we use Promotores/ Community Health Workers who live in the same communities as our members. These Community Health Workers connect members to the care and services they need, including well care screenings. We incorporate these local strategies into our full-spectrum care coordination approach, emphasizing an individualized, member-centric focus that supports self-direction and recovery.
- **Alternative payment models.** MCOs have the expertise and infrastructure to support alternative payment models, which require advanced analytics, ongoing data mining, and reporting. Since 1997, Gateway Health has deployed payment models that reward quality and better health outcomes. We recognize that Louisiana is unique and that payment models must be tailored to meet the specific needs and capabilities of providers in the state. Further, payment methodologies must be transparent, reflect the true cost of care for each provider, consider member acuity, and include measures that are meaningful to the population they serve. The collaborative relationships we have today greatly enhance our ability to structure value-based payments that yield greater satisfaction for both member and provider and lower costs all around.
- **Resources that support multi-system collaboration.** In our experience, collaboration across systems is critical for ensuring member access to appropriate services, reducing duplication, and creating administrative efficiencies. We believe that true member-focused care is only achieved when all parties collaborate and coordinate care across systems and company lines. As part of our commitment to system-wide collaboration, we have dedicated resources and tools to coordinate with all system partners. We stand ready to bring our approach to Louisiana, working with ACOs and other organizations.
- **Claims payment.** MCOs have the infrastructure to process claims that are submitted from multiple providers and provider types. While ACOs may need to develop these capabilities, it is a core competency for MCOs who are accustomed to processing and paying claims timely and accurately. They also have processes in place for managing provider disputes, appeals, and pharmacy rebates. This functionality is critical for

ensuring provider satisfaction and network adequacy.

- **Program integrity.** Fraud, waste, and abuse is a significant issue in Medicaid programs across the country. The U.S. Office of Management and Budget estimates that improper payments made under the Medicaid program totaled \$29.12 billion in FY 2015<sup>3</sup>. This represents a 9.78% improper payment rate. MCOs have robust processes for preventing, detecting, and investigating potential cases of fraud, waste and abuse resulting in millions of dollars in savings for state Medicaid programs. These systems require tremendous effort and resources to build and maintain. Leveraging existing program integrity systems available through MCOs will be cost-effective and efficient for the system, providers, and ACOs.
- **Provider Relations.** Maintaining positive relationships with provider organizations is important for maintaining an adequate and accessible network. As a provider-led organization, we know the challenges providers face and constantly seek to reduce/minimize administrative burdens. 2015 satisfaction results indicated that over 90% of PCPs and specialists were satisfied with Gateway Health. Our history of standardizing provider toolkits and processes and removing administrative roadblocks has proven successful in the communities we serve.

If LDH allows ACOs to partner with insurance companies or health plans, we also recommend that the state include partnership requirements as part of the ACOs' state contract to ensure transparency at all levels.

**Question 2. Are there any key functions that LDH should not permit the provider led ACO to delegate to another entity?**

No response.

**Question 3. Are there certain functions that LDH should consider standardizing or centralizing to facilitate ACO development and to ease provider administrative burden?**

**(a) Should these functions be standardized across ACOs and MCOs?**

In our experience, the most effective programs reduce system complexity and administrative burden. To that end, Gateway Health recommends that LDH consider standardizing the following functions across both ACOs and MCOs:

- **Centralized HIE** that aggregates data and shares data and information real time with mandates that all parties share information (e.g., health plans, ACOs, hospitals)
- **Community-Based Care** that requires that use of and reimbursement for services delivered by community health workers, embedded case managers, and/or peer

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<sup>3</sup> <https://www.cms.gov/Medicare-Medicaid-Coordination/Fraud-Prevention/Medicaid-Integrity-Education/Downloads/fwa-overview-booklet.pdf>

support specialists

- **Standard Metrics** for functions such as quality management, value-based payments, and/or referrals
- **Standard Toolsets** across all payers simplifies the payer-provider relationship (e.g., single credentialing process, common claims process)
- **Consistent and clear standards** to ensure quality, accurate data
- **Provider credentialing** is an administratively burdensome process for providers contracted with multiple MCOs/ACOs that could be centralized by contracting with a single entity

In our experience, developing uniform requirements and standards is an important way to ensure consistency in service and quality while reducing administrative burden on providers. For example, centralizing functions and standardizing requirements enables providers to focus on delivering care instead of managing processes to meet standards that may be inconsistent across payer sources.

### C. *ACO Populations*

**Question 1. Should LDH permit ACOs to serve specific regions, rather than enrolling Medicaid members statewide?**

**(a) Would ACOs be able to develop statewide networks?**

No response.

**Question 2. If LDH were to permit ACOs to serve specific regions, would the ACOs have large enough enrollment to support the infrastructure needed for ACO functions and to take on financial risk?**

To help guarantee that ACOs are able to take on the financial risk of serving a specific region only, we recommend that LDH set algorithms to ensure a minimum membership of 50,000 lives. Our experience has shown that this threshold is the critical mass for a successful program for the following reasons:

- **Savings:** Sufficient enrollment is essential to produce savings through better service coordination, promotion of preventive services, transition to home and community-based services, and diversion from institutional settings to home and community-based services.
- **Equitable Distribution of Members:** Sufficient enrollment is necessary to ensure the highest need members are distributed equitably across health plans.
- **Program Development:** To effectively implement innovative programs in a cost effective manner, adequate membership is required for widespread implementation of evidence-based practices.
- **Data Analytics:** To truly bend the curve and have a meaningful impact based on true analytics is difficult at lower membership levels.

- **Program Evaluation:** Large-scale participation is necessary so there can be a meaningful assessment of the model of care in the early stages of implementation, facilitating proactive intervention to make course corrections.

We encourage the State to consider implementing an auto-assignment process based on algorithms that consider continuity of care and member choice. In order to ensure equitable distribution of members, we recommend that the State establish a maximum threshold and a minimum threshold of members assigned to each MCO/ACO. The State can then adjust the auto-assignment process as MCO/ACO membership achieves the maximum or sinks below the minimum enrollment, ensuring that each health plan has the membership required to implement program requirements. We further recommend LDH limit the number plans per region.

### **Question 3. How should populations defined or limited for ACO enrollment, if at all?**

No response.

#### **D. Selection of ACOs**

##### **Question 1. What are the most important characteristics and qualifications for LDH to consider in selecting ACOs?**

When evaluating and selecting ACOs, we believe LDH should consider the following key characteristics:

- We recommend that ACOs be required to demonstrate at least 50% ownership by local provider organizations. True local, provider-owned ACOs or FQHC-owned ACOs have an understanding of the local community and a desire to serve the community in which they are located because they are accountable to its citizens. Because Gateway Health is a provider-owned, not-for-profit company, we focus on serving the member first and have produced a track record of collaborating to improve the overall health of the communities we serve.
- For any company to be successful it needs to focus on its strengths. For ACOs, those strengths center around delivery of care and patient engagement. It is therefore critical that they have partners or supporting organizations that can provide strength and support in more administrative areas like claims processes and appeals. By playing to each entity's strengths, the overall system becomes more efficient, resulting in higher quality and better outcomes at a lower cost.

### **E. Other Strategies**

#### **Question 1. Are there other managed care contracting or payment models that LDH can implement to achieve its goals?**

##### **(a) For example, should LDH encourage or require MCOs to contract with ACOs or implement other alternative payment arrangements with providers?**

To encourage provider accountability for care management and the total cost of care for Medicaid beneficiaries, Gateway Health offers LDH the following considerations:

- Create a standardized value-based payment continuum with gain share and ultimately capitation. LDH should consider aligning payment models with existing quality programs (e.g., MACRA, etc.).
- Tie the VBP model to LAN framework to reduce administration and increase tracking and reporting. The LDH will then have the data and near-real time insight into the success of the program.
- Through their contracts with the state, require MCOs to have ACOs in their network with a certain percentage of the MCOs' enrolled members receiving care from the contracted ACOs.
- Tie accountability and payment to a bonus pool with the goal of having at least 50% of members enrolled in an ACO in order to release funds from bonus pool.

To ensure ACOs' focus remains on bettering the overall health of the population, ACO responsibilities under a state contract should include clinical delivery, member engagement, and care delivery at the point of care. Traditional managed care organizations (health plans) should continue to handle administrative functions (e.g., claims, appeals) and enable data and information exchange/sharing across ACOs and other providers (e.g., population trends, care management best practices).

### **Section IV. Statement of Interest (if applicable)**

No response.

- Question 1.
- Question 2.
- Question 3.
- Question 4.
- Question 5.
- Question 6.
- Question 7.
- Question 8.
- Question 9.
- Question 10.
- Question 11.

**Respondent Information**

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Responding as an Individual: (Y/N) No

Responding on Behalf of Organization: (Y/N) Yes

Check all that describe your organization:

Hospital or Hospital System

Clinical System

Advocacy Organization

Health Plan

Physician

Non-physician Health Care Provider

Other – Please Describe

## ACO RFI Response

Blue Cross and Blue Shield of Louisiana (Blue Cross) appreciates the opportunity to provide comments to the Louisiana Department of Health on introducing provider-led Accountable Care Organization (ACO) arrangements to Louisiana Medicaid. Like the Louisiana Department of Health, Blue Cross is working diligently to increase the quality of care received by all Louisianans and reduce the overall cost of care. We recognize that the State of Louisiana has an opportunity to improve in these two important areas, and this is precisely why we have instituted quality programs in the market that have been recognized nationally. Further, the statewide improvements in these two key areas resulting from our efforts have been independently validated by the academic community.

We understand that the Louisiana Department of Health is striving to improve quality for Medicaid patients and control costs to ensure a sustainable program for this population. To promote better health, we are in agreement with the Louisiana Department of Health seeking to shift its payment system from volume to value and its delivery system from a focus on disease to a focus on population health. Improving the patient care experience, improving population health and spending resources wisely are all necessary for our members and for the state's financial stability. We believe that providing high-quality, coordinated care to the Medicaid population is best achieved through collaboration between the payer and provider communities, rather than looking to one or the other for the answer.

We believe that the Louisiana Department of Health would best meet its goals and achieve the desired results through models that promote payer and provider collaboration toward measurable improvement in quality and cost. Further, such collaboration would benefit from the strengths and capabilities of each. Given the maturity of these programs to date, MCO contractors are best positioned to lead that effort and drive the results that the Louisiana Department of Health is seeking.

The Louisiana Department of Health should request or require MCOs to enter into value-based payment relationships with providers under an MCO-led model. This structure would be more aligned with how payer and provider collaborate for Medicare and commercial health insurance programs, and could leverage and build on those efforts rather than setting up a competing set of structures. Such a model would position the State to benefit from financial strength and management of MCOs, while also taking advantage of care improvement, care coordination and cost reduction opportunities led by provider organizations. This would avoid scenarios where providers are directly competing with payers as contractors with the state, which would work against stated objectives of enhancing payer-provider collaboration. This would be of particular concern in addressing the dual eligible population (Medicaid and Medicare, where Medicare is primary), since all Medicare contracting is done by the federal Centers for Medicare and

Medicaid Services (CMS) with MCOs.

Beyond our belief that the MCO led model is a better approach, there are a number of challenges facing a provider-led model which suggest to us that it is a less preferred approach. These issues should be considered and addressed by the State to ensure adequate protections for the Medicaid population and to ensure a level playing field for all contracting entities in the Medicaid program. We have organized these challenges below for your consideration.

**Financial stability** – ensuring the financial stability of the contracting entity is critical to any model the Louisiana Department of Health adopts. This aspect ensures protection for residents seeking care in this program, and for the State from unexpected liabilities. Given the critical nature of this issue, it is imperative that the Louisiana Department of Health ensure all contracting entities abide by the same financial solvency requirements and provide transparency in the reporting of capitalization. The recent financial problems and bankruptcies experienced by health CO-OPs under the ACA is a good example of why this is necessary.

**Maturity** - Nationwide ACO experience, in all settings, has shown that Federal and State governments have had to financially support this immature model beyond their intentions. Under the best programs, CMS has seen low returns in key care and cost areas, low penetration rates and long timetables to self-sustaining plans. The Pioneer ACO program has seen a majority of the participants leave the program. These were participants who were noted as having already demonstrated an ability to operate in this model. Under the worst circumstances, we have seen scores of ACO plans struggle and even fail financially.

Specifically within the Medicaid program, there are only a handful of states that have embarked upon this endeavor and they all have been met with the same unremarkable results. In Florida, a substantial number of initial Medicaid ACO plans were acquired by payers due to financial instability. In Iowa, after initially introducing an ACO model, the state has reversed course and focused more on the MCO model for similar reasons. Of those states that have ACO models, half are so small in scale (e.g. Rhode Island, Vermont) that they cannot be used for comparison purposes.

The immaturity of this model and the history of substandard performance should serve as an indicator to the Louisiana Department of Health that initiating provider-led ACOs would come with significant risk, given the State's inability to provide for additional financial support. Furthermore, with potentially reduced federal funding being discussed in Congress, the Louisiana Department of Health would be prudent to follow a more established path to protect the Medicaid population and while providing care for the greatest number of recipients.

**Value-based care** –for the Louisiana Department of Health to achieve financial sustainability, value-based care is essential. Therefore, all contracting entities should be required to demonstrate the ability to implement measurable programs regarding quality of care and reduction of overall costs. Again, we believe the Louisiana Department of Health should look to those entities that provide the best opportunity to deliver this critical facet of the delivery system and across the greatest number of recipients.

**Statewide networks** – preferring a contracting entity to provide a statewide network is important for various reasons. Controlling cost is hampered by regional-only enrolled recipients who seek care outside of the plan’s region, which results in higher costs. Further, regional-only plans create inequalities among the contracting entities, given the ability for such plans to focus only on higher-populated areas and neglect the state’s overall population and the effort needed to provide quality care in rural areas. MCO contractors are required to provide coverage to all citizens, not just the highest-populated areas. We believe that provider led ACOs will be more regional in focus rather than state wide, and will be in more densely populated areas. Allowing provider entities to compete only in the densely populated regions of the state, and expecting MCOs to cover the remainder of the state, if excluded from the major markets, is not a reasonable expectation.

**Plan functions** – As it is anticipated by the Louisiana Department of Health that provider-led ACOs would need to maintain all the same plan functions currently required of MCOs, they should consider that providers are not currently structured to provide the required functions. This assuredly will result in the need for contracts between the ACOs and service entities (e.g. TPA entities or MCOs). Requiring ACOs to obtain and oversee health plan functions will lead to the distraction of ACOs from the core value of delivering care because of time spent on other functions (e.g. claims, accreditation). By having MCOs and ACOs compete with each other, the state may also create conflicts where the better performing MCOs do not wish to partner with the provider ACOs in the same market.

**Conclusion** - We applaud the Louisiana Department of Health in its efforts to seek higher quality and reduced overall total cost of care for Louisiana residents who obtain health care through Medicaid. Blue Cross stands ready to work with the Louisiana Department of Health in this pursuit.

Blue Cross has built successful partnerships with providers and has seen the transformation of the health care delivery system when payers and providers align in these programs. Our Quality Blue Primary Care (QBPC) model already has 728 Primary Care doctors and over 200, 000 members attributed to the program. QBPC program results are exhibiting more preventive services, fewer hospitalizations, and lower costs. During the first year of the program, in 2014, QBPC showed improved health results. Fifty-two percent of the members in the program had their hypertension symptoms under control. In 2016, that same number increased to 69%. In

2014, 14% of the members in the program had their diabetes symptoms under control. In 2016, that same number increased to 33%. In addition, our 2016 goal for hypertension is 70%. As of October, 2016, 163 QBPC providers have already achieved this result.

Given the history of instability of provider-led ACOs and their relative immaturity as an alternative payment model, the State's current financial status and a need to meaningfully transform the healthcare delivery model to ensure sustainability into the future, we strongly recommend that the State consider model(s) that demonstrate measurable successes in the Louisiana market today to bring the improved quality and cost reductions desired in the Medicaid system. It is our opinion, that model would be an MCO-led plan that collaborates with qualified providers who are willing to deliver on the objectives of the Louisiana Department of Health.

## Section III.

### A. ACO Requirements

- 1. Are there any exceptions or modifications to current requirements that LDH should consider to encourage ACO participation (e.g., special licensure and solvency requirements):**

For the protection of the recipients, the State and the Medicaid competitive landscape, provider-led ACOs should be held to the same standards that MCOs are currently required to meet. This would include financial stability requirements, including risk-based capital, statutory deposits and net worth. Additionally, provider-led ACOs should be required to meet mandatory operating requirements, including all certifications and accreditations.

Given the limited national experience of provider-led ACOs and their ability to succeed financially, financial reserve requirements would need to be in place to protect all stakeholders. A preferred model would be to request/require MCOs to collaborate with willing providers in ACO-type models.

- 2. What governance principles and/or requirements should LDH consider implementing to ensure that ACOs are governed and led by Louisiana providers?**

Given that the suggested model requires majority ownership of the ACO by a provider, consideration should be given to the fact that it is not clear that any providers currently have the capital, operations capabilities or statewide presence to meet the stated requirements. Therefore, cultivating a partnership that allows a provider to meet these requirements may be difficult, given the majority ownership requirements. Allowing equal governance between partners, particularly considering capital contributions, would serve to hamper opportunities for success.

- 3. Are there any interim steps or technical assistance that LDH could provide to promote providers' ability to develop ACOs over time?**

No comment provided

- 4. Are there any other unique requirements that LDH should consider applying to ACOs?**

The requirements for ACOs should be consistent with the current requirements for the MCOs to ensure a level playing field. ACOs should be required to meet the same standards in the evaluation, selection, and member assignment process that are applied to MCOs.

## B. ACO Functions

### 1. **Should ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan?**

If an insurance company or health plan partners with a provider-led ACO, each could bring value through their own specific competencies. It is not likely that an ACO would have the capacity, considering both financial stability and capital requirements, the experience or the scope to administer an ACO as a stand-alone entity. The ACO, more than likely, would need to partner with a payer and other providers. Therefore, the program may be more successful if the provider-led ACO is supported by or in collaboration with a MCO. This is of particular interest to the Louisiana Department of Health when considering improving value based care.

### 2. **Are there any key functions that LDH should not permit the provider-led ACO to delegate to another entity?**

No comment provided

### **Are there certain functions that LDH should consider standardizing or centralizing to facilitate ACO development and to ease provider administrative burden?**

The standardization and transparency of data exchanged between MCO, ACOs and the State is important to afford the State and contracted entities opportunities to create the greatest value to the Medicaid program and reduce costs.

#### **a. Should these functions be standardized across ACOs and MCOs?**

Yes, standardization of processes and data exchanges should be consistent across both MCO and ACO entities.

## C. ACO Populations

### 1. **Should LDH permit ACOs to serve specific regions, rather than enrolling Medicaid members statewide?**

Allowing regional ACOs would potentially serve to undermine the Louisiana Department of Health's overall objectives of reducing costs, increasing quality and providing an equally competitive landscape. Specifically, more members would potentially seek care on an out-of-network basis, given the smaller, regionally based network. Higher instances of Medicaid recipients seeking out-of-network care would lead to higher costs overall. Also, regional ACOs could choose to operate only in

higher-populated areas and possess competitive advantages that other ACOs or MCOs would not have because they would be operating under a statewide coverage requirement. Economies of scale would be incongruent with all participating entities and create an unequal landscape. Finally, it is unlikely that any provider that is contracting with the state through their own ACO is also going to contract with an MCO for their service area. This means that the only option for members to see those providers would be through the provider led ACO.

**2. If LDH were to permit ACOs to serve specific regions, would the ACO have large enough enrollment to support the infrastructure needed for functions and to take on financial risk?**

In addition to the other concerns expressed related to this question (see response to question 1), the number of competing entities would be higher in those regions (e.g. metropolitan areas) selected by ACOs. Therefore, the available membership necessary to reach financial stability would be challenging. As seen in Louisiana and the federal Exchange (healthcare.gov), the inability to achieve sufficient membership by the Louisiana Co-Op (a regional carrier) resulted in bankruptcy that caused losses exceeding \$50 million.

**3. How should populations be defined or limited for ACO enrollment, if at all?**

Any auto-enrollment processes should follow sound equity principles at all levels. This would include volume and risk-adjusted factors to ensure an equal playing field for all participating entities.

**D. Selection of ACOs**

**1. What are the most important characteristics and qualifications for LDH to consider in selecting ACOs?**

The most important characteristics and qualifications in selecting an ACO need to include:

- financial solvency and capitalization levels
- ability to deliver high-quality care and manage medical costs through a value-based approach
- ability to achieve and maintain all proper accreditation requirements

E. Other Strategies

- 1. Are there other managed care contracting or payment models that LDH can implement to achieve its goals?**
  - a. For example, should LDH encourage or require MCOs to contract with ACOs or implement other alternative payment arrangements with providers?**

Nationwide experience (commercial and government plans) has shown that the best results are achieved when payers and providers collaborate to deliver value-based care. We strongly believe that the State should place an emphasis on these models to achieve the results it seeks. Particular areas where these benefits can be achieved include ER diversion, Primary Care Physician (PCP) lock in and specialty drug policies.

**Section IV Statement of Interest (For Potential ACO Respondents Only)**

Blue Cross is not responding to this Request for Information as a potential ACO, and this section is therefore not applicable.



**Louisiana Department of Health**

**Request for Information for Provider-Led Accountable Care Organizations**

**Respondents:** Franciscan Missionaries of Our Lady Health System and LCMC Health

**REDACTED COPY**



January 6<sup>th</sup>, 2017

Louisiana Department of Health, Bureau of Health Services Financing  
628 North 4<sup>th</sup> Street  
Baton Rouge, LA 70802  
Attention: Frank Opelka, M.D.

**Re: Request for Information for Provider-Led Accountable Care Organizations**

Dear Dr. Opelka:

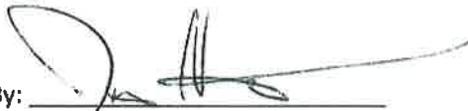
Franciscan Missionaries of Our Lady Health System and LCMC Health are pleased to submit a joint response to the Request for Information for Provider-Led Accountable Care Organizations. Our health systems are dedicated to strengthening the health of the communities we serve and this begins by improving quality and access to care for our Medicaid and uninsured populations. As culturally aligned health systems and the safety net providers in our regions, we are uniquely prepared to perform this important work. The population health impact we will make by working together in partnership with the LDH is much greater than what we could accomplish alone.

Privileged, Confidential or Proprietary information

The data contained in Section 4: Statement of Interest on pages 9-15 of this response have been submitted in confidence and contain trade secrets and/or privileged or confidential information, and such data shall only be disclosed for evaluation purposes. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the proposer, without restrictions.

Very Truly Yours,

Franciscan Missionaries of Our Lady Health System and LCMC Health

By: 

Richard Vath, M.D.  
Senior Vice President / Chief Clinical Transformation Officer / President Health Leaders Network  
Franciscan Missionaries of Our Lady Health System

By: 

Gregory C. Feirn  
Chief Executive Officer  
LCMC Health

## Louisiana Department of Health Request for Information for Provider-Led Accountable Care Organizations

**REDACTED Version** (Pages 9-15 of the response which include Sections IV. Statement of Interest and Section VI. Additional Information – Purpose, Disclaimer, Ownership, and Confidentiality have been removed from this version of the response.)

### Respondent Information:

#### Respondent 1

First Name, Last Name: Richard Vath, MD

Title: Senior Vice President / Chief Clinical Transformation Officer and President of Health Leaders Network

Organization: Franciscan Missionaries of Our Lady Health System

Address: 4200 Essen Lane, Baton Rouge, LA 70809

Contact Phone: (225) 922-7462

Contact Email: [richard.vath2@fmlhs.org](mailto:richard.vath2@fmlhs.org)

#### Respondent 2

First Name, Last Name: Greg Feirn

Title: Chief Executive Officer

Organization: LCMC Health

Address: 200 Henry Clay Avenue, New Orleans, LA 70118

Contact Phone: (504) 896-3035

Contact Email: [greg.feirn@lcmchealth.org](mailto:greg.feirn@lcmchealth.org)

## Section III. Questions for Respondents

### A. ACO Requirements

**Question 1.** Are there any exceptions or modifications to current requirements that LDH should consider to encourage ACO participation?

Yes, there are exceptions and modifications that should be outlined by LDH in order to encourage ACO participation. As listed within the Request for Information, solvency requirements must be discussed in the discovery period with interested parties responding to the RFI to ensure that provider-led ACO participants have the capacity to meet the needs of the population.

The solvency requirements identified should depend on the proposed risk models and would need to be adjusted as models move from shared to full risk with the state. There should be requirements focused on provider-led ACOs having re-insurance access, as well as requirements on mandatory reserves.

Additionally, LDH should consider requirements designating the minimum sized panel allowable for provider-led ACOs. We recommend a minimum of 10,000 patients to help protect organizations in risk contracting arrangements by mitigating the financial risk of applicants. There should not be prescriptive requirements on staffing models or the general operations of the ACO.

**Question 2. What governance principles and/or requirement should LDH consider implementing to ensure that ACOs are governed and led by Louisiana providers?**

We strongly support LDH's vision to pay for value by promoting the Triple Aim of improving patient care experience, improving population health and spending resources wisely. To accomplish this vision, LDH must be supported by Louisiana-based ACOs whose guiding principles, governance structure, and health care experience support physician driven population health initiatives.

LDH should stipulate that all respondents to the provider-led ACO RFI be licensed organizations within Louisiana and have participated for a minimum of three to five years in the Louisiana Medicaid program. This should be an endeavor led by experienced Medicaid providers and not by outside entities who see an immediate business opportunity. To achieve a true provider-led accountable care organization that will improve quality of care and create financial stability, we need providers committed to Louisiana's Medicaid population today and well into the future.

Additionally, LDH should outline governance structure requirements associated with the board composition of the provider-led participating ACOs. Greater than 50% of the Board composition should include practicing physicians within the Louisiana Medicaid program who have a minimum of three to five years of experience managing Medicaid lives in Louisiana. Of the practicing physicians on the Board, greater than 50% should be primary care providers. There should also be a requirement for behavioral health representation from a practicing physician on the board. Our collective experience has proven that a Board comprised of a majority of practicing physicians currently serving the population under contract, results in an engaged, enlightened and vested Board focused on improving program performance and innovative care design.

LDH should strongly consider a requirement that provider-led ACOs have experience in managing populations, regardless of payor, for a minimum of one year. The concept of population health is very different from the traditional episodic fee for service approach to healthcare management. Providers must understand that in a clinically integrated model they are part of a team of providers who have the shared responsibility to manage the health of a defined population. Additionally, primary care education focused on population health management is fundamental to the success of an ACO. Education that leads to true change in how care is delivered does not happen overnight. ACOs that educate and regularly engage with their providers will be the most successful in implementing cultural and behavioral improvements within the practice setting.

Lastly, faith-based organizations must be allowed to manage clinical service requirements in concert with their sponsored directives.

**Question 3. Are there any interim steps or technical assistance that LDH could provide to promote providers' ability to develop ACOs over time?**

There are interim steps and technical assistance that LDH should provide to promote ACO development. One of these interim steps includes the allowance for participating ACOs to begin in select markets that have population management experience and where there is the greatest chance of success due to available services and providers. This approach is in line with other ACO pilots across the country. These select markets should include those with the largest number of

Medicaid primary care providers who have patient panels totaling at least 10,000 lives, and who have the experience and existing infrastructure to succeed.

Additional items that would promote providers' ability to develop ACOs over time include:

- Separate pediatric-focused ACOs from adult-focused ACO entities. Managing these two dissimilar populations requires different care management strategies and access to different community resources and providers in a given market. For example, chronic disease management and utilizing predictive analytics are integral to the success of adult ACOs, whereas pediatrics ACOs are often more focused on prevention and wellness.
- Consider capitation for primary care services alone for the adult ACOs and allow specialty care contracting to continue in a traditional payment model.
- Develop a deliberate plan outlining the partnership between mental and behavioral health providers who care for the Medicaid population and the primary care and specialty providers who care for the same population. Mental and behavioral health cannot be a separate contracted function. These providers must be part of the care team and held to the same set of expectations as all other clinical providers.

Technical assistance that we believe is necessary includes:

- Creation of a means to share data across the ACOs throughout the state. The provider-led ACOs must have access to meaningful data so they can analyze performance, identify care gaps and take action. Data access and integrity is critical to the success of any ACO or clinically integrated network. Therefore, we believe provider-led ACOs must have access to a single statewide HIE provided by LDH.
- Actuarial services support.
- Outside consultants who work with provider group on Medicaid risk contracting and delivery experience.

**Question 4. Are there other unique requirements that LDH should consider applying to ACOs?**

There are a number of unique requirements that LDH should consider applying to ACOs. Some of these requirements have been mentioned in earlier responses within this RFI and others are captured for the first time below:

- Access to well-designed mental and behavioral health solutions.
- Robust care and case management programs designed for this specific population.
- Identification of post-acute care providers who will serve this population.
- Clarity on long-term care partners and approach to be used in the state. For example, are there certain nursing home care models that should be utilized to support this work.
- Adequate primary care and specialty access.
- Funding mechanisms that focus on non-hospital care and instead incentivize appropriate preventative and ambulatory care delivery models.
- Statewide HIE provided by LDH that is compatible with select EMRs.
- Required EMR use by all provider-led ACOs with data input into the statewide HIE.
- Solvency requirements applied to ACOs.
- Previous experience in utilizing data to manage high-risk patients.
- LDH must issue a mandatory statewide Medicaid formulary.

## **B. ACO Functions:**

**Question 1.** Should ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan?

Yes, this must be permitted. It is anticipated that seriously interested applicants will need to enter into a TPA or joint venture with an insurance company or health plan in order to participate successfully.

**Question 2.** Are there any key functions that LDH should not permit the provider-led ACO to delegate to another entity?

The defined set of quality and utilization performance measures supporting the Triple Aim must be set by the provider-led ACO and not delegated to another entity.

**Question 3.** Are there certain functions that LDH should consider standardizing or centralizing to facilitate ACO development and to ease provider administrative burden? Should these functions be standardized across ACOs and MCOs?

Yes, there are certain functions that should be standardized across ACOs and MCOs to facilitate ACO development and ease provider burden.

- LDH should standardize the statewide HIE.
- Standard EMR requirements should be applied across all provider-led ACOs with required data input into the statewide HIE. Minimum requirements should be outlined for all EMRs including verification of their level 2 meaningful use status.
- A statewide formulary must be mandated for use across ACOs and MCOs.

## **C. ACO Populations**

**Question 1.** Should LDH permit ACOs to serve specific regions, rather than enrolling Medicaid members statewide?

Yes, LDH should allow ACOs to serve specific regions. ACOs with a regional focus are able to drill down and act on the specific health care needs of a community. LDH should identify a limited number of initial service areas to implement ACOs. This will ensure that a full evaluation of the first pilots is completed and ongoing improvements to the models are made. The ability of the potential organizations to meet the outlined requirements and demonstrate that they have the appropriate infrastructure and experience in a specific region should be part of the evaluation of ACO candidates.

a) Would ACO's be able to develop statewide networks?

Yes, the establishment of the regional ACO's can result in the creation of a statewide ACO network. Across the nation, many existing statewide networks began as regional models. In

time as regional ACOs experience success taking on risk and managing their populations, LDH should encourage and support them in their efforts to grow statewide.

**Question 2.** If LDH were to permit ACOs to serve specific regions, would the ACOs have large enough enrollment to support the infrastructure needed for ACO functions and to take on financial risk?

Yes, ACOs serving specific regions could have large enough enrollment pools and meet the minimum requirement of 10,000 patients. This creates a large enough panel for the organization to absorb risk as well as build out capacity to provide all ACO services.

**Question 3.** How should populations be defined or limited for ACO enrollment, if at all?

Current waived groups should continue in this status and not be part of initial ACO enrollment. A controlled, methodical development of the ACO population at risk should provide the ability to evaluate the effectiveness of the models in improving care and reducing cost. As the ACOs build their experience and capacity, other unique risk pools could be folded into functional ACOs.

#### ***D. Selection of ACOs***

**Question 1.** What are the most important characteristics and qualifications for LDH to consider in selecting ACOs?

As LDH evaluates organizations for the ability to manage a large ACO, understanding their existing and planned infrastructure as well as the ability of the organization to expand capacity to provide services to the population enrolled in the ACO is critical. The ACO should primarily include providers that have experience providing care to the local Medicaid population in order to minimize the disruption of care to patients. In addition to having the minimum 10,000 attributed Medicaid lives, the base assessment of an organization should include the following:

- **Access** - When selecting an ACO organization, both geographic access and access to providers across all specialties should all be considered. Providers who are not easily accessible to their patients will have difficulty managing their patients' health and wellbeing. Our experience in managing populations has taught us that the development of core access standards is critical to success.
  - The Number of Healthy Louisiana lives– While we have already identified that 10,000 patients should be the minimum number of lives in an ACO, it is important to recognize that the greater the number of lives attached to the participating providers, the fewer primary care providers you need to get to 10,000 lives. An organization with ready access to primary care providers with large Medicaid panels of well managed patients is a tremendous asset.
  - Geographic Access – The ACO footprint should extend to the geographies where the panel has easy access to providers. Providers' offices should be located in the communities they are serving or near public transportation. Proximity to other downstream healthcare services should also be assessed.
  - Provider Access – How easy or difficult it is for a patient to be seen by their primary care provider impacts an ACO's ability to manage that patient's care. Appointment availability, practice hours, days of operation, and experience serving diverse populations who may be

receiving primary care services for the first time are all important factors. In addition, access to specialty care, substance abuse and mental health services is critical for primary care providers to be able to manage their patient's health.

- Data Management and Analytics Competencies  
LDH must establish a statewide HIE to ensure data flows consistently, timely and accurately to the ACOs. Successful ACO providers are data driven and receive strong analytics support to help them identify and take action on their high risk patients.
  - System Requirements –The requirement should be EMR use by all provider-led ACOs with data input into the statewide HIE. Minimum requirements should be outlined for all EMRs including verification of their level 2 meaningful use status. Successful ACOs must meet minimum technology standards in order to comprehensively support population health management functions and operations.
  - Data Analysis and Integration – The ACO must ensure through their governance structure that providers are supportive and comfortable with the use of EHR's, claims data, and registry information to analyze and report performance. The organization should also take the lead in ensuring that providers can easily access and integrate with an appropriate IT platform to perform these functions.
- ACO Leadership and Governance Structure – The ACO leadership team must understand and buy into the health care paradigm shift from fee for service care to population health management. Appreciating the distinction between the performance measurement of a group versus an individual patient's episode of care is foundational to this work. Practicing physicians who understand value based care should make up the majority of the governing Board. These sophisticated providers have the ability and desire to develop performance measures, identify and credential new providers, as well as hold physicians accountable for their results.
- Care coordination experience – An ACO should have experience and infrastructure in care coordination. An ACO's care coordination expertise should be reflective of the population being served - including demographic challenges, literacy levels, and other identified barriers to care. An ACO must be systematic in its approach to information exchange amongst clinicians, patients and caregivers. ACOs must have procedures to transition patients from varying risk levels seamlessly. Providers who are experienced in patient centered medical home models are excellent candidates to recruit into an ACO structure.
- Population Health – ACO administrators and care providers must perform proactive outreach to every patient who has a relationship with a provider in the ACO. Outreach and education are extremely important in the overall identification and management of those patients most at risk. Population Health strategies should also recognize that the patient panel is part of a larger community to which the health outcomes of the ACO participants can impact. Regional ACOs are closer to home for patients and can better coordinate outreach and education with community outlets and programs to help achieve their goals. ACOs who have built and encouraged these relationships will be in a stronger position to build capacity to meet performance metrics and contain costs. ACOs should develop performance measures in alignment with Community Health Assessments. If the ACO is part of a hospital system, then alignment and participation in these assessments would not only be beneficial, but could help drive successful management of the population.

## ***E. Other Strategies***

**Question 1.** Are there other managed care contracting or payment models that LDH can implement to achieve its goals? For example, should LDH encourage or require MCO's to contract with ACOs or implement other alternative payment arrangements with provides?

LDH should consider a primary care cap for adult PCP's and bundled payments for specialty care such as elective surgery and certain medical conditions managed by medical specialists. MCO's should only be required to contract with ACOs for TPA services such as enrollment and should be at a pre-determined fixed rate determined by the state. Patients should be linked directly to the ACO and not an MCO.



January 26, 2017

Mr. Frank Opelka  
Medicaid Program Manager  
Louisiana Department of Health  
628 N. 4<sup>th</sup> Street  
Baton Rouge, LA 70802

Re: Louisiana Department of Health Request for Information for Provider-Led Accountable Care Organizations

Dear Mr. Opelka:

Aetna appreciates the opportunity to support the Louisiana Department of Health (LDH) in its efforts to identify potential strategies for the involvement of provider-led ACOs in the Louisiana Medicaid landscape. We are strongly positioned to comment on and support the LDH's desire to shift from paying for *volume* to paying for *value* and to improving health care quality and outcomes.

Aetna's Medicaid organization brings over 30 years of experience and expertise delivering successful solutions to complex problems for Medicaid populations. We have built upon this foundation as it has expanded across the nation. We have a solid footprint in 15 states where we currently serve more than three million TANF, CHIP, SSI, Dual-eligible, and LTSS members. While our programs and services continue to evolve and expand, our mission remains the same—building a healthier world by improving the lives and well-being of every member we are privileged to serve.

Aetna's numerous initiatives and processes across the country, including contracts with Medicaid agencies and providers, and provider-led ACO organizations inform our commentary. We are innovators in value based solutions nationwide, transforming health care through progressive purchasing arrangements.

As an enterprise, Aetna contracts with more than 300 Accountable Care Organizations (ACOs) across the country. We operate over 800 value based programs and support nearly one million members in Patient Centered Medical Homes (PCMH) programs. Aetna has developed its value based programs in collaboration with provider groups of varying capabilities and geographies. We recognize the value of rewarding providers for improving quality of care through programs that pay for value as opposed to volume.

Our programs offer incentives for the additional administrative and clinical care that providers deliver to our members through PCMH. Our contributions to this discussion reflect our experience in Louisiana, as well. Currently, Aetna has four shared savings agreements that include PCMH operational in Louisiana. We also have physicians in our Pay-for-Quality programming for 2016 and are expanding these agreements to 2017, as well.

- **Franciscan Missionaries of Our Lady Health (FMOLHS) transitioned from a PCMH to Shared Savings:** One of the leading health care innovators in Louisiana, FMOLHS brings together



outstanding clinicians, the most advanced technology, and leading research to help ensure patients receive the highest quality and safest care possible. This organization serves more than 3,500 Aetna members and includes over 240 primary care physicians (PCPs).

- **Access Health - Shared Savings:** Access Health Louisiana, a nonprofit network of clinics, includes over 330 PCPs and supports Aetna membership of over 4,200 across South Louisiana. The clinics all share a common mission—bringing quality, convenient primary care to communities and individuals who experience difficulty accessing health care. Access Health Louisiana is the largest network of Federally Qualified Health Centers (FQHCs) in Louisiana and offers comprehensive medical, behavioral, and dental health care to communities.
- **HealthLink - Shared Savings:** HealthLink of Louisiana, an Independent provider practice association for Louisiana’s Association of FQHCs, has more than 275 primary care physician participants and nearly 4,800 Aetna members. HealthLink partners with FQHCs and managed care plans to improve the quality of care of FQHCs. HealthLink’s goal is directed at FQHC patients, aiming to improve their quality of care and access to care.
- **Verity - Shared Savings:** Verity HealthNet is a progressive, statewide physician-hospital network based in Louisiana, with over 240 PCP participants and over 3,300 Aetna members. Verity develops and maintains the highest quality, cost-effective network of choice with minimal disruption to the patient/physician relationship. Verity’s local presence and market knowledge positions them to excel at responding to the needs of their providers and members, particularly in rural areas throughout the State.

We are proud to work with these outstanding organizations and continue to survey other systems to increase our understanding and contributions to the future ACO landscape in Louisiana.

Aetna has learned from experience and is constantly open to innovative partnerships for the advancement of the Triple Aim. As an established Managed Care Organization, we understand and have proven our abilities to help provide technical assistance, education, technology, and tools to support and advance the infrastructure necessary for ACO success.

Leveraging lessons learned across all of Aetna’s Medicaid plans, we can act quickly to tailor programs to local conditions. While not all systems currently possess the infrastructure necessary to immediately enter into an ACO arrangement, we are in a solid position to work with those systems to provide tools and necessary support to help them along the way.

Aetna welcomes the opportunity to further explore with the LDH the ways in which ACOs can effectively and efficiently impact care to Louisiana’s Medicaid populations. We look forward to future discussions as the LDH continues to shape its vision of a vibrant and productive Louisiana health care landscape.

Sincerely,

A handwritten signature in black ink that reads "Richard C. Born". The signature is written in a cursive, flowing style.

Richard C. Born

Chief Executive Officer

Aetna Better Health of Louisiana

# Response Form

## RESPONDENT INFORMATION

First Name: Richard  
Last Name: Born  
Title: Vice President and CEO  
Organization: Aetna Better Health of Louisiana  
Address: 2400 Veterans Memorial Blvd., Suite 200,  
Kenner, Louisiana 70062  
Contact Phone: 504-667-4580  
Contact Email: MBURFP@aetna.com

Responding as an Individual: N  
Responding on Behalf of Organization: Y

Check all that describe your organization:

- Hospital or Hospital System
- Clinical System
- Advocacy Organization
- Health Plan
- Physician
- Non-physician Health Care Provider
- Other – Please Describe: \_\_\_\_\_



## SECTION III. QUESTIONS FOR RESPONDENTS

### A. ACO Requirements

#### Question 1.

LDH envisions establishing requirements for provider led ACOs that mirror requirements for the Medicaid managed care organizations currently participating in the Healthy Louisiana Managed Care Program. LDH seeks the following information related to requirements for ACOs.

1. Are there any exceptions or modifications to current requirements that LDH should consider to encourage ACO participation (e.g., special licensure and solvency requirements)?

Given our experience, participation, and observations of successful ACOs, we believe some exceptions to current requirements will enable the LDH to inspire and encourage increased ACO participation and evolution in Louisiana. These exceptions for the LDH's consideration include:

- **Inclusive ACO Composition:** Aetna believes it is in the LDH's interest to promote ACOs that are inclusive of nurse practitioners, physician assistants, and more. This inclusive affiliation provides a broader spectrum of services and support, along with increased opportunity for penetration in both urban and more rural and isolated areas. Additionally, nurse practitioners play an integral role in team-based and patient-centered models of care such as ACOs. Improving care, particularly for individuals with chronic and complex health care needs, necessitates a care delivery system that is effective in organizing care, enabling access, and improving outcomes.
- **Phased ACO Development:** Aetna recommends the LDH allow a phased approach for the development of ACOs. For a group of participants new to the idea and business processes of an ACO, this approach allows for a "fledgling" ACO to grow into a more comprehensive and sophisticated ACO over time. We use the term "fledgling" to refer to the way in which a group receives reimbursements—less complex and less risk-based than a more sophisticated group. ACOs evolve by gaining experience in managing a specific population, developing processes supporting that management, and the requisite infrastructure. Perhaps most importantly, groups develop the ability to take data that may come from payers and use it to facilitate care management.
- **Loose Affiliations:** Another way the LDH can nurture ACO development and participation of caregivers is to allow loose affiliations as entrants into the ACO field. We define loose affiliations as groups not necessarily legally combined but that have agreements in place to work together. Again, this will make it easier for a group to assemble and enter the ACO arena and, in time, evolve into a comprehensive ACO. In essence, the LDH will help these groups launch over a period of time until they are stable and capable of assuming additional risk.

The challenges with which emergent ACOs are confronted are formidable. Basic requirements, including licensed as insured, proof of solvency, and NCQA accreditation, are all essential for the success of the organization, as well as for the safety and security of their members. Requirements should apply to ACOs, as well as MCOs.



**SECTION III. Questions for Respondents**  
**A. ACO Requirements**

The success of any ACO or VBS initiative in Louisiana is dependent upon strong and transparent relationships with both the LDH and the MCOs to help ensure all goals are and continue to align. Provider education, ongoing support, and helping providers to understand the benefit of ACOs to both the member's health and the provider's bottom line are critical to widespread adoption. This three-way partnership stabilizes service delivery and growth. Because of the magnitude of these challenges, partnership with an MCO ensures both success and stabilization.

In our experience, a successful ACO/MCO partnership is based on MCO support in key enablement areas for our provider partners to ensure a robust and comprehensive approach to population health management. For example, data integration and sharing capability is critical to ensure capacity is built in to the relationship to support bi-directional, real-time sharing of data designed to optimize care coordination and tracking of quality outcomes and total cost of care. Moreover, we have found that when we share resources and technical assistance from our staff and clinical experts, we are able to more effectively compliment and support our provider partners to build upon what they are already doing well, but then also give them access to additional expertise to care for the complex Medicaid population. Dedicated staff, coupled with a commitment to data sharing technology and shared accountability for providing the full complement of services, creates a trusting relationship that ultimately results in more effective clinical workflows for both organizations that lead to better outcomes and a more efficient use of resources for all involved.

As part of our VBS approach, Aetna offers support to ACOs through an implementation team that includes data analysts and population health specialists. These teams provide the ACOs with proper resources and necessary data to drive success. This foundation drives and supports ACO creation and evolution as providers begin to realize the true benefits to both their patients and their organizations and become empowered through their partnership with the MCO and the State.

## **Question 2**

### **2. What governance principles and/or requirements should LDH consider implementing to ensure that ACOs are governed and led by Louisiana providers?**

Given our understanding of the LDH's approach and its use of the CMS definition and requirements for an ACO, a Louisiana ACO board will be comprised of at least 75 percent Louisiana licensed PCPs. We echo CMS's determination that every board includes a consumer representative who is a part of the population served, and a Louisiana-licensed medical director. We also recommend the LDH require 75 percent of the board members in urban areas be physicians, and recommend that allowances be made for board composition in rural areas.

Similarly, the LDH may add a minimum ownership requirement—a percentage of ownership required to be held by Louisiana physicians or a Louisiana-based health care-related company. Our recommendation is at least 80 percent, with a preference of 100 percent. Anyone with ownership of five percent or more interest should be disclosed. This requirement reinforces the importance of local ties and weaves in the essential understanding of the local population, its needs, challenges, and support mechanisms. In turn, this supports care coordination and successful outcomes while supporting savings. It also helps to secure the greater goal of healthier citizens while securing the ongoing success of the ACO.

SECTION III. Questions for Respondents  
A. ACO Requirements

### Question 3.

**3. Are there any interim steps or technical assistance that LDH could provide to promote providers' ability to develop ACOs over time?**

Aetna's recommends three steps that will serve the LDH well in its work to support ACO development and sustainment:

- **Formation of a best practices workgroup designed to encourage participation in ACOs and further develop organizational expertise:** By reaching out to and involving members of the health care community, potential participants will feel they have a voice in the LDH's development of ACOs and will feel supported. This type of information-sharing enables networking and idea development that speaks specifically to the needs of Louisiana. An ongoing Learning Collaborative (LC) is an excellent option between the LDH, providers, and MCOs. We have had expansive LCs in the past that were very well received.
- **Development of the value proposition for the "why" Louisiana providers should participate:** Developing and communicating this message will enable the health care community to understand the LDH's goals. More importantly, it will help potential ACO organizers and members to truly understand the benefits to providers and their patients.
- **Development of a basic "ACO 101" education session to educate providers on basic principles:** This type of information delivery will enable those interested in starting an ACO to better understand what the State envisions as the necessary provider and ACO commitment and participation.

To advance health care in Louisiana, the LDH must facilitate a learning network that can assemble more seasoned care providers to help educate and inspire new groups and physicians. These individuals can help to translate best practices and share knowledge and experience to inspire and instruct a new generation of ACOs.

The State may also consider facilitating sessions, as well as content (e.g., a newsletter that fosters networking). One idea might be to invite guest speakers from other states to serve as the vehicle for face-to-face discourse. While funding is always the challenge for such events, MCOs may assist with underwriting the costs. To fulfill a state contract, there is significantly more assistance required for the development of an ACO.

In our experience, there are seven, key ingredients to the environmental mix that nurtures and supports the relationship-building, adoption, and success of a provider-led ACO:

1. **Goal alignment:** The ACO leadership and clinical teams must be committed to care delivery transformation and align its quality improvement goals with those of the LDH and the surrounding MCOs.
2. **Provider engagement:** Successful provider engagement facilitates moving providers along the value based continuum as their organizations mature and inspires others to form ACOs.
3. **Integrated care management:** Coordination through an integrated care *team* approach drives quality outcomes.
4. **Analytics and data sharing:** Access to and sharing of actionable, real-time data among all key stakeholders enables providers to manage member health needs in a timely manner, close gaps in care, and achieve population health management success.
5. **Health care technology:** Access to and use of innovative data sharing tools and applications to enhance and advance provider capabilities give providers greater visibility into and capability to impact patients' health



SECTION III. Questions for Respondents  
A. ACO Requirements

and meet broader needs across the care continuum.

6. **Member engagement:** Share critical health care information with members to empower and encourage active participation to promote self-management and support the provider by aiding them in closing gaps in care.
7. **Support:** Continuous support that begins in the implementation phase and continues throughout the program in the form of regular provider plan collaboration team meetings is crucial to building relationships, ensuring alignment on an ongoing basis, and continually evolving the programs to meet the ever-changing landscape of the health care delivery system.

All of these factors are addressed through partnership with a larger established MCO to help launch a successful ACO. These create a scalable, sustainable model that directly supports LDH's vision for expanding access to quality care and expansion of provider participation in value-based arrangements across Louisiana.

#### Question 4.

##### 4. Are there any other unique requirements that LDH should consider applying to ACOs?

Yes; Aetna recommends the LDH ensure groups seeking to operate as an ACO can demonstrate their shared savings methodology and capabilities. This ensures the benefits reaped from savings through the more efficient model are available to the downstream providers providing the care. Examples include a risk-based model that ensures provider contracts/agreements with the ACO to reinforce value and quality improvement over volume and productivity. Another example is shared savings that are cascaded down to participating care providers. It is paramount for these organizations to follow a true value-based model. By that, we mean they should be able to demonstrate their ability to manage care and to subscribe to a payment model that pays for value as opposed to volume.

The LDH should also consider encouraging ACOs that not only include physicians employed within the group, but independent physicians as well. If the LDH is unable to mandate this type of configuration, we believe Louisiana will benefit from encouraging **independent physician groups to affiliate to create an ACO entity.**



SECTION III. Questions for Respondents  
B. ACO Functions

## B. ACO Functions

### Question 1.

ACOs would be expected to provide all functions of a traditional MCO, including but not limited to: claims adjudication and payment, marketing, member services, provider network development, credentialing, prior authorization, care management, data analytics and quality reporting. ACOs would also be expected to offer the same set of benefits to enrollees as that offered by current MCOs. LDH seeks the following information related to key ACO functions.

**1. Should ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan?**

Yes; Aetna is confident this type of relationship should not only be permitted but should be a requirement. Currently, very few provider entities can function as an MCO—and certainly lack the financial strength to do so. This is a significant challenge with a newly-formed group. Without this necessary partnership, the provider-led ACO is prone to failure.

An MCO offers greater infrastructure and capacity in several areas including, but not limited to:

- Investment in information technology to flag and address comprehensive population management, including care gaps, transition of care management, total cost of care and care coordination and optimization.
- Dedicated staff resources to access enhancement (e.g., arranging transportation to and from care, telephone calls regarding specific care gaps)
- Resources and tools that support an ACO's ability to improve quality scores
- A 360-degree view of the membership activity combining the MCO's claims state with the provider's EHR clinical data
- Actuarial bench strength
- Care management expertise that complements the provider's existing capabilities, especially around managing the high-cost, high utilizers with complex biopsychosocial needs
- Utilization management capabilities, especially with high cost areas such as high cost pharmacy and radiology management.

By combining the strengths of both types of organizations, additional expertise, resources, experience, and stability for members and their care experiences is achieved. For example, Aetna can support providers in meeting their ACO goals and objectives by:

- Engaging existing and new providers
- Providing regular reports obtained from financial records, claims encounters, predictive modeling, and other data



SECTION III. Questions for Respondents  
B. ACO Functions

- Meeting with Primary Care Medical Home (PCMH) and Shared Savings (SS) provider partners to review performance data, discuss challenges and barriers to improvement, and provide technical advice, as applicable, to improving population health capabilities
- Providing on-demand and on-going education to partners on a variety of population management topics
- Providing member engagement support and alignment with the ACO's primary care team/PCMH
- Aiding providers in closing gaps in care by providing resources to help members schedule and keep appointments

These are some of the most crucial pieces requisite to transitioning from volume to value and represent the infrastructure necessary to actualize the Triple Aim for the LDH.

### Question 2.

**2. Are there any key functions that LDH should not permit the provider led ACO to delegate to another entity?**

Yes; there are three areas of operation we consider problematic for provider ACO delegation:

1. **Care management:** Managing patient care may be more effective when performed by a provider group, if it has the necessary infrastructure. The ACO should originate and conduct all oversight of care management. Full delegation should not be permitted. Again, the importance of the local connection to quality care management is paramount.
2. **Compliance:** Internal compliance necessarily requires a fully engaged and informed leadership team and board of directors. Keeping this internal nurtures and maintains an organizational culture, with clear expectations of ethical and proper behavior. Proactive monitoring and measures guide comprehensive identification and response to compliance risk and is the organization's commitment to accountability.
3. **Grievances and appeals:** An ACO's ability to handle grievances and appeals internally is an indication of its capabilities for success. Grievances and appeals are an important feedback loop that an ACO needs to be closely aware of and capable of managing and addressing. Being in tune with grievances and appeals is essential to an ACO's comprehensive commitment and capability of expediting response to patient needs.

### Question 3.

**3. Are there certain functions that LDH should consider standardizing or centralizing to facilitate ACO development and to ease provider administrative burden?**

Yes; we believe there are certain functions that LDH should standardize or centralize to help ACO development and ease provider administrative burden. Because credentialing can be a time-consuming, expensive, and labor-intensive effort, a credentials verification organization would centralize and facilitate this process and ease the administrative burden for all parties. The LDH should require any new entity to use this organization for the credentialing process.

The LDH should also require the use of the Council for Affordable Quality Healthcare credentialing form. This form is proven to help physicians more easily and cost-effectively provide the required credentialing information



**SECTION III. Questions for Respondents**  
**B. ACO Functions**

to health care organizations. Standardizing the initial capture and update and storage of this information simplifies the process and minimizes disruption during transitions.

While standardizing data aggregation might also be considered, the cost to do so is considerable given the number of different platforms. There are, however, vendors capable of such work; such work currently being conducted in other states includes the all payor claims base in Pennsylvania. We also believe the LDH should consider standardizing metrics, measurement tools, and data sharing technical requirements across ACOs, MCOs, and other community health care partners.

Any standardization or centralization of functions should exclude care management, as this function should remain with providers. Centralized care management services do not always achieve the same results as care management rendered through a patient's PCP. Again, the importance of the local connection is critical.

**a. Should these functions be standardized across ACOs and MCOs?**

Yes; we recommend credentialing requirements be standardized for both ACOs and MCOs; any incumbent organization—ACO or MCO—should not be required to re-credential care providers in this manner. The LDH, however, should require any new organization to credential in this manner.



SECTION III. Questions for Respondents  
C. ACO Populations

## C. ACO Populations

### Question 1.

LDH envisions that ACOs, like the state’s traditional MCOs, would serve all Medicaid members who are eligible for enrollment in Healthy Louisiana. LDH seeks the following information related to populations to be served by ACOs.

**1. Should LDH permit ACOs to serve specific regions, rather than enrolling Medicaid members statewide?**

Yes; by the LDH’s definition, an ACO in Louisiana comprises local provider participants supporting members within their local communities. A local commitment is essential to providing the foundation for quality care coordination and management, as well as to achieving successful outcomes and accompanying savings. We understand the LDH’s vision of multiple ACOs across the State that assist with meeting all points on the care continuum.

Initially, it will be easier to allow ACOs to serve specific regions, thus enabling them to become accustomed to running an ACO on a smaller scale prior to assuming a larger scope. This, however, brings a different set of issues. For example, how are out-of-network patients handled if the geography is restricted? Some provider groups cannot serve statewide, because they are unable to form a statewide network. Some ACOs may not be interested in expansion. This raises the question as to whether or not the LDH really wants to require a statewide network or does it risk alienation of important groups for the LDH’s success. A regional approach may present the right-sized geographic “chunk” necessary to make the associated risk attractive to new ACOs. It is crucial to establish the parameters to a size and level that will involve and engage physicians and inspire participation.

To advance the goal of statewide ACOs, MCOs currently in place can support and partner for future aggregation of regional ACOs into statewide ACOs through standardized contracts.

**a. Would ACOs be able to develop statewide networks?**

Yes; with the right support and a solid start, it is possible for these new fledgling ACOs to grow into a level of sophistication that supports statewide networks. This is where the LDH’s current work to establish the initial parameters is so important.

The configuration and limits of the initial set of ACOs will set the stage for success or failure. The creation of groups that succeed initially supports future growth, expansion, and the willingness and capability to assume additional risk and responsibility. To achieve this, the ACOs must include all provider types and levels of service needed to provide adequate access for patients served. Their success will serve as the example for other groups to assume the challenges with both in-house models and mentors.

Another important consideration for the LDH is the possible danger of membership cannibalization. As a group’s geography expands, it is possible the group’s service area could overshadow those smaller groups. It is crucial to build in the right membership protection to enable these smaller groups to survive and thrive.

MCOs are also positioned to enhance network capabilities. By helping networks collaborate together, MCOs are better positioned to expand the ACOs’ capacity and geography.



SECTION III. Questions for Respondents  
C. ACO Populations

**Question 2.**

- 2. If LDH were to permit ACOs to serve specific regions, would the ACOs have large enough enrollment to support the infrastructure needed for ACO functions and to take on financial risk?**

Yes; an organization with the capabilities required for success should be able to support a minimum membership of 10,000; this number allows the ACO to spread risk appropriately across the organization. This assumes a full risk payment structure which translates into a strictly population based payment arrangement and complete absence of fee for service. It greatly depends upon the infrastructure of the ACO as to whether or not it can manage the risks associated with a particular size of membership and still deliver improved population health.

**Question 3.**

- 3. How should populations defined or limited for ACO enrollment, if at all?**

The LDH envisions ACOs should take care of the population across the care continuum. Populations should initially be limited to allow the ACOs to become accustomed to the demands and intricacies associated with the varying Medicaid populations.

We recommend initial populations be TANF/CHIP individuals that are traditionally representative of a population with less complex care needs. As the ACO gains maturity, other populations with more complex medical needs can be added into the mix.



## D. Selection of ACOs

### Question 1.

LDH would likely procure ACOs as part of its standard MCO procurement process. LDH seeks the following information related to ACO selection.

#### 1. What are the most important characteristics and qualifications for LDH to consider in selecting ACOs?

There are several characteristics and qualifications the LDH should consider, including:

- Must be licensed to operate as a managed care organization if they are not in partnership with an MCO
- Must demonstrate financial solvency
- The appropriate number and mix of providers (primary care physicians/nurse practitioners)
- Geography/coverage
- Infrastructure
- Governance aligning with our earlier recommendations in response to item A.2.
  - Internal mechanisms for quality measures, e.g. electronic health record connectivity and meaningful use
- Operational sophistication of operations
  - Experience in other Alternative Payment Models (APMs)
  - Demonstrated quality improvement or the ability to create the same
  - Experience converting volume to value
  - Experience with supporting the needs of the Medicaid population
  - Demonstrated capabilities in care management
  - Community-based care and the importance of events outside the provider's office

The State should be selective; organizations that are less than qualified are at risk of failure, which in turn results in a long term negative impact on the program overall and deter others from attempting to work with the LDH. The LDH should also consider the number of ACOs it is able to manage given the administrative burden of State oversight, rate setting, managing reporting including encounters, etc.

## E. Other Strategies

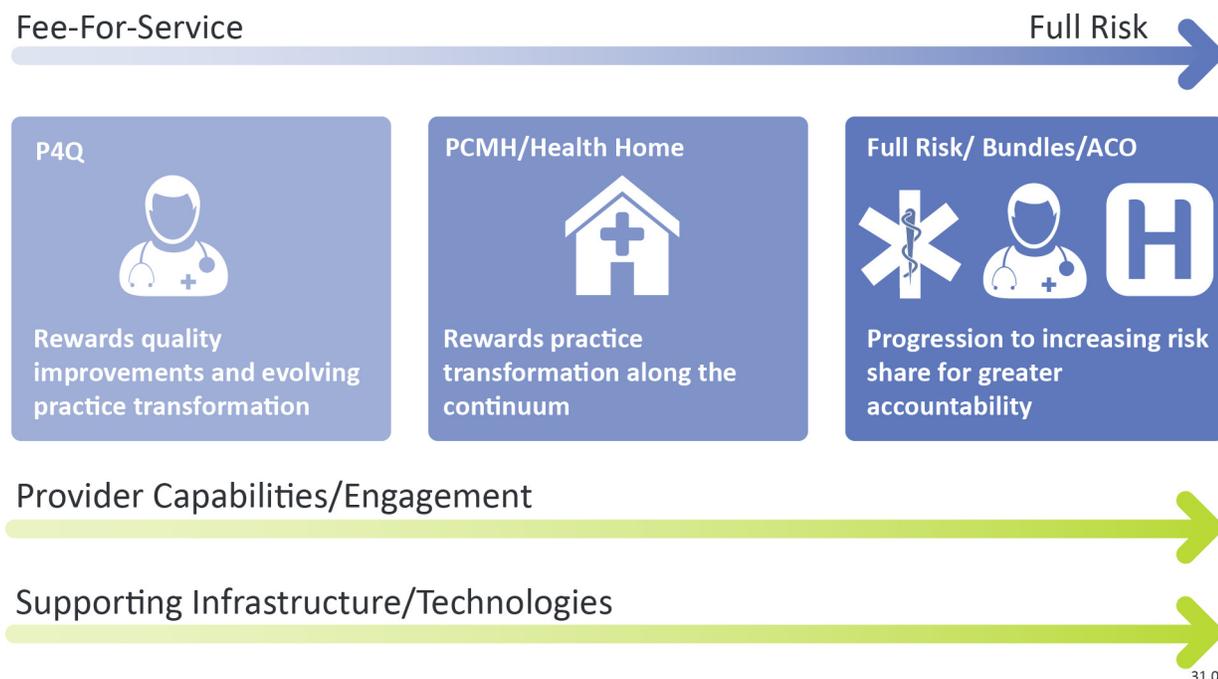
### Question 1.

As described above, LDH is seeking to implement strategies that promote and encourage provider accountability for care management and the total cost of care for Medicaid enrollees.

1. Are there other managed care contracting or payment models that LDH can implement to achieve its goals?

Yes; Aetna recommends the LDH begin to explore bundled payments, which enable PCPs and specialty providers to become part of the opportunity. Bundled payment mechanisms hold promise for containing costs while improving quality of care for the population. The approach should be taken on slowly because bundles are limited for specific care episodes but can be difficult for many entities. This is especially true for ACOs comprised of physician groups with little to no control of inpatient work flow and processes.

We recommend the introduction of Pay for Quality (P4Q) and PCMH be added, as shown in the **Pay for Volume to Pay for Value Continuum** illustrated in *Exhibit III.1*.



**Exhibit III.1: Pay-for-Volume to Pay-for-Value Continuum**

One of the challenges facing Louisiana is that it is still operates in a per diem environment. Not only is this costly, but it also holds the State back from moving to more current and widely used payment structures. Efforts should be made to move to a diagnosis-related group (DRG) structure as a step towards the capacity for handling



SECTION III. Questions for Respondents  
E. Other Strategies

bundled payment. This serves as a step to align incentives with providers and eases provider administrative burden.

**a. For example, should LDH encourage or require MCOs to contract with ACOs or implement other alternative payment arrangements with providers?**

Yes; the LDH should require ACOs to contract with an MCO, as well as implement alternative payment arrangements that fit the Healthcare Payment Learning and Action (HCP LAN) APM framework. By permitting the APM framework, the LDH will enable MCOs to create and implement new and innovative payment models. Most MCOs are already engaged in Alternative Payment Models (APMs) with providers and should be allowed to continue this type of innovation to help reduce per capita costs.

We also strongly encourage a phased approach to support assuming risk in a manner reflective of programming progression; this enables providers to move their organizations forward during transition to varying levels of ACO maturity. One path of progression may be the establishment of shared savings programs for entry and then progression to population-based payments. Bundled payments must also be considered as an APM and a manner in which to engage provider types in the ecosystem.

We have experienced success working with ACO partners and understand the importance of assisting them in their transition. When our ACO partnerships succeed, our members improve their health status and the overall healthcare system is more efficient. For example, we have a partnership with a large ACO care network where we delegate utilization management, disease management, case management, and credentialing services. The ACO serves as the primary care providers for 70,000 children in their particular geography.

In terms of utilization, practices within the ACO have lower inpatient and Emergency Department utilization than non-PCMH practices. Emergency Department visits per 1,000 members in practices were 27 percent lower than rates for non-PCMH practices. Inpatient admissions per 1,000 members in PCMH practices were 13 percent lower, and days per 1,000 members were 29 percent lower in PCMH practices than non-PCMH practices.

In addition to our response and discussion in Section B. Question 1, we offer additional areas where MCOs can be of great help to ACOs. MCOs can offer support to the ACOs while offering a more comprehensive view of whole-person coordinated care through a fully integrated approach to care for all member-facing services—including physical health, behavioral health, pharmacy, transportation, and LTSS—and thus improved health outcomes and lower costs. Most MCOs also possess the infrastructure necessary to manage a comprehensive network of medical, pharmacy, behavioral health, and LTSS providers, including inpatient care and home and community-based services providers, along with other nontraditional providers.

Creating connected data sets among other key stakeholders such as Health Information Exchanges (HIE) provides a more robust data network. For example, we encourage the use of the Louisiana Health Information Exchange (LaHIE) and Greater New Orleans Health Information (GNOHIE) exchange as another avenue for data gathering. Aetna Better Health is connected and actively incorporating information from these HIEs to create a more meaningful and whole picture of patient care. This is just one example of how MCOs can contribute data to support broader population health management applications, such as with the sharing of admission, discharge and transfer (ADT) data and other information such as social determinants of health.



**SECTION IV. Statement of Interest**

**SECTION IV. STATEMENT OF INTEREST**

**At this time Aetna is not responding to this section.**



January 30, 2017

Louisiana Department of Health, Bureau of Health Services Financing  
Frank Opelka  
Medicaid Program Manager  
Frank.opelka@la.gov

**RE: Amerigroup Louisiana Response to Louisiana's Department of Health (LDH) for Provider-Led Accountable Care Organizations.**

Dear Mr. Opelka:

Amerigroup Louisiana is pleased to submit a response to the Request for Information (RFI) for Provider-Led Accountable Care Organizations issued by the Louisiana Department of Health (LDH) on November 4, 2016. We appreciate the opportunity to provide input to the LDH regarding the structure of the Healthy Louisiana Medicaid managed care program.

Amerigroup proudly has participated in the Healthy Louisiana program since implementation and currently serves more than 220,000 Louisianans. Our associates live throughout the state, providing a local presence and commitment to the communities we serve. This presence, combined with our strong partnerships with providers and community-based organizations across Louisiana are at the heart of our efforts to improve the health and well-being for our members in Louisiana.

Supporting our strong local presence and experience, we also benefit from the extensive national experience of our parent company, Anthem, Inc. and our family of affiliate health plans. Collectively, we serve more than 6 million members through state sponsored programs across 20 states. We are leaders in developing Value-Based Purchasing (VBP) models to support states in achieving their Medicaid program goals. Nationally, over 60 percent of members enrolled in our state-sponsored programs receive health care from providers in models that emphasize paying for value, improved access to higher quality care and services, cost efficiencies, and better overall health outcomes.

As an existing MCO, we look forward to continuing our collaboration with LDH and Louisiana providers to improve the quality and value of care for Healthy Louisiana Program members. We greatly appreciate the opportunity to participate in this information-gathering process and look forward to speaking with you soon.

Sincerely,

A handwritten signature in blue ink that reads "Sonya Nelson".

Sonya K. Nelson  
President  
Amerigroup Louisiana

3850 North Causeway Blvd., Suite 600  
Metairie, LA 70002  
(504) 834-1271

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## Attachment: Response Form

### RESPONDENT INFORMATION

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Contact Phone: (504) 834-1271 Ext. 88854  
Contact Email: sonya.k.nelson@amerigroup.com

Responding as an Individual: (Y/N) N

Responding on Behalf of Organization: (Y/N) Y

Check all that describe your organization:

Hospital or Hospital System

Clinical System

Advocacy Organization

Health Plan

Physician

Non-physician Health Care Provider

Other – Please Describe: \_\_\_\_\_

## **RESPONSES**

### **Section III.**

#### ***A. ACO Requirements***

**Question 1:** Amerigroup supports Louisiana in its desire to continue its shift from volume- to value-based payments. In partnership with the State, Managed Care Organizations (MCOs) have made significant strides in moving the Louisiana Medicaid program in this direction. We believe that building upon the current, proven model is in the best interest of the program and members. In our opinion, ***integrating Accountable Care Organizations (ACOs) into the MCO delivery system offers the most promising opportunities to advance Value-Based Purchasing (VBP) initiatives while benefitting from the strengths of both models.***

We recommend that the Louisiana Department of Health (LDH) consider establishing clear expectations for VBP arrangements between MCOs and providers during the next procurement. Currently there is a limited number of ACOs in the market. Promoting an environment in which MCOs can work in conjunction with ACOs through a contractual relationship will improve member outcomes and function in a population health environment. As the ACOs focus on member care and increased member and provider communication, the MCOs can provide the administrative support.

Amerigroup and our affiliate health plans are leaders in fostering provider collaboration and VBP models. Our experience has shown the greatest innovation can stem from MCOs and providers working together to improve quality and outcomes. If LDH decides to implement ACOs as a standalone option with the Healthy Louisiana Program, ***we do not recommend exceptions or modifications to the current requirements.*** ACOs should incur the same level of risk as MCOs. It is critical that all entities serving Healthy Louisiana Program members are held to the same quality and administrative standards, including, but not limited to:

- Licensure
- Financial solvency (including minimum net worth)
- Statutory deposits
- Risk-based capital requirements
- NCQA certification
- Program integrity
- Credentialing and recredentialing
- Encounter submission compliance
- Other mandatory operating requirements

These standards will ensure ACOs are held to the same level of accountability as MCOs, and offer the same level of protection, transparency, and quality improvement to members. By applying common requirements and expectations, providers who contract with both MCOs and ACOs will not be burdened by multiple sets of standards. We encourage LDH to use the same rules for fee schedules, network participation, and adequacy requirements for both ACOs and MCOs.

Since their inception more than 10 years ago, ACOs have been challenged with redesigning care, including quality and cost measures, using technology for population health, aligning the organization to gain buy-in, and achieving financial sustainability. For example, ACOs participating in the Pioneer ACO model show inconsistent financial results two years after implementation. The unproven financial stability of the model may place both the State and providers at risk. Additionally, some ACOs may face challenges with developing the infrastructure to successfully perform the core functions such as administrative, financial, organizational, data sharing, technology, community partnerships, quality and cost evaluation, and reporting. These considerations make it even more critical that ACOs are held to the same set of standards and qualifications as other participating entities.

**Question 2.** To achieve LDH's vision for a Louisiana provider-owned and led model, we recommend that ACOs be required to be led by local Louisiana providers with both legal ownership and representation on the governing bodies. This will ensure that the program leverages the relationships and knowledge of the Louisiana delivery system and its providers. Using a collaborative model between MCOs and locally owned and operated ACOs would allow ACOs to benefit from MCO experience and infrastructure, while keeping the benefits of local provider engagement.

**Question 3.** To move to a model that encourages greater provider capabilities and innovative VBP models, Amerigroup recommends LDH consider the following:

#### **Strengthen Value-Based Purchasing Requirements in Upcoming Procurements**

In 2015, Amerigroup paid Louisiana providers more than one million dollars in provider incentive payments, based on provider performance. We have several programs designed for large and small provider practices, as well as primary care and specialty care providers. Our programs address the goals and priorities of the State. As our VBP programs have matured, we have been able to use best practices and lessons learned from our affiliated health plans to broaden them. Because of the progress that has already been made in this area, we recommend building upon the VBP programs already developed within the current Healthy Louisiana MCO system.

***We recommend establishing clear expectations for VBP through the upcoming procurement to gauge and build provider capacity to bear the program risk.*** To effectively drive quality and reduce cost across Louisiana's Medicaid system, we believe the most effective VBP models must be designed to "meet providers where they are" to help move them along the continuum of population health management. Experienced MCOs are in the best position to build relationships with each provider, and to work collaboratively to choose a payment model, data tools, and care management support to best assist each provider's practice. Our models align with Centers for Medicare & Medicaid Services (CMS) defined VBP categories 2, 3, and 4. Across our affiliate health plans, approximately 40 percent of Medicaid members receive services from a provider in Categories 3 and 4, and 62 percent of members received services from a provider in Categories 2 through 4. We focus on developing long-term relationships and breaking down silos to deliver seamless care and strengthen the bonds between patients, doctors, and hospitals; enabling seamless delivery of the right care at the right time.

We support VBP programs that balance both upside and downside risks using nationally recognized and proven total cost of care and quality measures. This effectively incentivizes everyone involved in health care to improve performance. We have the experience, resources, tools, and staff to support providers through the transition into a VBP program.

***We recommend LDH allow bidding entities flexibility in their proposed VBP models.***

MCOs and ACOs should be free to innovate and collaborate to create incentives and VBP arrangements that support each member's needs while increasing independence, attainment of goals, overall health, and well-being. If LDH grants flexibility to bidding entities, then VBP models can expand to a range of provider types from primary care to attendant care, and from small providers to large provider groups. This includes incentive programs that reward providers for connecting members to the behavioral, physical, and long-term services and supports they need. MCOs are better positioned to work collaboratively with providers based on their size and capabilities, provide them with actionable information, meet them at their level of technology sophistication, and provide the technical support they need to succeed. The transition to shared savings and risk-based arrangements is a journey, and providers vary in their level of readiness to take on VBP arrangements. MCOs have the unique capabilities and experience needed to work with providers at their own pace, and help move them along the continuum of VBP.

In addition to the programs Amerigroup has established in Louisiana, our affiliate health plans have successfully implemented VBP models in other states by providing the tools, resources, and staff to help support providers. For example, our Provider Care Management Solutions (PCMS) is a web-based reporting platform that supports providers in population management as well as program-specific financial performance management. To support population management, PCMS offers providers actionable clinical insights, such as care gap messaging and preemptive flagging of members with high risk for readmission. To support performance management, PCMS helps providers monitor and improve their performance, connecting the dots between the actionable activities that tie to financial incentives and quality outcomes.

#### **Investing in Health Information Exchange**

Louisiana has a need for standardized data sharing tools between LDH and providers. ***We recommend LDH consider investing in Louisiana's provider technological capabilities.*** The investments could be grants (using DSRIP funding) that encourage electronic document sharing to enhance care coordination. MCOs have the capabilities and resources to support these efforts and can begin working with providers immediately to develop the necessary data and interfaces they need.

#### **Expand Innovative Techniques**

***The State should promote the use of telemedicine by updating regulations to reflect current technology,*** thereby removing barriers and expanding access. MCOs are well positioned to work with LDH and providers to develop effective and efficient telemedicine strategies that will increase access to care, particularly to specialty services that are not readily available in many communities in Louisiana.

#### **Standardize Quality Measures and Other Data Tools**

When establishing the appropriate measures for a health plan VBP program, ***we recommend that LDH align measures with the program's defined quality goals.*** Effective programs use measures that are nationally recognized, evidence-based, and peer reviewed to ensure meaningful and measurable results. HEDIS<sup>®</sup> and the CMS Child and Adult Core Set measures provide these standards. LDH can use national and State performance information to set appropriate goals and benchmarks.

**We recommend LDH select measures that are specific to covered populations and match their specific health and wellness needs.** For example, the following factors could be considered:

- Age
- Gender
- Disability type
- Race/ethnicity
- Population-specific measures that relate to high prevalence or high-impact conditions

LDH should consider the appropriate number of measures to establish for the program. To ensure that resources are effectively focused on LDH priorities, we recommend no more than 10 measures, equally weighted within the financial withhold and incentive system. This limit helps health plans dedicate adequate resources to make significant improvement in any one area. We believe it is important for the State to set the goals and then allow the plans the latitude to reach them.

#### **Collaborate with Health Plans**

Throughout implementation and ongoing operations, it is critical for LDH to have collaborative discussions with health plans as they implement VBP or specific ACO programs. As LDH works to strengthen VBP programs, it will be important for LDH, health plans, and providers to continue to work together to establish the broad program design, including overall benchmarks, categories, and goals.

**Question 4.** Should LDH move forward with implementing ACOs within the Healthy Louisiana Program, Amerigroup recommends that LDH consider the following requirements for ACO development:

#### **Require Providers and Health Systems that Own or Operate an ACO Contract with Healthy Louisiana Health Plans**

If LDH incorporates ACOs into the Healthy Louisiana Program, some ACOs will likely include hospital systems or a collaborative of multiple hospital systems. These systems have an inherent incentive to limit network participation with other health plans. If such limited contracting were allowed, it would destabilize the Healthy Louisiana Program, because other health plans may be unable to meet network adequacy standards, which significantly restricts member access and choice.

If there is a lack of provider options, ACOs can require competing health plans to reimburse providers at rates that are higher than Medicaid Fee for Service (FFS). This may cause the program to become financially unsustainable for non-ACO plans, resulting in an anti-competitive environment. This would also result in higher expenses to the State, because the increased costs will ultimately affect program rates. To avoid this, ***we recommend LDH require health systems or providers that own an ACO to contract with all Healthy Louisiana health plans at terms equal to the Medicaid FFS rate.***

***LDH should hold ACOs to the same minimum payment and fee schedule requirements as MCOs*** to avoid creating a financial disadvantage for MCOs. Allowing ACOs to contract with their providers at lower rates will skew the health and financial measures used to evaluate ACO success.

### **Distribute Members across Participating Entities**

***We recommend that LDH use auto-assignment algorithms to distribute membership and safeguard against “cherry picking” healthy and low-risk members.*** We suggest that LDH lead collaborative discussions with all stakeholders to establish auto-assignment methodology that avoids shifting members with complex care needs out of ACOs and into MCOs. This will help ensure continuity of care and services.

As noted above in Question 1, ***we believe ACOs should be held to the same standards and requirements to balance all entities administering benefits and services for Healthy Louisiana members.*** Keeping the same set of requirements will help ensure that members who have complex needs will be evenly distributed among plans, and will keep members from opting into ACOs because they have less stringent requirements and standards.

### **Balanced Risk Adjustment**

***We recommend using the same risk score adjustment that is in place for MCOs now.*** LDH should expand the current process to include members who select an ACO, and balance them across MCOs and ACOs. The right risk adjustment is needed to account for variables such as health status (for example, chronically ill members) and regional variances (for example, rural vs. urban population densities).

## **B. ACO Functions**

**Question 1.** We understand that ACOs may need to enter into third party administrator (TPA) or joint venture arrangements. However; ***we recommend LDH implement requirements that safeguard member choice and prevent potential conflicts of interest for MCOs with a financial interest in both a participating MCO and ACO.*** This can occur when an MCO serves as a back office for an ACO while operating a separate MCO. We recommend LDH restrict such conflicts of interest and inappropriate financial incentives by requiring bidding entities to disclose any business relationships (including financial or ownership interest, common ownership, subcontracting arrangement, etc.) they have with other health plans as part of the procurement response. ACOs should not be eligible for selection if they have a business relationship with any other health plan that is selected for that same contract.

As an example, LDH could look to the most recent Florida Medicaid managed care procurement’s requirements for sample language around this subject:

*An eligible plan must disclose any business relationship it has with any other eligible plan that responds to the invitation to negotiate. The agency may not select plans in the same region for the same managed care program that have a business relationship with each other. Failure to disclose any business relationship shall result in disqualification from participation in any region for the first full contract period after the discovery of the business relationship by the agency. For the purpose of this section, “business relationship” means an ownership or controlling interest, an affiliate or subsidiary relationship, a common parent, or any mutual interest in any limited partnership, limited liability partnership, limited liability company, or other entity or business association, including all wholly or partially owned subsidiaries, majority-owned subsidiaries, parent companies, or affiliates of such entities, business associations, or other enterprises, that exists for the purpose of making a profit.*

This prohibition should extend to health plans that may also provide back office or administrative management services to ACOs. One of the most successful and long-standing Medicaid managed care programs in the country, the Arizona Health Care Cost Containment

System, has incorporated similar language in their program. Its contracts explicitly prohibit the Medicaid agency from permitting an organization and its affiliated companies from owning or managing (through an administrative subcontract) more than one contract in the same program in the same region.

**Question 2. *We recommend that the State hold ACOs to the same standards and requirements for delegating key functions as for MCOs.*** Before any functions are delegated, the ACO should thoroughly assess and verify that the delegated subcontractor has the financial stability, compliance with Contract requirements, and standards that the State would expect from the bidding entities. All potential delegated entities should also be submitted in advance for State approval. Further, ACOs would remain accountable for overseeing and ensuring compliance with any delegated required functions.

**Question 3.** There are several functions we believe should be standardized or centralized across ACOs and MCOs to ensure program success and prevent additional administrative burden on providers. First, ***data exchange capabilities are critical and should be centralized.*** MCOs and ACOs both need data analytics to optimize member health outcomes and quality and to coordinate care thoroughly. To facilitate ACO development and ease burden, ***we suggest that LDH invest in increasing Louisiana providers' technology capabilities,*** by offering grants that encourage widespread adoption of electronic document sharing to enhance care coordination. MCOs have the capabilities and resources to support these efforts and can begin working with providers immediately to develop the necessary data and interfaces they need.

In addition, ***we recommend that credentialing requirements be standardized across MCOs and ACOs.*** This minimizes the administrative burden for providers who want to contract with multiple bidding entities. The credentialing requirements should reflect NCQA standards, and require collection of all necessary information that MCOs use to monitor and oversee providers.

### ***C. ACO Populations***

**Question 1.** Through our extensive experience developing and managing provider networks and programs across the country, ***we believe a statewide contract will be more beneficial than region-specific contracts.*** A regional ACO model has significant disadvantages. Members relocate frequently, so regional plans would increase transitions between health plans, potentially disrupt care and services, and decrease continuity of care. The current statewide contract minimizes the potential of members falling between the cracks if they move from one region to another.

Additionally, permitting ACOs to serve specific regions could result in unequal distribution of membership. ACOs are most likely to operate in urban areas, while MCOs would continue to be statewide and solely responsible for rural areas. ACOs in urban areas would have a different member mix than MCOs. Instead, we recommend a statewide MCO model that would allow MCOs to contract with and work collaboratively with ACOs. When ACOs contract with MCOs, ACOs can be regional under the umbrella of a statewide MCO, without the concerns of unbalanced membership distribution.

#### a. ACOs Developing Statewide Networks

ACOs would likely face challenges to developing a statewide network, but encouraging participation under an MCO contract will ensure members can reap the benefits of a statewide network.

**Question 2.** We believe that it would be difficult for a regional ACO to achieve enough member enrollment to develop and sustain the infrastructure needed to manage care effectively and to assume the financial risk associated with a full-risk model. Therefore, ***we do not recommend permitting ACOs to serve specific regions. Instead, we suggest a statewide model*** that requires MCOs to increase VBP arrangements with all provider types, including ACOs, and align with CMS defined VBP categories. Contracting with MCOs would allow ACOs to function regionally and, over time and with support from the MCOs, allow ACOs and providers the opportunity to develop the capabilities to take on greater risk.

**Question 3.** *Amerigroup recommends using the same population standards that are used for Healthy Louisiana MCOs when developing the ACO model to ensure an equal distribution of membership.* However, we recommend excluding Foster Care and Coordinated System of Care (CSoC) members from this program.

As LDH considers the best approach to serve Foster Care enrollees through the upcoming procurement, we recommend continuing with the existing structure. The existing structure provides a continuum of care that meets the unique needs of children and youth in child welfare. The selection of a single statewide health plan (or a minimal number of plans) manages the full range of benefits and services more effectively for these children, youth, and their families. Effectively serving these members requires extensive coordination with multiple stakeholders. Moving these children and youth to an unproven model could place them at risk. Using a minimum number of health plans reduces fragmentation and ensures member and family access to the care and services they need through a single point of entry. This model requires the health plan or plans to be responsible for all services and supports. This enhances accountability for access to care and improved health outcomes, minimizes administrative burden for agencies and providers, and allows for economy of scale for the health plans. We feel this is the best model to support children and youth staying in their communities, having permanent living situations, and developing the life skills they need to be independent, well-functioning adults.

#### D. Selection of ACOs

**Question 1.** As LDH develops the request for proposals (RFP) and associated scoring methodology, ***it is critical that the RFP places the appropriate emphasis not only on the bidders' experience and capability to deliver traditional acute care services, but also on effective case management and care coordination across the continuum of services.*** This includes long-term services and supports and other populations that may be served as part of future program expansions. Given the distinct differences in the systems, experience, and competencies necessary to deliver the full scope of program services, LDH must assess all bidders, whether structured as a traditional MCO or as an ACO, using the same standards and scoring methodology.

***ACOs should demonstrate the ability to be accountable for a population and to perform the functions of care coordination, care management, and disease management.*** To improve Louisiana's health care delivery system, it will be important for MCOs to work collaboratively with ACOs to leverage their strengths and local innovations in combination with MCOs' experience, programs, and infrastructure.

While the ACO model has received significant attention in recent years, the research behind its effectiveness is still new and developing. Additionally, ACOs are at varying degrees of maturity. Organizations that label themselves or are designated as ACOs vary widely in their size, quality, level of integration, ability to take on greater responsibility, and other factors. To be successful as an ACO, an organization must have a structure that supports ACO providers as they implement new care models, transform their practices, and adapt to new payment methodologies.

**Within the procurement process, we suggest LDH select qualified ACOs that have the capital and infrastructure to support operations, including:**

- The ability to manage the full continuum of health care services for its assigned members
- A health information technology platform that connects providers, supports active patient management, and supports incentive-driven payment models that drive total cost of care accountability to the provider level (for example, shared savings programs)
- Strong leadership and commitment among the ACO partners to drive changes in process, culture, and cost structure

As part of procurement, ***LDH should require bidding entities, including ACOs, to clearly show evidence of their experience and these capabilities.***

Above all, ***member experience should be the same quality across all MCOs and ACOs.*** Thus, when selecting ACOs, LDH should look for the same high level of operational and staffing standards as well as licensing requirements, NCQA certification, financial solvency standards, and other key requirements that apply to MCOs. When selecting ACOs, LDH should evaluate for capabilities and experience in network development, IT infrastructure in population management and care coordination, monitoring and reporting quality and cost measures, and ability to manage financial risk. Given the scope of managed care populations and services, ACOs must have experience serving populations and programs of similar size and scope.

***LDH may want to consider adding a preliminary Request for Qualification (RFQ) component to its bid process.*** As an example, the state of Georgia evaluated bidder experience prior to issuing its most recent RFP for the Georgia Families and Georgia Families 360° programs. Through an RFQ process, Georgia required prospective bidders to submit evidence of organizational experience with comparable programs as a mandatory requirement to ensure that only qualified entities received consideration through the proposal evaluation process. Selecting MCOs and ACOs with the experience and infrastructure necessary to support innovative and effective care management across all populations and services is critical for the long-term success of the program.

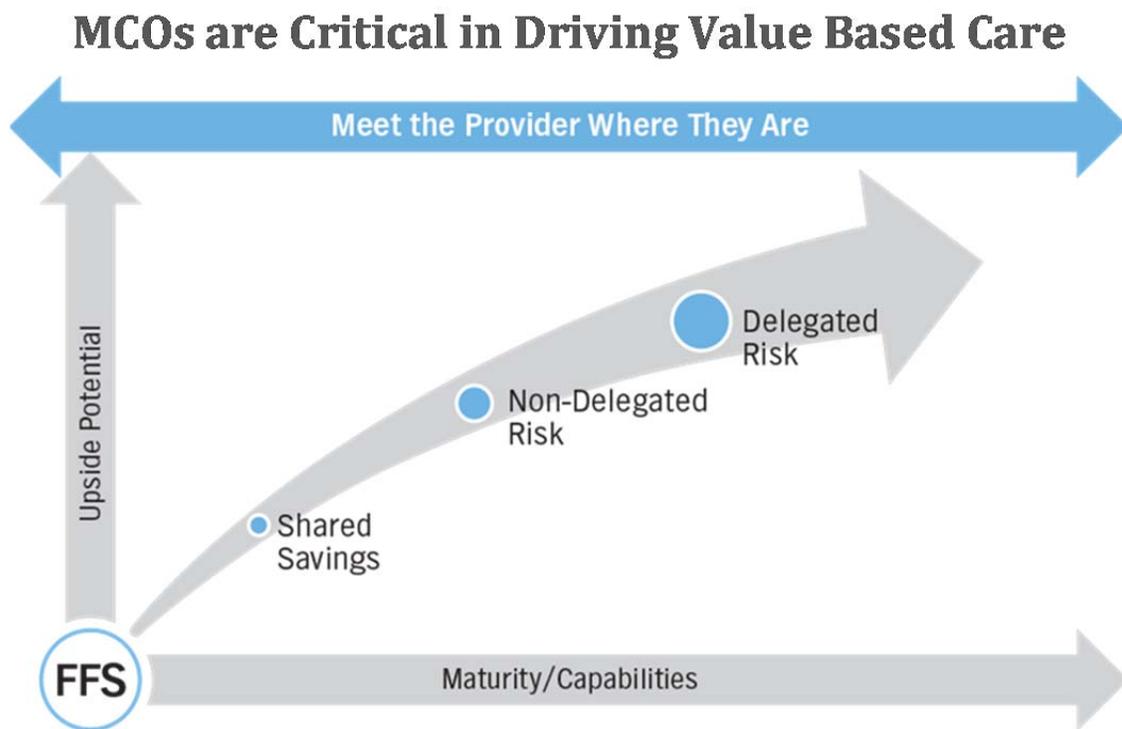
#### ***E. Other Strategies***

**Question 1. *As noted in Question A.1. above, we believe integrating ACOs into the MCO delivery system offers the most promising opportunity for advancing VBP while benefitting from the strengths of both models.*** We recommend requiring MCOs to contract with ACOs (as available and appropriate) as well as other provider types using a variety of VBP arrangements to achieve LDH's goals. We believe this model leverages the experience and strengths of both MCOs and ACOs, and will provide the greatest opportunity for innovation and improvement in quality and health outcomes.

**We encourage the State to consider innovative VBP arrangements between MCOs and providers during the next Healthy Louisiana procurement.** We feel this will be the best next step to serve Healthy Louisiana members better. This gives ACOs time to develop an appropriate infrastructure and foster a collaborative environment where ACOs and MCOs work to develop mutually beneficial agreements. As noted in Question C, we recommend adjusting MCO contract language to require them to work collaboratively to set up a model that emphasizes a VBP system while ACOs build their programs and infrastructure.

**We also recommend that LDH establish expectations for MCO levels of VBP (for example, spend levels).** Models must address a range of provider types, size, specialties, and capabilities. We do not believe a “one size fits all” approach will be effective. Rather, reaching out to each provider “where they are” along the continuum of capabilities at their level of technology to provide tailored support will ensure success. As with any major initiative, it will be critical to have open and collaborative discussions with selected MCOs and ACOs throughout the implementation and operation of the program.

Figure E.1 shows our philosophy for moving providers along the continuum

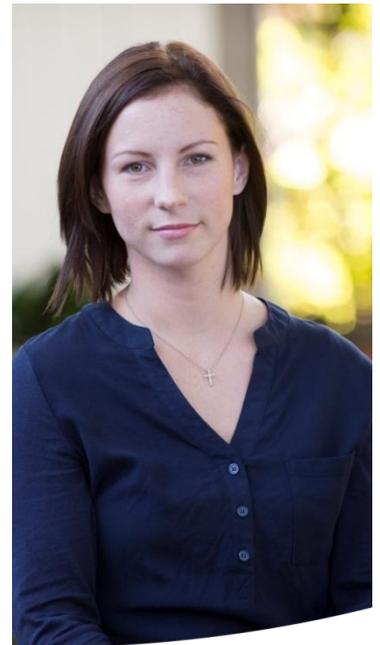
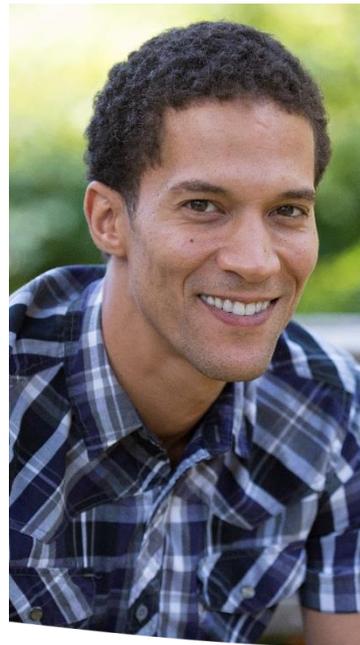


Amerigroup supports LDH’s goals aligned with the Triple Aim of improving quality care, improving the health of the populations we serve, and reducing health care costs. We believe that through implementing innovative VBP methodologies and incentive programs for providers, we can continue driving the achievement of these goals and create a system of care based on value rather than volume. We appreciate the opportunity to provide our recommendations as LDH seeks new and innovative ways to improve the quality of care delivered through the Healthy Louisiana Program and look forward to further collaboration with LDH on these efforts.

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# ACO RFI Response

## RESPONSE TO THE REQUEST FOR INFORMATION FOR PROVIDER-LED ACCOUNTABLE CARE ORGANIZATIONS



**Submitted to:** Louisiana Department of Health, Bureau of Health Services Financing, Frank Opelka, Medicaid Program Manager, [Frank.Opelka@LA.gov](mailto:Frank.Opelka@LA.gov)

**Responses due:** Tuesday, January 31, 2017, 5:00 p.m. CT



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*The data contained in pages 7-11 of this response have been submitted in confidence and contain trade secrets and/or privileged or confidential information, and such data shall only be disclosed for evaluation purposes. This restriction does not limit the State of Louisiana's right to use or disclose data obtained from any source, including the proposer, without restrictions.*

## SECTION III. QUESTIONS FOR RESPONDENTS

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### EXECUTIVE SUMMARY

Louisiana Healthcare Connections (LHCC) appreciates the opportunity to provide feedback on the Request for Information for Provider-Led Accountable Care Organizations. Our feedback is centered on our experience operating as a health plan in the State of Louisiana since the program's inception in February 2012 and applied lessons learned. As a trusted partner to the state, we possess an applied understanding of, and appreciation for, the needs of the population, its barriers to care and the unique issues it faces every day. Our success in quality outcomes is reflective of our successful partnerships with physicians and the investments we make to drive value within our network.

#### ACO Limitations

LHCC recognizes that ACO models have existed in Medicare under the Medicare Shared Savings Program for the last several years. However, a policy brief published by the Center for Health Care Strategies (CHCS) outlines several challenges around implementing a similar model with Medicaid providers and member populations. Because the ACO model is centered on Medicare – and, more recently, on Medicaid – recipients, it's critical to remember that this population can seek care anywhere it chooses, which can negatively impact the providers' ability to achieve savings. Patients may not realize that they are receiving care through an ACO, nor that, when seeking care outside the ACO, it impedes data sharing and care coordination – two critical components of an ACO. An ACO will have difficulty measuring its quality if all participating patients aren't receiving all their care through that ACO.

As the development of ACOs is in the early stages, there are important, unanswered questions about how to measure quality in an ACO, how to calculate financial rewards for participating providers, and even how to determine if the ACO structure will be viable for the long term. Historically, without a deep understanding of the strategic, operational, and organizational factors needed for success, health systems may end up repeating mistakes of the past.

Like any program, it is critical to that those serving the Medicaid population have specific knowledge, training and outreach programs to address social determinants of health such as poverty, homelessness, low health literacy, and lack of transportation. Members who are homeless also bring with them unique challenges that provider offices may not be designed to address.

#### Value-based Contracts within MCO Model

LHCC encourages the proliferation of value-based contracts within existing MCOs as the preferred model to promote and encourage provider accountability for care management and the total cost of care for Medicaid enrollees. A "one size fits all" approach offered through an ACO model limits innovation and the ability to provide an incentive model that is the right fit for the right provider.

LHCC's success in payment innovation is due in large part to our collaborative partnership with physicians and our willingness to try innovative strategies. We meet regularly with providers to discuss their experience, address challenges, identify additional support we can provide, and solicit providers' recommendations. These techniques ensure our program is sustainable, improves providers' satisfaction, and allow us to react quickly to promote successful strategies and modify those that need improvement.

Our provider consulting team delivers one-on-one assistance to identify and build on providers' capabilities as opposed to complete delegation of these services. Through collaboration, we leverage both our experience and the expertise of our providers to successfully implement the four core components of our provider incentive model:

- Aligning appropriate programs and creating a credible pathway for providers to gradually adapt to outcome-based payment models
- Providing meaningful and timely information and insights to providers on their populations and helping them identify opportunities for improvement
- Implementing a provider consulting team and governance infrastructure that provides subject matter expertise in key areas
- Providing complementary skill sets (e.g., care coordination, UM) that are appropriately tailored to meet the needs of providers and support their efforts to care for their patients

Outlined in our response are the answers to the RFI questions for Provider-Led Accountable Care Organizations and details on our position that are based on our local experience working collaboratively with providers is to incorporate elements of an ACO while placing emphasis on tailored innovative payment models that meet individual provider needs.

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## **A. ACO REQUIREMENTS**

***LDH envisions establishing requirements for provider led ACOs that mirror requirements for the Medicaid managed care organizations currently participating in the Healthy Louisiana Managed Care Program. LDH seeks the following information related to requirements for ACOs.***

***1. Are there any exceptions or modifications to current requirements that LDH should consider to encourage ACO participation (e.g., special licensure and solvency requirements)?***

To preserve continuity of care for the member and ensure ACOs comply with the same taxpayer safeguards and consumer protections as MCOs, Louisiana Healthcare Connections (LHCC) believes that equivalent program requirements for MCOs and ACOs are essential to a successful program. If an ACO cannot meet the MCO contract requirements for the Healthy Louisiana program, they should be allowed to contract with an MCO for participation in the Healthy Louisiana program in a manner that is agreed upon by both entities.

If LDH desires ACOs to be offered contracts independently from MCOs, there must be a level playing field including both up and downside risk, licensing/certification and quality measurement. There should also be a clear delineation of roles and responsibilities, including alignment of financial, quality, and clinical/care management processes.

LDH should also consider requiring MCOs and ACOs to make good faith efforts to negotiate value-based contracts that are in line with standard Medicaid market reimbursement rates.

**2. What governance principles and/or requirements should LDH consider implementing to ensure that ACOs are governed and led by Louisiana providers?**

LHCC recommends that LDH require ACOs to establish governance and ownership requirements to validate that provider-led ACOs are owned by active, local, Louisiana providers to ensure a local knowledge and presence. LHCC also recommends provider-led ACOs be predominantly managed by physicians.

**3. Are there any interim steps or technical assistance that LDH could provide to promote providers' ability to develop ACOs over time?**

An ACO model requires significant up-front investments in infrastructure (data analysis systems, electronic health records (EHR), data sharing technology, care management personnel, care coordination systems, Health Information Technology (HIT) staffing, upgrades and maintenance, etc.) on the part of the participating physician.

Timely and accurate data collection and analysis are essential to ACO operations to ensure that members benefit from appropriate care management interventions and programs in managing their health. Establishing and maintaining a data infrastructure to support ACOs is key to the development and success.

As the overall capacity for HIT and Health Information Exchange (HIE) progresses, providers will need financial resources to facilitate the implementation of HIT to support data management, technical assistance and education to adopt and meaningfully use of EHR technology and interoperability of data sharing. ACOs must be ready to manage their members using data, such as claims, HEDIS, utilization, etc., that will be fed into their EHR and payment systems. Special considerations and support should be given to safety net providers that lack the capital needed for HIT infrastructure.

**4. Are there any other unique requirements that LDH should consider applying to ACOs?**

In terms of providing the functions of an MCO, LHCC recommends that requirements are equitable for ACOs and MCOs to ease implementation, provide continuity of care and ensure accountability. Unique requirement considerations for ACOs should include:

- Implementing a streamlined ACO certification process that accounts for the needs of the Medicaid population, and consideration for working with a third party accreditation body to develop the criteria
- Building in requirements that ACOs must participate in HIEs

We have seen in one of our affiliate markets that applying unique requirements to an ACO model can lead to unsustainability. In Florida, the state had two different delivery systems operating in the same environment to serve Medicaid enrollees - Managed Care Companies and Provider Service Networks (PSNs). PSNs were provider-owned networks that served Medicaid enrollees on a non-risk basis, whereas MCOs operated on a full-risk basis. Different requirements were applied to the PSNs than the MCOs. For instance, PSNs couldn't pay more than 100% of the Medicaid fee schedule while the MCOs had to negotiate contracts with provider groups and hospitals, resulting in contracts that were well above 100% Medicaid. PSNs were paid a percentage of what they saved but not held accountable for not having savings results. Ultimately the situation created a few issues:

1. There was no level playing field so it was difficult to gauge the relative effectiveness of either model.
2. The difference in reimbursement created the risk that the members were moved around the system so providers could take advantage of favorable pricing dynamics.
3. This resulted in four PSNs selling their membership to the MCOs and currently only one PSN operating today.
4. As the PSN program is ultimately going away, a situation was created where many transactions took place which created large movement of members within the program and presented a large administrative burden on the agency to review and approve those transactions.

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## **B. ACO FUNCTIONS**

*ACOs would be expected to provide all functions of a traditional MCO, including but not limited to: claims adjudication and payment, marketing, member services, provider network development, credentialing, prior authorization, care management, data analytics and quality reporting. ACOs would also be expected to offer the same set of benefits to enrollees as that offered by current MCOs.<sup>4</sup> LDH seeks the following information related to key ACO functions.*

**1. Should ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan?**

Yes. If an ACO cannot provide all functions or the same set of benefits offered by a traditional MCO, LHCC recommends that ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture. This would allow the leveraging of experience and resources to jointly ensure that members, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

**2. Are there any key functions that LDH should not permit the provider led ACO to delegate to another entity?**

Functions, such as board governance, should remain with the ACO and not delegated to ensure that the ACO is led by a provider, preferably physician provider(s).

**3. Are there certain functions that LDH should consider standardizing or centralizing to facilitate ACO development and to ease provider administrative burden?**

**a. Should these functions be standardized across ACOs and MCOs?**

LHCC recommends that certain functions be standardized across the Healthy Louisiana program (both MCOs and ACOs) to ease provider administrative burden, including a standardized provider credentialing process and a coordinated process for conducting provider after-hours availability surveys.

## C. ACO POPULATIONS

*LDH envisions that ACOs, like the state's traditional MCOs, would serve all Medicaid members who are eligible for enrollment in Healthy Louisiana. LDH seeks the following information related to populations to be served by ACOs.*

**1. Should LDH permit ACOs to serve specific regions, rather than enrolling Medicaid members statewide?**

**a. Would ACOs be able to develop statewide networks?**

If LDH pursues incorporating an ACO component into the Healthy Louisiana program, LHCC shares the same vision for ACOs to provide holistic care to all Medicaid members who are eligible.

LHCC does not recommend an approach that permits ACOs to serve specific regions. ACO contracts should require statewide operations in order to avoid disruption when members move or providers cross arbitrary boundaries established by a regional design.

Permitting ACOs to serve only specific regions – presumably a more densely populated and urbanized region – could undermine the sustainability of Healthy Louisiana operations in rural areas, and exacerbate health care inequities between urban and rural communities.

In certain areas of the state, providers have access to more resources and may be more advanced in their infrastructure than in others. Certain rural providers are frequently smaller by volume and may have less infrastructure than their urban counterparts have – making economies of scale difficult to achieve. In certain rural areas, members may have a limited number of health care access points, making coordination of those services more challenging. Rural providers are often required to be more creative in their provision of services and meeting member needs.

Yes, we believe that ACOs would be able to develop statewide networks.

**2. If LDH were to permit ACOs to serve specific regions, would the ACOs have large enough enrollment to support the infrastructure needed for ACO functions and to take on financial risk?**

We do not expect that regional ACOs would have large enough enrollment to support the infrastructure needed to perform ACO functions and ultimately take on financial risk.

A regional approach would create inconsistency and inequity for the members served in the Healthy Louisiana program. Some areas of the state would yield better outcomes due to the infrastructure and social supports available. Additionally, a regional approach would limit the development of a provider network, and could revive provider fragmentation.

Since MCOs are providing Medicaid managed care statewide, if ACOs were regional it would be difficult to manage and implement, and would create administrative burden for LDH.

**3. How should populations be defined or limited for ACO enrollment, if at all?**

Consistent with the MCOs, populations should not be defined or limited for ACO enrollment. LHCC opposes the segregation of patient populations into specialty plans, whether ACO or MCO. A substantial proportion of beneficiaries suffer from multiple chronic conditions. Limiting the population results in segregating members by condition rather than addressing their holistic care. Additionally, mandating enrollment into an ACO (especially if one were region-specific) would diminish member empowerment in their own health care and raise concerns about steering Medicaid beneficiaries into limited health system networks.

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## **D. SELECTION OF ACOS**

*LDH would likely procure ACOs as part of its standard MCO procurement process. LDH seeks the following information related to ACO selection.*

**1. What are the most important characteristics and qualifications for LDH to consider in selecting ACOs?**

Important characteristics and qualifications for LDH to consider in selecting ACOs include complying with the same taxpayer safeguards and consumer protections as MCOs, including, but not limited to the following:

### **Health and Quality Improvement**

- Monitor and improve the same Quality Performance Measures
- Develop and implement a Quality Assessment and Performance Improvement Program including a comprehensive Quality Improvement (QI) Committee Structure
- Routine reporting to LDH such as process metrics for service delivery and health outcomes
- Secret shopper audits and/or External Quality Review audits
- Monitor Member and Provider Satisfaction through surveys and tracking grievance and appeals
- Implement multidisciplinary care teams
- Fraud, waste and abuse monitoring and reporting

### **Operational Standards**

- Local leadership and governance to be able to communicate more effectively with the state, providers and members
- IT infrastructure and systems
- Full financial risk management and maintenance of adequate financial reserves
- Meet Provider access and availability standards
- Maintain pay for performance withhold of premiums to ensure contract compliance
- Accreditation from a national organization
- Create substantive partnerships with local community agencies

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## **E. OTHER STRATEGIES**

*As described above, LDH is seeking to implement strategies that promote and encourage provider accountability for care management and the total cost of care for Medicaid enrollees.*

*1. Are there other managed care contracting or payment models that LDH can implement to achieve its goals?  
a. For example, should LDH encourage or require MCOs to contract with ACOs or implement other alternative payment arrangements with providers?*

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## Attachment: Response Form

### RESPONDENT INFORMATION

First Name: Jamie  
Last Name: Schlottman  
Title: Plan President & CEO  
Organization: Louisiana Healthcare Connections  
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Contact Email: JSCHLOTTMAN@CENTENE.COM

Responding as an Individual: (Y/N) N  
Responding on Behalf of Organization: (Y/N) Y

Check all that describe your organization:

- Hospital or Hospital System
- Clinical System
- Advocacy Organization
- Health Plan
- Physician
- Non-physician Health Care Provider
- Other – Please Describe: \_\_\_\_\_

January 31, 2017

Louisiana Department of Health  
Office of the Medicaid Director

RE: Request for Information, Provider-Led Accountable Care Organizations

UnitedHealthcare Community Plan is pleased to respond to the Louisiana Department of Health, Office of the Medicaid Director's Request for Information (RFI) regarding Provider-Led Accountable Care Organizations in Medicaid managed care. We have worked closely with the State and its Healthy Louisiana program since the program's inception in 2012, and are eager to continue supporting the State as it contemplates program enhancements.

Our response to the RFI is included in the following pages. In accordance with the requirements of the RFI we have provided respondent information as an Appendix to the response. Should you have any questions or seek further information, please do not hesitate to contact me at (504) 849-3520 or [allison\\_young@uhc.com](mailto:allison_young@uhc.com).

Sincerely,



Allison J. Young  
CEO and President, Louisiana Community Plan

The Louisiana Department of Health (LDH) has requested feedback regarding the possibility of engaging provider-led managed care plans to participate in Healthy Louisiana as Accountable Care Organizations (ACOs). The State is interested in facilitating a shift away from paying for volume to paying for value, while continuing to further the State's goals to improve health care quality and outcomes.

UnitedHealthcare appreciates the opportunity to provide insights to the State on this important topic. We currently contract with more than 200 ACOs in Medicaid programs across the country, covering more 632,000 Medicaid members, and we have seen real results in shifting toward value and improved outcomes. For example, among some of our more established ACO partnerships, we have seen a 16.8% decrease in inpatient admissions (Tennessee) and 13.8% decrease in emergency room visits (Arizona).

Additionally, UnitedHealthcare Community & State has extensive experience supporting states' broader goals of caring for vulnerable populations, demonstrated by our participation in Medicaid programs across 24 states plus Washington D.C. and the nearly 6 million Medicaid beneficiaries we serve. For more than 28 years, we have developed, in partnership with states, models to improve the quality and outcomes of healthcare by providing fully-insured, risk bearing models that bend the cost curve and create more predictable Medicaid budgets.

Serving more than 400,000 Medicaid beneficiaries in the State, we have a keen understanding of the unique needs of Medicaid enrollees in Louisiana and an appreciation of the local provider community. This local expertise, coupled with our experience across diverse Medicaid programs nationwide, has allowed us to identify best practices and successful approaches that Louisiana might consider as it thinks through the inclusion of provider-led managed care plans in the Healthy Louisiana program.

## RESPONSES

### Section III

#### A. ACO Requirements

**Question 1. Are there any exceptions or modifications to current requirements that LDH should consider to encourage ACO participation (e.g., special licensure and solvency requirements)?**

We encourage LDH to apply insurance regulations and requirements consistently across all organizations who administer the Medicaid program under a fully capitated arrangement and participate in the Healthy Louisiana Managed Care Program. Uniform application of requirements ensures equitable beneficiary protections and consistent product quality across plan offerings. In particular, we recommend LDH hold ACOs that assume risk to the same standards as MCOs in areas of beneficiary protection (e.g., adhering to requirements for member complaints and appeals, quality oversight, provider credentialing and licensure standards, and network adequacy). Additionally, risk-bearing ACOs should be held to the same solvency requirements as risk-bearing or capitated MCOs. Requirements should include

financial viability, minimum reserve requirements to cover claims costs, operating cash flow, and financial statement reviews. The ACO initiative should require practices participating in full risk to be continuously monitored for financial health, and we encourage LDH to consider requiring stop-loss insurance to protect against catastrophic events that could financially dissolve an organization (e.g., an emergent event for an attributed member that requires a month-long acute inpatient stay out of state). Finally, we recommend that ACOs be held accountable for the same coordination expectations of MCOs and other risk-bearing entities. This ensures a minimum standard of quality and access for Medicaid beneficiaries in ACOs and across all risk-bearing systems.

**Question 2. What governance principles and/or requirements should LDH consider implementing to ensure that ACOs are governed and led by Louisiana providers?**

We recommend LDH establish minimum, but not overly prescriptive, standards for ACO governance structures. ACOs should have the flexibility to determine a governance structure that best aligns with the needs of its organization and demonstrate to the satisfaction of LDH that it is competent to be effectively managed as an ACO. Because LDH intends for ACOs to take on full risk, the ACO should be required to demonstrate core governance competencies in alignment with existing requirements for MCOs.

LDH also should consider leveraging a robust stakeholder engagement process to assist with program design. Stakeholder engagement is valuable during the design phase, implementation, and program maturity, but should not be a substitute for an ACO governance structure. LDH should consider requiring ACOs to develop a stakeholder subcommittee.

In addition, we encourage LDH to establish governance standards that include a balance of participants on the board that appropriately represent providers participating in the ACO as well as other organizations supporting the ACO structure. We have found that ACO governance predominantly filled with provider representatives may not have the necessary expertise to advise an ACO.

**Question 3. Are there any interim steps or technical assistance that LDH could provide to promote providers' ability to develop ACOs over time?**

A critical first step to implementing provider-led ACOs is to ensure that the provider community has both the capacity and willingness to embrace this program. It is UnitedHealthcare's experience that these programs succeed best when providers in a delivery system have the ability to bear risk, the appropriate infrastructure, and the expertise necessary to manage the full continuum of care (e.g., across settings and provider types). Not all practices or systems will be equal in their sophistication level, readiness to accept risk, availability of technology solutions, etc., to participate in an ACO initiative (depending on how participation is defined). Thus, the type of technical assistance providers need will depend on the individual practice's capabilities and existing infrastructure.

As a result of this variation in practices, the most successful accountable care systems are able to customize assistance at the individual practice level coupled with targeted investments to support practice transformation (e.g., information technology solutions such as electronic health records, data analytics capabilities, health information systems, experience benchmarking performance, total cost of care management, and data collection methods that support performance measurement and reporting). LDH should establish a core set of competencies and require ACOs to demonstrate compliance to participate in the program.

Additionally, LDH might consider procuring an experienced vendor to be responsible for overall program administration. Either this vendor or LDH will need to assist ACOs in developing capabilities or providing access to claims detail and real-time utilization data to support clinical analytics. In addition, the accountable entity for program administration will need to support a wide variety of incentive models, manage performance oversight, ideally have access to a multi-payer database to evaluate overall system performance, and support or develop the sophisticated infrastructure to facilitate the dissemination of information across the ACO system.

#### **Question 4. Are there any other unique requirements that LDH should consider applying to ACOs?**

To complement the responses provided above, our experiences suggest that the ACO model should have robust strategies to evaluate each individual practice's capabilities and align advanced payment partnerships to experience and tolerance for risk. LDH should consider experience such as budget development, performance benchmarking, capturing total cost of care, and developing baseline utilization trends. Developing an ACO model that uses a statewide contractor (as mentioned above) to coordinate accountable care models, oversee model performance, determine program effectiveness, and deploy tactical real-time strategies that support continuous improvement greatly assists with mitigating potential failures in the system.

Additionally, working holistically with providers around their panel of patients is the only path to improving health care. To be successful, practices will need to develop or have access to tools that support clinical model capabilities including sophisticated clinical analytics, access to real-time utilization information, strategies to manage care transitions, and capabilities to track and report performance metrics. Furthermore, to address and reduce outcome disparities, ACOs should be encouraged to have culturally and linguistically matched physicians and care managers, in-depth and culturally appropriate educational materials, improved access, and team training on cultural competency. Because of the robust infrastructure that is necessary to successfully manage a panel of Medicaid patients under accountable care partnerships, we encourage the development of a flexible ACO model that supports practices with variable infrastructures and competencies. Overly stringent requirements likely will limit practices' ability to participate.

The ACO model should ideally incent practices – to the extent appropriate – across the entire delivery system at a total cost of care threshold to encourage an integrated approach to care management and whole-health population management. This includes services offered within

the ACO partnership and services received outside the ACO partnership. Total cost of care management and/or full risk is difficult and there may be a limited number of practices that have the experience or the readiness to enter in to a full-risk partnership.

Finally, research<sup>1</sup> suggests that ACO ability to save and earn shared savings payments is related to the proportion of primary care providers in the ACO, more practicing physicians on the governing board, physician leadership, active engagement in reducing hospital re-admissions, financial incentives offered to physicians, a larger financial benchmark, and greater ACO market penetration. ACO prior experience with risk-bearing contracts was positively correlated with savings and significantly increased the likelihood of receiving shared savings payments.

Given these findings and the evolving evidence base, we encourage LDH to support broad diversity in organizational structures for ACO participants, and provide alternative funding and risk bearing mechanisms to continue to allow a diverse group of organizations to participate.

## **B. ACO Functions**

**Question 1. Should ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan?**

We recommend that LDH not prescribe contracting requirements for ACOs, but rather, allow ACOs to develop innovative approaches to evaluating partnerships based upon capabilities and customized to ACO needs. This encourages ACOs to develop partnerships that advance practice sophistication through focused support and investment in areas most valuable to the practice and their patients. These partnerships should be developed within parameters set by LDH to drive consistency across the system. For example, UnitedHealthcare has a history of developing customized relationships with ACOs to retain, as needed, key administrative functions such as claims processing, utilization management, and quality measurement. Such flexibility is responsive to the diversity in provider capability and readiness to participate in an ACO and allows us to align with provider needs to ensure program success.

We also recommend that LDH not permit ACOs or their TPA/joint venture partners to prohibit or disincentivize providers (e.g., through reduced payments or contract termination) from contracting with other health insurance carriers or hospitals. Such exclusive provider relationships negatively impact the broader healthcare system by reducing consumer access, limiting choice of provider, interrupting continuity of care, and increasing system costs. LDH might also pursue this by reducing the value of exclusivity, for example by creating payment ceilings for Medicaid non-contracted services.

**Question 2. Are there any key functions that LDH should not permit the provider led ACO to delegate to another entity?**

As noted above, we recommend that LDH allow ACOs to develop innovative approaches to evaluating partnerships based upon capabilities and customized to ACO needs. However, in

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<sup>1</sup> <http://www.sciencedirect.com/science/article/pii/S2213076416300793>

instance where an ACO is fully risk-bearing, we believe certain functions should not be delegated either to the State or another entity, including quality assurance and quality of care. Such functions are critical elements of risk-bearing entities, and similarly, should not be delegated from NCQA-accredited MCOs who contract with ACOs.

**Question 3/3(a). Are there certain functions that LDH should consider standardizing or centralizing to facilitate ACO development and to ease provider administrative burden? Should these functions be standardized across ACOs and MCOs?**

Given the diversity in provider readiness to serve as a managed care entity or ACO, we encourage the state to centralize functions including:

- The dissemination of data such as Medicaid claims (e.g., through a health information exchange)
- Data analytics support
- Evidence-based practice information
- System performance monitoring
- Reporting

We also encourage LDH to develop agreed-upon quality measures that reach a larger number of physicians, across multiple systems, to get the largest share of total health care spending. We recommend performance measurements be aligned, to the extent possible, across programs and standards and reflect national standards (e.g. NQF) where appropriate. The design of performance measures should encourage acceptance by and the participation of the provider community and should reflect consumer preferences and priorities where appropriate. Additionally, these measures should be appropriate to the population(s) being served.

Regarding standardization across ACOs and MCO, we recommend LDH align goals and objectives across the entire health care delivery system while preserving stakeholders' ability to innovate. This includes standardization across ACOs and MCOs to ease administrative burden on providers participating across multiple payers. Standardization should be applied to functions such as, but not limited to, marketing requirements, member services, and beneficiary protections such as network adequacy standards.

### **C. ACO Populations**

**Question 1/1(a). Should LDH permit ACOs to serve specific regions, rather than enrolling Medicaid members statewide? Would ACOs be able to develop statewide networks?**

It is UnitedHealthcare's experience that statewide, at-risk organizations are more effective in delivering high quality, accessible care for their members being served. A statewide system with a limited number of contractors also will attract more sophisticated, experienced contractors. A statewide organization can better leverage the resources necessary to provide access to high quality care and drive cost savings. If LDH elects to move forward in the direction of statewide

and/or regional accountability, ACOs should be required to fulfill readiness review requirements similar to managed care requirements to ensure they are prepared to implement the necessary operational/administrative functions to manage their attributed membership.

**Question 2. If LDH were to permit ACOs to serve specific regions, would the ACOs have large enough enrollment to support the infrastructure needed for ACO functions and to take on financial risk?**

We support LDH's recognition of an adequate panel size of no fewer than 10,000 Medicaid beneficiaries, as our experience shows that small patient panels are difficult to risk adjust and do not provide sufficient volume to justify the necessary infrastructure investments to manage the risk. An adequate panel size also increases an ACO's ability to obtain practically meaningful results on cost and quality of impacts and incentivizes providers to invest in meaningful practice transformation.

Attribution models should maximize the number of Medicaid beneficiaries assigned to practices participating in accountable care systems. This assists with incentivizing the shift of the delivery system away from fee-for-service and encourages providers to engage in practice transformation. All attributed Medicaid beneficiaries should be subject to the terms of the accountable care partnership. This simplifies the administrative responsibilities of providers at the point of service understanding which of their patients are attributed to the ACO.

Practice capacity and/or size should also be a factor of attribution to ensure an optimal volume and critical mass of Medicaid patients. This increases the ACO's ability to obtain practically meaningful results on cost and quality of impacts and incentivizes providers to invest in meaningful practice transformation.

Typical approaches include prospective or retrospective assignments or a combination of both. The key is for providers to be aware as early as possible which patients are attributed to their practice to maximize the potential impact of strategies to holistically manage the patient. Practice churn may contribute to inaccurate attribution, depending on how the model is set up and the period of time in which the attribution period applies. It is essential LDH provides support that enables visibility to utilization data across the entire accountable care system and the analytical capability to track patient movement, as it may be difficult for practices to accurately identify ACO members that frequently change physicians.

We encourage LDH to consider this in concert with panel size (and the considerations listed in response to question C1) as it thinks through regional versus statewide reach.

**Question 3. How should populations be defined or limited for ACO enrollment, if at all?**

For complex populations and persons with special health care needs, the key to successful management is access to clinical information, such as historical claims experience and real-time utilization data, coupled with effective clinical strategies that enhance performance. If LDH elects to administer the ACO program, it will need to develop the infrastructure needed to supply this information to practices. There is a suite of tools that are fundamental to an ACO's

successful management of complex populations including clinical management strategies, administrative capabilities such as patient reminders, person-centered care management, high-touch care coordination, cultural competencies and patient engagement approaches to incentivize healthy behaviors. Supporting the intense needs of ACOs focused on complex populations will require establishing incentive models that specifically reward providers for engaging and managing a broad spectrum of benefits and services including physical health and behavioral health as well as services to support functional and social needs.

#### **D. Selection of ACOs**

**Question 1. What are the most important characteristics and qualifications for LDH to consider in selecting ACOs?**

As noted previously, it is UnitedHealthcare's experience that these programs succeed best when providers in a delivery system have both the capacity and willingness to embrace this program. Such providers also must have the following characteristics:

- Experience managing complex populations
- Experience managing across the full continuum of care
- Ability to bear risk
- Adequate financial reserves
- Large patient panel size
- Appropriate infrastructure that includes an electronic health record system, data analytics, integration of clinical and financial data, and reporting capability
- Ability to engage and coordinate with providers outside the ACO network

History demonstrates that provider groups that have failed under risk arrangements cause disruption of care, confusion to the community, and reduced delivery system capacity. Incentivizing physicians to improve quality and lower cost works but there is no one-size-fits-all solution in working with physicians in the state. What we have learned is there is a wide spectrum of physician/practice infrastructure and ability to thrive under different forms of incentives. LDH should consider this diversity in practice capability as it navigates the potential addition of provider-led ACOs to the managed care program.

#### **E. Other Strategies**

**Question 1/1(a). Are there other managed care contracting or payment models that LDH can implement to achieve its goals? For example, should LDH encourage or require MCOs to contract with ACOs or implement other alternative payment arrangements with providers?**

We agree that LDH should expand alternative payment model offerings and delivery system reform, such as ACO initiatives, to advance the State's goal of shifting from paying for volume to paying for value and to improve health care quality and outcomes. Such efforts, when

appropriately structured, assist with advancing practice transformation across the entire Medicaid system, and can support evolution at the individual practice level.

However, we also recognize the challenges in successfully implementing these programs within the health care delivery system, given the variance in tolerance for risk bearing arrangements, the infrastructure needs, analytic capacity, etc. As a result of these challenges, we encourage LDH to leverage its partnerships with Medicaid MCOs to advance value-based payment models.

Practice transformation is challenging, requiring time and investment. Leveraging an organization with deep experience in transformative practice strategies and value-based contracting will elevate LDH's current efforts to drive toward value-based care, align alternative payment models within Medicaid, and ensure effective, sustainable delivery system transformation. A robust partnership with an experienced contractor, such as Medicaid MCOs, can assist state purchasers as they evaluate the efficacy of alternative payment models. The benefits include:

- The ability to aggregate smaller, value-based contracting provider practices (contracting with MCOs) into a larger ACO
- Statewide accountability controls performance variability at the practice and/or regional level.
- Robust strategies to assess participation in advanced payment models and include a disciplined, data-driven approach to practice assessments, tools to monitor system performance, and methods to sequentially progress practices across value based initiatives.
- Customizable supports at the practice level across the continuum of value based payment programs that progresses the system as a whole toward transformation. This approach begins to prepare physicians who are less prepared for transformation and ensures the continuous growth of practices that can take on more accountable partnerships, up to and including risk.
- System performance becomes aligned within the goals of the Medicaid program and creates greater accountability for alignment across Healthy Louisiana MCOs and other public and private systems within the state.
- A nimble approach to practice support across the continuum of value based payment offerings based upon the needs of the individual organizations progresses capabilities such as data analytics, care coordination, population health strategies, performance maximization, reporting, and continuous process improvement.
- Strategic, targeted, and disciplined approach to infrastructure investments supports practice evolution.
- Development of effective methods of provider engagement helps to identify the optimal balance of accountability, integrated delivery systems, and practice activation to provide the most complete and effective patient care.

We encourage LDH to establish a program that adheres to a core set of accountable care principles but allows for MCO and provider flexibility within minimum standards for participation, as determined by LDH. For example, it is important that LDH not mandate the number or

percentage of providers that must engage in these efforts with the State or MCOs, given the diversity of provider practices and their readiness to be paid under more sophisticated value based payment arrangements.

Program principles can include:

- Better overall health through higher quality and lower costs with a focus on patients.
- Establishment of provider organizations accountable for achieving better results for all of their patients at a lower cost.
- Alignment of financial, regulatory and performance incentives with the goal of better health through higher quality care and lower costs.
- Valid, meaningful performance measures that support provider accountability for goals and support informed and confident patient care choices.

This systematic and flexible model, managed by MCOs, would create an approach adaptable to practice variation. This approach also would allow LDH to maximize the number of practices engaged in payment transformation, and create administrative simplification for LDH.

Through our experience with multiple payment reform strategies we have learned that effective, efficient transformation takes coordination, robust collaborative care tools, strategic infrastructure investments, and experienced resources to provide one-on-one practice support. This ideal creates a model where all key constituents in the community can successfully evolve.

## Section IV

Not applicable

## APPENDIX: RESPONDENT INFORMATION

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**Last Name:** Young  
**Title:** Health Plan CEO  
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**Responding as an Individual: (Y/N)** No  
**Responding on Behalf of Organization: (Y/N)** Yes

**Check all that describe your organization:**

- Hospital or Hospital System
- Clinical System
- Advocacy Organization
- Health Plan
- Physician
- Non-physician Health Care Provider
- Other – Please Describe:

**Louisiana Department of Health Request for Information for Provider-Led  
Accountable Care Organizations  
504HealthNet**

504HealthNet is a member association comprised of 23 community-based health care providers, including 12 Federally Qualified Health Centers, who provide essential primary, preventive, and behavioral health care services for over 160,000 low income Louisianans, regardless of their ability to pay. Members independently operate over 70 sites and are serving the health care needs of the working poor, the unemployed, the undocumented, and other medically underserved populations. Collectively we serve the majority of the adult Medicaid-expansion population's primary care needs in the Greater New Orleans region, and are dedicated to caring for them. As an organization focused on primary care and behavioral health, we are not applying as an ACO, but would like to participate in shaping the ACO model the state is considering. 504HealthNet provides a robust, existing collaborative framework of Medicaid providers that may serve as an ideal environment to pilot and study a Medicaid ACO model.

ACOs can face substantial challenges in understanding patient utilization patterns, identifying high-risk patients, patient engagement, and implementing care coordination strategies. Community-based clinics and in particular FQHC's, because they understand the unique clinical and social needs of the Medicaid population, are best positioned to help shape a future ACO model. 504HealthNet member organizations are poised to take on the challenge and care of Medicaid patient in an ACO setting.

504HealthNet members have been caring for the Medicaid population and have a deep understanding of their needs, the challenges they face and care utilization patterns. The members of 504HealthNet stand out for their established commitment to continuous quality improvement, including experience with population health management, disease registries, adopting the medical home care model, and implementation of electronic health records (EHRs). At many sites, patient navigators are embedded on care teams, and help coordinate care for highly complex patients, including scheduling appointments, arranging home-based services or transportation, providing medication reminders, and ensuring that patients do not fall through the cracks. In addition, the FQHC financing model encourages longer clinic visits, care coordination services, or other high-touch care which has been demonstrated to improve health outcomes.

504HealthNet has a strong history of collaboration, with a focus on financing through the Greater New Orleans Community Health Connection (GNOCHC) program and health information technology through the Beacon-funded Greater New Orleans Health Information Exchange (GNOHIE). We have played an important role with enrolling patients in health insurance, including Medicaid, and have been strong supporters of Medicaid expansion. We regularly work in partnership with University Medical Center (UMC) to improve care coordination and services for the patients we share. Participating in an ACO partnership would help to further strengthen the ties between community-based health care organizations and the communities we serve.

504HealthNet would like to collaborate with LDH as they develop and implement their value-based strategy to improve the Medicaid program and support the triple aim by providing the expertise from providers on the ground who are currently caring for the Medicaid population.

## Section III. Questions for Respondents

### A. ACO Requirements

**Question 1.** Are there any exceptions or modifications to current requirements that LDH should consider to encourage ACO participation?

**Question 2.** What governance principles and/or requirement should LDH consider implementing to ensure that ACOs are governed and led by Louisiana providers?

LDH should require ACOs to include Federally Qualified Health Centers and other safety-net providers in their network. We support LDH's implementation of a value-based strategy, and want to ensure 504HealthNet member organizations are included in the changes to the Medicaid program so we can continue providing quality care to the patients that need it most. It is essential that patients are able to maintain their existing doctor and receive care at their medical home during this transition and thereafter. We advocate for patients, and want to continue providing care to vulnerable populations, consistent with our mission of providing care to all. 504HealthNet providers are committed and dedicated to serving the existing population, and through the GNOCHC Waiver have been creating stability for providers and patients to establish trust and improve health outcomes. We recommend LDH requires the respondents to the provider-led ACO be licensed within Louisiana and have participated in the Louisiana Medicaid program for a minimum of three years.

The governance structure requirements for the board composition of the provider-led participating ACOs should include a patient representative so that the consumer voice is heard. Additionally, LDH should require 50% of the board to be comprised of experienced, practicing physicians who are currently caring for Medicaid patients. Additionally, over 50% of the representation on the board should be primary care physicians, with a requirement for behavioral health representation from a practicing psychiatrist on the board. There should also be at least one board member who can provide technical expertise on technology and population health management.

**Question 3.** Are there any interim steps or technical assistance that LDH could provide to promote providers' ability to develop ACOs over time?

In successful ACOs, providers need timely access to accurate, comprehensive data they can analyze to make decisions to improve health outcomes. LDH support and technical assistance for this is essential, along with access to a robust health information exchange that allows for analytics.

Support and technical assistance around patient engagement is paramount to forming functioning ACOs. 504HealthNet requests support from LDH to pilot evidence based strategies for patient engagement and behavior change that translate into better health outcomes. This pilot would be expanded state-wide and the lessons learned distributed.

It is also important for LDH to provide time and technical expertise to providers as they make the switch to a risk-bearing ACO model. Allowing components of the ACO model to be phased in over time so providers can adjust is key to ensuring the success of the model. Developing

payment methodologies that maintain adequate reimbursements to safety net primary care providers are essential.

**Question 4.** Are there other unique requirements that LDH should consider applying to ACOs?

LDH should strongly consider the following:

- Network requirements to ensure access to mental health and substance abuse services including inpatient psychiatric hospital beds as well residential/inpatient detox programs, residential rehab programs, and ambulatory medication-assisted treatment (MAT) programs.
- Network requirements to ensure access to adequate and timely specialty care services.
- A core Medicaid formulary, including a transparent process to review and add medications.
- A feedback loop and communication channel between LDH and providers to make improvements and solve issues that arise.
- A publically displayed dashboard with performance and outcome metrics.
- Consistent, simplified outcome measures for providers.
- Robust patient engagement strategies, including patient education and outreach.
- Case management programs designed for this specific population.

### ***B. ACO Functions:***

**Question 1.** Should ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan?

Yes, ACOs should be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan, provided there is a robust feedback mechanism which allows enrollees and providers to address concerns directly with LDH.

**Question 2.** Are there any key functions that LDH should not permit the provider-led ACO to delegate to another entity?

**Question 3.** Are there certain functions that LDH should consider standardizing or centralizing to facilitate ACO development and to ease provider administrative burden? Should these functions be standardized across ACOs and MCOs?

Yes, LDH should consider standardizing or centralizing certain functions across MCO and ACOs to facilitate ACO development and to ease provider administrative burden. Data sharing and reporting is one such function, as the state should support and standardize through the GNOHIE and state-wide HIE. A state-wide formulary is another area for standardization, along with a process for a formulary advisory board to review and make changes to the formulary.

### ***C. ACO Populations***

**Question 1.** Should LDH permit ACO's to serve specific regions, rather than enrolling Medicaid members statewide?

Yes, as health care delivery is largely regional, LDH should permit ACO's to serve specific regions, rather than enrolling Medicaid members statewide.

a) Would ACO's be able to develop statewide networks?

Yes, ACOs should be allowed to develop statewide networks

**Question 2.** If LDH were to permit ACO's to serve specific regions, would the ACOs have large enough enrollment to support the infrastructure needed for ACO functions and to take on financial risk?

LDH would need to designate the regions large enough to permit ACO's to serve specific regions, so that they have sufficient enrollment to support the infrastructure needed for ACO functions and to take on financial risk. The Greater New Orleans region would benefit from a regional ACO. In many ways this would be preferable, since local organizations are already familiar with the health care delivery landscape and patient populations in the region.

**Question 3.** How should populations be defined or limited for ACO enrollment, if at all?

In the beginning, special populations which are currently covered under Medicaid waivers should not be included. These populations need special considerations, and it would be overly burdensome for the ACO to try and take on caring for all populations at once. A phased-in approach would allow for the ACO to effectively develop processes and procedures to build capacity and experience before taking on more complex patients.

#### ***D. Selection of ACOs***

**Question 1.** What are the most important characteristics and qualifications for LDH to consider in selecting ACOs?

It is essential that LDH ensures the ACO includes providers that have experience providing care to the local Medicaid population in order to minimize the disruption of care to patients. Provider-led ACOs should emphasize care coordination, the medical home model, patient navigation, and value a patient-centered approach to care delivery. 504HealthNet clinics have developed a working knowledge of how to best manage care for more complex patients that face challenges such as transportation, literacy, and other barriers to care. This work should be replicated and encouraged to grow as it saves the state and taxpayers money, and improves health care outcomes for the patient population.

Prompt access to services, particularly specialty care, substance abuse, and mental health services is critical for primary care providers to be able to manage their patient's health. Metrics should be set for availability, and network requirements must be established to ensure timely care.

Without data sharing and analytics, providers do not have the tools they need to effectively manage patient care and ensure success in a provider-led ACO. The state's role and support of a health information exchange and analytics is key to a functioning ACO so that providers can make data-driven decisions.

### *E. Other Strategies*

**Question 1.** Are there other managed care contracting or payment models that LDH can implement to achieve its goals? For example, should LDH encourage or require MCO's to contract with ACOs or implement other alternative payment arrangements with providers?

LDH should consider Medicaid Health Homes and global payments as ways to transition FQHC and primary care providers to participation in a full ACO model. LDH should consider implementing payment strategies that address social determinants of health.

### **Section IV. Statement of Interest (For Potential ACO Respondents Only)**

**Question 1.** Please describe your interest in becoming an ACO.

**Question 2.** Please describe the Medicaid population(s) you currently serve. Please describe the services you currently provide to these populations.

**Question 3.** Please describe the services you currently provide to these populations.

**Question 4.** Would your ACO be able to enroll and serve all Healthy Louisiana populations statewide? If not, please describe the region(s) of the state you would be able to serve.

**Question 5.** Would your ACO be able to enroll and serve all Healthy Louisiana eligibility groups? If not, please describe the population your ACO would serve.

**Question 6.** Does your organization currently participate in any risk arrangements or contracts with Medicaid, Medicare or commercial payors? If so, please describe these (e.g., the type of arrangement, the payor—Medicaid, Medicare or commercial, etc.).

**Question 7.** Does your organization currently participate in or own an Accountable Care Organization (ACO)?

**Question 8.** Does your organization currently have capacity in the following areas needed to serve as an ACO?

- Marketing
- Claims adjudication and payment
- Network development
- Provider services
- Member services
- Prior authorization
- Patient outreach and education
- Care management
- Data analytics
- Quality measurement and reporting

**Question 9** What capacity would your organization need to obtain to serve as an ACO?

**Question 10.** How might your organization obtain needed capacity?

**Question 11.** When would your organization be ready to respond to an LDH procurement for ACOs?

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January 31, 2017

Submitted by email to:

Louisiana Department of Health  
Bureau of Health Services Financing  
Frank Opelka, Medicaid Program Manager  
[Frank.Opelka@l.gov](mailto:Frank.Opelka@l.gov)

**Re: ACO RFI Response**

Dear Mr. Opelka,

GlaxoSmithKline (GSK) appreciates the opportunity to submit comments to Louisiana's Request for Information (RFI) regarding the possible addition of provider-led managed care plans to the *Healthy Louisiana* Medicaid managed care program as accountable care organizations (ACOs) in 2019. We applaud the Department of Health's efforts to modernize payment mechanisms to shift from paying for volume to value and to improve health care quality and patient outcomes. GSK recommends that the Department consider adopting a comprehensive quality strategy as a part of considering an ACO approach and improving the quality of patient care in the Medicaid program.

GSK is a science-led global health care company that researches and develops a broad range of innovative medicines and brands to help patients do more, feel better, and live longer. While GSK does not create quality measures, we have a committed interest in ensuring the robustness of quality that supports better care for individuals and improved overall population health within publically supported and market-based health care programs. The trends of linking quality to the value of care and using quality information to inform patient choices will continue to grow as they are critically important to assuring that health care reforms preserve and enhance patient outcomes

A well-constructed quality strategy is of vital importance to improving health outcomes and overall public health. To that end, GSK supports the implementation of quality measures that meet the following characteristics:

- Endorsed by multi-stakeholder, evidence-based quality organizations, such as the National Quality Forum (NQF);
- Reflect higher performance in helping to achieve patient-centered outcomes;
- Based on evidence-based processes; and
- Aligned across multiple care settings and providers to harmonize the use of measures in various reporting programs to help reduce reporting burden and accelerate improvement.

GSK supports the inclusion of the following quality measures in Louisiana's Medicaid managed care program with regards to ACOs:

**HIV Quality Measures**

GSK commends Louisiana for your commitment to reduce the viral load in people living with HIV. Providing a significant bonus to Medicaid managed care plans when they meet the baseline viral load suppression of 54.1 percent is an important step forward to improving quality of life and reducing transmission rates. As you may know, a 2011 clinical study from the National Institutes of Health (NIH) found that treating HIV-positive people with antiretroviral treatment (ART) reduces the risk of transmitting the virus to HIV-negative sexual partners by 96 percent.<sup>i</sup> We encourage you to build upon your existing strategy and adopt HIV quality measures in your Medicaid managed care program as a next step in reducing the incidence of HIV in Louisiana.

HIV quality measures are critical to the care and treatment of people living with HIV. Approximately 1.2 million people are infected with HIV, and one in seven (14 percent) are unaware that they are infected. Despite groundbreaking treatments that have slowed the progression and burden of the disease, the pace of new infections continues at a high level, especially among certain demographic groups including Blacks/African Americans and Hispanics/Latinos.<sup>ii</sup> Implementing the HIV viral load suppression quality measure would support public health priorities, such as reduced

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viral load, and the use of HIV Antiretroviral Therapy has been linked with improved overall health, quality of life, and decreased risk of HIV transmission.<sup>iii iv v</sup> GSK encourages the Department to implement the following measures:

- NQF #2082: HIV Viral Load Suppression (Clinician, Health System, Population)
- NQF #2083: Prescription of HIV Antiretroviral Therapy (Clinician, Health System, Health Plan, Population)

The Viral Load Suppression Measure has been nationally vetted and reported. In fact, the Centers for Medicare & Medicaid Services and America's Health Insurance Plans (AHIP) included NQF #2082: Viral Load Suppression, among other HIV measures, in their core measure set as a part of their broad Core Quality Measures Collaborative of health care system participants.<sup>vi</sup> The Core Quality Measures Collaborative, led by AHIP and its member plans' Chief Medical Officers, leaders from CMS and the National Quality Forum, as well as national physician organizations, employers, consumers, and patient groups worked hard to reach consensus on these core measure sets. The guiding principles used by the Collaborative in developing the core measure sets are that they be meaningful to patients, consumers, and physicians, while reducing variability in measure selection, collection burden, and cost.

### Immunization Quality Measures

During the 20<sup>th</sup> century, the life span of Americans has increased by more than 30 years in part because of the use of vaccines, and mortality from infectious diseases in the U.S. has been reduced 14-fold through the use of vaccines, according to the U.S. Department of Health and Human Services.<sup>vii</sup> The preventive nature of vaccines helps to improve patient outcomes and curtails treatment costs on the healthcare system. GSK recommends the following measures that support immunizations for routine use in adults and that have a recommendation from the Advisory Committee on Immunization Practices (ACIP).

- NQF #0041: Influenza Immunization (Clinician, Health System, Health Plan)
- NQF #0431: Influenza Vaccination Coverage among Healthcare Workers (Health System)
- NQF #0043: Pneumococcal Vaccination Status for Older Adults (Clinician, Health System, Health Plan)

GSK notes that despite ACIP recommendations and Healthy People 2020 targets, adult immunization rates remain low.<sup>viii</sup> Quality measures have the potential to increase immunization rates.<sup>ix</sup> Adult immunization quality measures currently focus on influenza and pneumococcal immunization. GSK supports the development of quality measures that increase adult immunization rates for ACIP recommended vaccines.

### COPD Quality Measures

Chronic obstructive pulmonary disease (COPD) is the third leading cause of death in the U.S. and causes serious, long-term disability.<sup>x</sup> As of 2011, 15 million Americans have been diagnosed with COPD; of this total, approximately 50% were not aware their lung function was not at full capacity, a primary symptom of COPD.<sup>xi xii</sup> Therefore the number of Americans with COPD may actually be greater than 15 million, indicating an under diagnosis of COPD exists.<sup>xiii</sup>

A recent study conducted by the Centers for Disease Control and Prevention (CDC) shows the significant economic and quality of life impact that COPD is taking on the U.S. The research found that:

- In 2010, total national medical costs attributable to COPD were estimated at \$32.1 billion and total absenteeism costs were \$3.9 billion for a total burden of COPD-attributable costs of \$36 billion.
- An estimated 16.4 million days of work were lost because of COPD.
- Of the medical costs, 18% was paid for by private insurance, 51% by Medicare, and 25% by Medicaid.
- National medical costs are projected to increase from \$32.1 billion in 2010 to \$49.0 billion in 2020.<sup>xiv</sup>

GSK considers COPD disease management a significant component for better patient outcomes and lower long-term costs. GSK supports the inclusion of the following COPD measures as they focus on diagnosis and adequate treatment and exacerbation control and may possibly help impact quality of life and healthcare costs.

- NQF #0028: Tobacco Use Assessment and Tobacco Cessation Intervention (Clinician)
- NQF #0091: COPD: Spirometry Evaluation (Clinician)

- NQF #0577: Use of Spirometry Testing in the Assessment and Diagnosis of COPD (Health System, Health Plan)
- NQF #0102: COPD: Inhaled Bronchodilator Therapy (Clinician)
- Former NQF #0549: Pharmacotherapy Management of COPD Exacerbation (Clinician, Health System, Health Plan, Population)
- NQF #0275: PQI 05: COPD or Asthma in Older Adults Admission Rate (Population)
- NQF #1891: Hospital 30 Day All Cause Risk-Standardized Readmission Rate following COPD Hospitalization (Health System)
- NQF #1893: Hospital 30 Day All Cause Risk-Standardized Mortality Rate following COPD Hospitalization (Health System)

### Care Coordination/Medication Management

Care coordination involves organizing activities and sharing information among all of the participants concerned with a patient's care to achieve safer and more effective care, according to the *Agency for Healthcare Research and Quality (AHRQ)*. Care coordination is identified by the Institute of Medicine (IOM) as a key strategy that could help improve the effectiveness, safety, and efficiency of the U.S. healthcare system.<sup>xv</sup>

An important part of care coordination is medication management. Proper use of medications can lead to improved health, enhanced quality of life, and increased productivity. Therefore, GSK supports medication management measures as well as the development and implementation of measures for Comprehensive Medication Management (CMM), a continuous, systematic process used by providers to ensure patients' medications are coordinated, appropriate, and understood by the patient.

GSK supports implementation of the following measures because they help encourage coordination between various aspects of an episode of care, including patient transitions between providers and from provider care to home health and post-acute care, which are the times that are prone to medical misadventures due to lack of coordination and interconnectedness between agencies.

- Pharmacy Quality Alliance (PQA) Measure: Medication Therapy Management (MTM) - Proportion of MTM-eligible members who received a Comprehensive Medication Review (CMR) (Clinician, Health Plan)
- NQF #0097: Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility (Clinician)
- NQF #0419: Documentation of Current Medication in the Medical Record (Clinician, Population)
- NQF #0553: Care for Older Adults – Medication Review (Health System, Health Plan)
- NQF #0554: Medication Reconciliation Post-Discharge (Health System, Health Plan)
- NQF #0648: Timely Transmission of Transition Record (Discharges from an Inpatient Facility to Home/Self Care or Any Other Site of Care) (Health System)

Thank you for your consideration and the ability to respond to Louisiana's RFI. GSK looks forward to working with the Department of Health and other stakeholders to ensure that patients in Louisiana's public programs continue to have access to quality care. Please feel free to contact me at (270) 791-6564 or [Christopher.J.Bryce@gsk.com](mailto:Christopher.J.Bryce@gsk.com) should you have any questions.

Sincerely,



Chris Bryce  
Government Relations Account Director  
GlaxoSmithKline

<sup>1</sup> <http://www.cdc.gov/hiv/prevention/research/art/>; Cohen MS, Chen YQ, McCauley M, et al. Prevention of HIV-1 infection with early antiretroviral therapy. *N Engl J Med* 2011;365:493-505.

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- <sup>ii</sup> Center for Disease Control and Prevention, HIV in the United States: *At A Glance*, <http://www.cdc.gov/hiv/statistics/basics/ata glance.html>
- <sup>iii</sup> D. Donnell, et al., *Heterosexual HIV-1 Transmission After Initiation of Antiretroviral Therapy: A Prospective Cohort Analysis*, 375 *The Lancet* 2092, 2095 (Jun. 2010)
- <sup>iv</sup> Guidelines for the Use of Antiretroviral Agents in HIV-1-Infected Adults and Adolescents, NIH, <http://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf>
- <sup>v</sup> World Health Organization (WHO). Adherence to long term therapies—evidence for action. 2003. [http://www.who.int/chp/knowledge/publications/adherence\\_full\\_report.pdf](http://www.who.int/chp/knowledge/publications/adherence_full_report.pdf)
- <sup>vi</sup> <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2016-Press-releases-items/2016-02-16.html>
- <sup>vii</sup> The State of the National Vaccine Plan, 2013 Annual Report
- <sup>viii</sup> *MMWR*, February 7, 2014/ 63(05); 95-10
- <sup>ix</sup> Performance Measures, Vaccinations, and Pneumonia Rates Among High-Risk Patients in Veterans Administration Health Care. *American Journal of Public Health*. December, 2007; 97(12): 2167-2172
- <sup>x</sup> Heron M. Deaths: Leading Causes for 2010. *National Vital Statistics Reports*. 2013;62(6)
- <sup>xi</sup> The Morbidity & Mortality: Chart Book on Cardiovascular, Lung, and Blood Diseases. The National Heart, Lung, and Blood Institute; 2012. Accessed on July 1, 2013.
- <sup>xii</sup> Mannino DM, Gagnon RC, Petty TL, Lydick E. Obstructive lung disease and low lung function in adults in the United States: data from the National Health and Nutrition Examination Survey 1988-1994. *Arch Intern Med*. 2000;160:1683-1689.
- <sup>xiii</sup> Centers for Disease Control and Prevention, “Chronic Obstructive Pulmonary Disease (COPD).” (2013 April 25). <http://www.cdc.gov/copd/>
- <sup>xiv</sup> Total and state-specific medical and absenteeism costs of chronic obstructive pulmonary disease among adults aged ≥18 years in the United States for 2010 and projections through 2020, Earl S. Ford, MD, MPH; Louise B. Murphy, PhD; Olga Khavjou, MA; Wayne H. Giles, MD, MS; James B. Holt, PhD; Janet B. Croft, PhD, *Chest*. 2014. doi:10.1378/chest.14-0972
- <sup>xv</sup> Care Coordination, The Agency for Healthcare Research and Quality, <http://www.ahrq.gov/professionals/prevention-chronic-care/improve/coordination/>



Louisiana Department of Health  
Request for Information: Provider-Led Accountable Care Organizations  
Response from the Louisiana Public Health Institute (LPHI)  
January 31, 2017

## Background

The Louisiana Public Health Institute (LPHI) is a 501c(3) nonprofit that translates evidence into strategy to optimize health ecosystems. LPHI is dedicated to advancing public health practice and making systematic improvements in population health. Our work focuses on uncovering complementary connections across sectors to combine the social, economic, and human capital needed to align action for health. We champion health for people, within systems, and throughout communities because we envision a world where everyone has the opportunity to be healthy.

LPHI has a strong history of designing and implementing solutions that advance population health in both healthcare and community settings. We have teams of experts in clinical transformation, family and behavioral health, healthy communities, and health services research. Through program administration, skilled coaching, health information technology assets, analytic tools, and other service offerings, we help healthcare organizations transform their operations to advance quality, improve patient experience, reduce costs, and engage communities. We collaborate on these efforts with a range of healthcare providers, including community health centers, behavioral health agencies, hospitals and health systems, health plans, and more.

LPHI is pleased to submit comments regarding LDH's efforts to modernize Medicaid payment mechanisms, incentivize improvements in quality of care, and empower providers to advance population health. As an agent of cross-sector collaboration for population health improvement, we have a unique understanding of the key stakeholders at hand as well as the opportunities and operational implications involved in developing a value-based model of care for Louisiana. LPHI welcomes any additional opportunities to provide feedback, share expertise, or facilitate engagements with our partnering providers.

## Section III. Questions for Respondents

### A. ACO Requirements

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**Question 1.** *Are there any exceptions or modifications to current requirements that LDH should consider to encourage ACO participation?*

**Question 2.** *What governance principles and/or requirement should LDH consider implementing to ensure that ACOs are governed and led by Louisiana providers?*

LPHI advocates for patient representation within ACO governance structures. It is important that the patient voice is heard at this level of decision making.

**Question 3.** *Are there any interim steps or technical assistance that LDH could provide to promote providers' ability to develop ACOs over time?*

Access to timely, accurate, and comprehensive data will be critical to the success of ACOs and any population health initiatives. Well-developed health information exchange functionalities will be necessary to ensure all participants have access to that data. LDH should continue to facilitate the growth of health information exchange adoption and implementation in order to encourage and assist providers to develop ACOs.

Additionally, as it stands today claims, enrollment and quality measure data from Medicaid health plans are siloed in individual plan-specific portals, making it difficult for providers to access and meaningfully use to improve patient care for their populations. It is important that LDH facilitate access to this information across Healthy Louisiana plans to be more accessible by the healthcare providers to manage their whole populations, not just plan by plan in separate systems. For example, the Louisiana Public Health Institute, in partnership with the Louisiana Primary Care Association and the Greater New Orleans Health Information Exchange, is putting in place a pilot among several Federally Qualified Health Centers to create a clinical (and claims) data warehouse to be used to create analytic tools for providers at the point of care and that can be aggregated at the panel, population and network levels for population health improvement purposes. LDH should compel Healthy Louisiana plans to contribute enrollment and claims data for FQHCs' panels to facilitate efforts to better manage cost and quality across Medicaid plans.

Technical assistance around data collection, data exchange, and analytics will be necessary to help providers shift their mindsets and their daily clinical operations from a patient-level to a population-level perspective. LDH should consider these technical assistance offerings to help build provider capacity to operate new information technology tools, leverage and interpret newly available data, and translate that into population-level strategies and interventions.

Furthermore, evidence shows that population health initiatives are more successful at improving health outcomes when they address patients' socioeconomic and environmental needs, such as transportation and housing. LDH should ensure that technical assistance on this issue is offered to providers so that more are aware of common barriers to care and know how to identify and address their patients' health-related needs.

Lastly, as providers begin to explore more advanced and innovative approaches to population health management, skill and capacity building around patient engagement and care coordination will be increasingly important. We recommend that LDH offers technical assistance on patient activation and motivational interviewing, successful models and workflows for complex care management, and tools for risk assessment and stratification.

**Question 4.** *Are there other unique requirements that LDH should consider applying to ACOs?*

When establishing ACO requirements, LDH should prioritize patient access to care and quality of care. In addition, LDH should make an effort to align with existing performance and quality measures to reduce administrative burden on providers engaged in other quality-related programs.

## ***B. ACO Functions***

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**Question 1.** *Should ACOs be permitted to obtain necessary functionality by entering into a TPA or joint venture with an insurance company or health plan?*

Yes, ACOs should be permitted to enter into a TPA or joint venture with an insurance company or health plan in order to obtain necessary functionality.

**Question 2.** *Are there any key functions that LDH should not permit the provider-led ACO to delegate to another entity?*

**Question 3.** *Are there certain functions that LDH should consider standardizing or centralizing to facilitate ACO development and to ease provider administrative burden? Should these functions be standardized across ACOs and MCOs?*

The usage of a standardized data and analytics platform would benefit all providers, whether in an ACO model or in the interim. As it stands, providers have multiple portals to individual payers, with different information available at different times in different formats. As Dr. Gee mentioned in her remarks at the Louisiana Association of Health Plans conference, this is an untenable situation if the goal is to create actionable information for providers to use to impact health outcomes.

A standardization of the information and availability of that information would greatly benefit providers. A model for this to be done successfully can be seen in the SDAC for the Colorado Regional Care Collaborative Organizations (RCCOs).<sup>1</sup> An initial area of focus should be increasing availability of claims data and making that information available to provider organizations. Furthermore, the use of health information exchanges to manage Medicaid populations was highlighted in the recent Audacious Inquiry report. Providing further access to claims or attribution information to health information exchange platforms would better allow providers to leverage all of their tools in a more unified approach.

### **C. ACO Populations**

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**Question 1.** *Should LDH permit ACO's to serve specific regions, rather than enrolling Medicaid members statewide?*

Yes, LDH should permit ACOs to serve specific regions of the state. First and foremost, ACOs must meet the needs of the community. Early evidence shows that a regional approach may be most effective at addressing varied regional needs and priorities within a given state. Below are descriptions of how regional ACOs can target and tailor their core functions to better meet local needs.

- Provider types and service offerings can be tailored to meet population needs and key access challenges.
- Care coordination and care management interventions are often operationalized at the regional level and can be tailored to meet the needs of enrollees and providers.<sup>2</sup> Furthermore, community-based models such as home visiting programs, which are often effective for the highest cost and highest need individuals, are more logistically feasible within a regional scope.

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<sup>1</sup>[https://www.colorado.gov/pacific/sites/default/files/Statewide%20Data%20Analytics%20Contractor%20Fact%20Sheet\\_0.pdf](https://www.colorado.gov/pacific/sites/default/files/Statewide%20Data%20Analytics%20Contractor%20Fact%20Sheet_0.pdf)

<sup>2</sup> [http://www.chcs.org/media/CoreConsiderationsforMedicaidACO\\_Final.pdf](http://www.chcs.org/media/CoreConsiderationsforMedicaidACO_Final.pdf)

- Quality and cost benchmarks can be tailored to population characteristics and risk levels (while continuing to move toward alignment with state and federal measures).
- Governing board can include representation from regional stakeholders and more accurately represent the service area.
- Partnership development and collaboration with local agencies is possible. For example, ACOs can partner with social service and community organizations to coordinate enrollees' health and social needs, and with local health departments to assess community needs and develop health improvement plans.<sup>3</sup>

a) *Would ACO's be able to develop statewide networks?*

Yes, ACOs should be able to develop statewide networks.

**Question 2.** *If LDH were to permit ACO's to serve specific regions, would the ACOs have large enough enrollment to support the infrastructure needed for ACO functions and to take on financial risk?*

Yes, if the regions are large enough, ACOs could have large enough enrollment to support the necessary infrastructure and take on financial risk. The Greater New Orleans area would be a good region to pilot this approach.

**Question 3.** *How should populations be defined or limited for ACO enrollment, if at all?*

It is important to consider the existing infrastructure when defining the enrollee population. As such, LDH should initially exclude populations currently covered by Medicaid waiver programs. These groups generally have unique and complex healthcare needs and require significant administrative and clinical support. Care management strategies, care team configuration, and care pathways and workflows also differ greatly with special populations.

After successfully implementing ACOs for the general Medicaid population, LDH should consider how waiver populations, as well as individuals dually eligible for Medicare and Medicaid, can be incorporated into a value-driven model of care.

#### **D. Selection of ACOs**

**Question 1.** *What are the most important characteristics and qualifications for LDH to consider in selecting ACOs?*

It is important that ACOs are made up of providers with records of high-quality, patient-centered care. To better serve the Medicaid population, provider policies and practices should be examined to assess access to care – for example, whether there are evening and weekend office hours. To ensure that ACOs will embrace this new kind of population health management, providers should demonstrate agility and flexibility, which will be necessary to successfully design and operationalize changes to clinical workflow, quality improvement processes, and care coordination strategies and standards.

Participating providers should have the ability to standardize data for querying and exchange. Providers should also have access to health information exchange capabilities (e.g. emergency

<sup>3</sup> [http://familiesusa.org/sites/default/files/product\\_documents/ACOs-in-Medicaid.pdf](http://familiesusa.org/sites/default/files/product_documents/ACOs-in-Medicaid.pdf)

department and inpatient hospitalization notifications) and data analysis tools to facilitate effective population management in terms of cost and quality.

### ***E. Other Strategies***

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**Question 1.** *Are there other managed care contracting or payment models that LDH can implement to achieve its goals? For example, should LDH encourage or require MCO's to contract with ACOs or implement other alternative payment arrangements with provides?*

An important component of successful ACOs around the country is their attention to addressing how social and environmental factors impact patient health outcomes and costs. Investments to support patient access to safe, affordable housing, transportation, food, utilities, and other social services can contribute to better health outcomes and lower costs.<sup>4</sup>

Recognizing LDH's pursuit of strategies that promote and encourage provider accountability for care management and the total cost of care for Medicaid enrollees, LPHI recommends that Louisiana's ACO strategy draw on innovative approaches explored by others. One example of a successful model is Michigan's Blueprint for Health, which focuses on healthy babies, emergency department super-utilization (8+ visits/year), and multiple chronic conditions.<sup>5</sup>

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<sup>4</sup> <http://www.ajmc.com/newsroom/how-hennepin-health-created-a-different-way-to-care-for-people>

<sup>5</sup> <http://www.malph.org/sites/default/files/files/Forums/Admin/2015%20Finance%20%26%20Admin%20Seminar/SIM%20Presentation.pdf>

Planned Parenthood Gulf Coast

January 31, 2017

Frank Opelka  
Special Projects Manager  
Louisiana Department of Health  
Bureau of Health Services Financing  
P.O. Box 629  
Baton Rouge, LA 70821-0629

VIA ELECTRONIC SUBMISSION

**Re: Request for Information for Provider-Led Accountable Care Organizations**

Dear Mr. Opelka:

Planned Parenthood Gulf Coast (PPGC) is pleased to submit these comments on the Louisiana Department of Health's (LDH) Request for Information related to Provider-Led Accountable Care Organizations. As a trusted women's health care advocate, we thank the LDH for seeking input from a cross section of stakeholders on this innovative proposal designed to shift payment from volume to value and to improve health care quality and outcomes.

PPGC is the largest sexual health organization in Louisiana. We serve more than 35,000 women, men, teens and parents through our health care, education, outreach and advocacy efforts. PPGC operates two health centers throughout Louisiana. During fiscal year 2015-2016 PPGC provided nearly 16,000 health care visits for women, men, and teens; over 1,300 of these patient visits were for routine, preventive care (well-woman exams, including clinical breast exams). We also provided over 1,300 cervical cancer-screening tests and diagnosed and provided treatment for nearly 140 precancerous cervical conditions. PPGC provided over 14,700 contraceptive services with an estimated 2,100 unintended pregnancies averted through birth control. We also provided almost 23,000 tests for sexually transmitted infections, enabling people to get treatment and learn how to prevent the further spread of diseases.

Reproductive care is at the center of what many women need to stay healthy according to the most recent guidelines issued by the American College of Obstetricians and Gynecologists.<sup>1</sup> Research also shows that low-income women tend

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<sup>1</sup> Well Woman Care: Assessments and Recommendations. The American College of Obstetricians and Gynecologists. July 16, 2013. <http://www.acog.org/-/media/Departments/Annual-Womens-Health-Care/PrimaryAndPreventiveCare.pdf>.

to think of reproductive health care providers as their primary (or only) source of care.<sup>2</sup> Reproductive health care providers serve as a pivotal entry point to the broader health care system for women of reproductive age and as a connector to other care and services, including behavioral health and social supports. Women report that they are 16 percent more likely to be open and honest with reproductive health providers over other providers, and studies show that trust in a provider is connected to improved health outcomes.<sup>3</sup>

Across the country, Planned Parenthood affiliates are leveraging health care sector innovation to improve access to quality care for women of reproductive age. The comments below suggest a path forward for Louisiana to transform Medicaid payment and delivery in ways that can improve quality and patient satisfaction, while potentially reducing health care costs related to women of reproductive age.

In responding to this request for information, we would like to specifically address Section E of the RFI. We provide recommendations for additional payment models that LDH should consider to help meet the stated goal of “improv[ing] quality for Medicaid patients while bettering the state’s financial stability by combatting rising healthcare costs.”

***As Louisiana considers developing and promoting the use of alternative payment models for Medicaid, PPGC urges the state to incentivize high-value services provided to women of reproductive age in community settings.***

Reproductive health care providers play, and will continue to play, a critical role for many women as a trusted source of primary preventive care, referrals, and ongoing care coordination. The high-value contribution of these providers in health system transformation should be elevated and rewarded along with other considered models, such as primary medical homes.

The state should prioritize development and adoption of innovative payment and delivery models that promote the health of reproductive-age women. The evidence is available to craft savings methodologies that capture the value of preventive interventions provided to enhance health outcomes and reduce systemic costs. For instance, recent estimates show that evidence-based interventions, such as tobacco cessation and family planning, create a significant return on investment (\$2-3 in

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<sup>2</sup> PerryUndem Research & Communication. “Women & OB/GYN providers”. Research conducted for Planned Parenthood Federation of America, November 2013.

<sup>3</sup> Hall, Mark A., L. Gregory Pawlson, and David H. Thom. (2004). “Measuring Patients’ Trust in Physicians When Assessing Quality of Care.” Health Affairs. Vol.23, No. 4, p. 124.

tobacco cessation savings and \$7 in family planning savings for every \$1 invested in each category) in addition to improving health outcomes.<sup>4</sup>

Value-based payment models should also have components that address health care disparities among women, and incentivize prevention and services that address social determinants of health. Women of reproductive age are a unique and diverse patient population. Medicaid transformation should prioritize their needs, while also setting about to reduce disparities among women of all races, ethnicities and socioeconomic status.

Below we provide two examples of value-based payment model that center women of reproductive age and would support LDH in meeting the goals of the RFI.

**Example 1 - Preventing Unintended Pregnancies.** One example would be the development of a project to address the rate of unintended pregnancies among adults and adolescents in all the targeted populations. In Louisiana, 60 percent of all pregnancies are unintended.<sup>5</sup> Unintended pregnancy is associated with delays in accessing prenatal care, poor birth outcomes, and negative health, social and economic consequences for women and their children. Reducing unintended pregnancy rates would not only have a positive impact on maternal and child outcomes, but would also help bend the cost curve in Louisiana, where 65 percent of births are Medicaid-financed.<sup>6</sup> Pregnancies are a key driver of Medicaid costs, and an estimated \$7 is saved for every \$1 invested in family planning services.

**Example 2 - High-Impact Preventive Services to Women.** Reproductive health and other preventive services lead to positive health outcomes for women across their lifespans. High-value, low-cost women's health services include screenings for cervical and breast cancer, screening and counseling on smoking and weight, behavioral health screening, and testing for chlamydia, HIV, and other STIs. When women have access to these services, provided in a culturally competent manner in their communities, early intervention is enabled, poor outcomes are averted, and the healthcare system achieves considerable savings over time. Value-based payment models in use or in development today generally do not calculate the full value of these impacts to the system, nor do they accurately account for the costs of providing this high-quality care. We recommend that when developing value-based

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<sup>4</sup> Guttmacher Institute. "Publicly Funded Family Planning Services in the United States." (Mar. 2016). <https://www.guttmacher.org/fact-sheet/2015/publicly-funded-family-planning-services- united-states#15>

<sup>5</sup> Guttmacher Institute. "State Facts About Unintended Pregnancy: Louisiana" (Sept. 2016). <https://www.guttmacher.org/fact-sheet/state-facts-about-unintended-pregnancy-louisiana>.

<sup>6</sup> Kaiser Family Foundation, State Health Facts, Louisiana. <http://kff.org/medicaid/state-indicator/births-financed-by-medicaid/?currentTimeframe=0&selectedRows=%7B%22nested%22:%7B%22louisiana%22:%7B%7D%7D%7D>.

payment models, LDH considers projects that support access to important preventative care women's health services, and compensates providers for the value these services bring to the system.

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We once again thank LDH for the opportunity to submit these comments. We look forward to working together in our shared goal to improve health care access in the state of Louisiana. If you have any questions, please do not hesitate to contact me at 713.831.6618 or Jeffrey.Palmer@ppgulfcoast.org.

A handwritten signature in black ink, appearing to read "Jeffrey Palmer", with a long horizontal flourish extending to the right.

Jeffrey Palmer  
Chief Operating Officer  
Planned Parenthood Gulf Coast

# Program Design Considerations for Medicaid Accountable Care Organizations

*By Rob Houston and Tricia McGinnis, Center for Health Care Strategies*

## IN BRIEF

Medicaid accountable care organizations (ACOs) are becoming increasingly prevalent throughout the United States. Eight states have successfully launched such programs with the goal of improving health outcomes and reducing health care costs.<sup>1</sup> States are looking to this model to shift more accountability to providers through strategic monitoring of quality measures tied to alternative payment models (APMs), such as shared savings arrangements. This brief distills key lessons from the early experiences of state Medicaid ACO programs and offers considerations for additional states designing ACO approaches.

**A**ccountable care organizations (ACOs) are designed to shift responsibility for patient outcomes and health care costs to health care providers, instead of payers such as managed care organizations (MCOs) and Medicare and Medicaid agencies. Through refined payment incentives, quality measurement and monitoring, analysis of patient and population health data, and an increased emphasis on care coordination, ACOs have the potential to improve health care quality while reducing costs.

Over the past four years, eight states – Colorado, Illinois, Maine, Minnesota, New Jersey, Oregon, Utah, and Vermont – have launched Medicaid ACO or ACO-like programs.<sup>2</sup> These programs serve more than 2.5 million beneficiaries and have saved roughly \$167.9 million to date.<sup>3</sup> Of these eight states, four of the more mature programs have reported promising cost and utilization results:

- Colorado achieved \$77 million in net savings over four years;<sup>4</sup>
- Minnesota saved \$76.3 million over two years;<sup>5</sup>
- Oregon decreased emergency department (ED) visits by 23 percent and held costs under the programs' required two percent growth rate since 2011;<sup>6</sup> and
- Vermont saved \$14.6 million in the program's first year.<sup>7</sup>

Most ACOs in these four states have met or exceeded quality performance standards.<sup>8</sup> These initial outcomes are encouraging, and 10 more states have begun to develop ACO models.<sup>9</sup> Unlike Medicare ACO models such as the Medicare Shared Savings Program (MSSP) and the Pioneer ACO model, there are no uniform national standards for Medicaid ACO programs. While the Centers for Medicare & Medicaid Services (CMS) has issued federal guidance pertaining to shared savings arrangements<sup>10</sup> and integrated care models,<sup>11,12</sup> states have flexibility in designing

Medicaid ACO models. As a result, state ACO programs vary significantly, driven by the specifics of each state’s health care market and political environment.

Since 2012, the Center for Health Care Strategies’ (CHCS) *Medicaid ACO Learning Collaborative*, which is supported by The Commonwealth Fund, has helped 13 states design, launch, and improve their Medicaid ACO models through peer-to-peer collaboration and technical support.<sup>13</sup> Through these efforts, CHCS has learned a great deal about Medicaid ACO models, including important decisions that must be made in designing a program. This paper distills these lessons and discusses key considerations for additional states interested in building ACO programs.

## Designing a Medicaid ACO Program

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While states’ programmatic goals, structures, and scope will vary, many common elements must be considered when developing a Medicaid ACO program. Three basic steps define the process: (1) evaluate the current environment; (2) define program goals and framework; and (3) develop a structural model.

Exhibit 1: Steps to Design a Medicaid ACO Program



### Evaluate the Current Environment

Assessing the existing health care environment helps states weigh the feasibility of potential program elements and narrow potential options. It also helps determine how prescriptive to make the program’s regulations. States typically assess four main factors:

1. **Provider readiness.** Providers’ ability to perform ACO financial and care management activities is a key consideration for determining provider participation in the program as well as effectiveness of potential approaches. In addition to existing knowledge of the provider environment, many states have used provider readiness assessments or requests for information (RFIs) to examine the capacity of providers to accept financial risk; electronic health record (EHR) penetration; data analysis, exchange, and reporting capacity; network adequacy; and other factors.
2. **Market dynamics.** A state’s Medicaid ACO program will be driven by market dynamics. An environment with few dominant provider organizations or hospital systems may call for a different model than one with several smaller providers and evenly distributed market power. Additionally, if the state currently contracts with providers via Medicaid MCOs, the market power of MCOs relative to providers will likely be an important factor.

3. **Existing programs.** States need to examine how Medicaid ACO programs will interact with existing care delivery models and health reform efforts, such as patient centered medical homes (as Colorado, Minnesota, and Oregon have done), health homes (as in Maine), and other programs. If there is a significant presence of Medicare or commercial ACOs in the state, a state may want to align with those programs as well, though significant adjustments may be required to address the needs of Medicaid enrollees relative to Medicare and commercial populations (Maine, Minnesota, New Jersey, and Vermont used the MSSP as a basis for their programs).<sup>14</sup> Designing a program that builds on successful existing programs and/or existing resources can benefit both a state and its providers by reducing administrative burden and costs.
4. **Political factors.** Political factors may include budget deficits, trends in Medicaid spending, grassroots efforts, and lobbying, among others. The impetus for an ACO program may come from the state legislature, the governor's office, Medicaid agency, public interest, or a combination of these factors. Where the program is initiated will likely play a part in which policy or regulatory levers, such as legislation, executive/Medicaid department action, or contracting, can be used for implementing the program.

## Define Program Goals and Framework

The state should have a clear vision of its Medicaid ACO program objectives and its health care market. Goals should be clear and measurable, address specific issues that the state is seeking to improve, and directly relate to program-wide cost targets and quality improvement opportunities. For example, Oregon's Coordinated Care Organizations (CCOs) must collectively reduce the state's per capita Medicaid spending by two percent during the three-year demonstration period, while improving quality and access to care.<sup>15</sup>

Before diving into the details of the ACO model, many states first develop a general framework. In doing so, it is helpful to consider: (1) the scope of the model; (2) the level of program prescriptiveness/flexibility; and (3) if there are any structural elements that must be included in the model. The scope of the model depends largely on the program's goals. Six states (Illinois, Maine, Minnesota, New Jersey, Utah, and Vermont) launched their Medicaid ACO programs as voluntary pilot demonstrations. These states gave interested providers the opportunity to enter into ACO arrangements, while not requiring all providers to participate. Two states, Colorado and Oregon, implemented statewide models that cover the vast majority of their Medicaid enrollees because broad reach was a key goal of their programs. However, Colorado did use "focus communities" to pilot the program in the first year before going statewide.

States may seek to be more or less prescriptive in their structural model, particularly around care delivery requirements. Some states, such as New Jersey and Utah, specifically wanted to give their ACOs flexibility to design their own models for improving care delivery. Other states have taken a more nuanced approach, being flexible on certain program elements, but firm on others. For example, Vermont allowed its ACOs flexibility on whether to include pharmacy and non-emergency transportation services, but clearly defined care management requirements. States may want to retain the ability to modify the program during a demonstration period based on

results to date or allow more ACOs of varying size, experience, or sophistication to participate in the program. Both Maine and Vermont allowed their ACOs to select a risk-based or non-risk-based payment track, while Minnesota assigned a risk track to ACOs based on the ACO’s structure and size. Finally, probability that providers and MCOs (if applicable) will embrace the program and help achieve its goals will be critical. If the state believes it will not be able to achieve the voluntary commitment from its stakeholders, it may require provider participation.

A state may also include a few essential elements of its structural model in their Medicaid ACO framework. For example, if a state’s goal is to improve outcomes associated with behavioral health conditions, it could include related services in its total cost of care calculation (TCOC), the total spending on services from which shared savings or capitation rates are based. Determining these key elements early in the process can help focus program design discussions, ease model development decisions, and identify policy and regulatory levers to aid program implementation.

### Develop a Structural Model

States must address eight key questions in designing a Medicaid ACO program. These questions and state examples are listed in Exhibit 2 and discussed below. While this is not an exhaustive list of options, they help clarify how states have approached structural elements of their programs:

Exhibit 2: Key Design Questions and State Approaches to Creating a Medicaid ACO

Question	Examples of State Approaches
1. Who will lead the ACOs?	<ul style="list-style-type: none"> <li>Provider-led organizations (IL, ME, MN, NJ, VT)</li> <li>Payer-led organizations (OR<sup>16</sup>, UT)</li> <li>Regional Care Collaborative Organizations (CO)</li> </ul>
2. Whom will ACOs serve?	<ul style="list-style-type: none"> <li>Medicaid enrollees (IL, MN, UT, VT)</li> <li>Medicaid and Medicare-Medicaid enrollees (CO, ME, NJ, OR)</li> </ul>
3. How will patients be attributed?	<ul style="list-style-type: none"> <li>Prospectively based on geography (CO, NJ, OR)</li> <li>Prospectively based on patient selection (UT)</li> <li>Retrospectively based on utilization (IL, ME, MN, VT)</li> </ul>
4. What services will the ACOs provide?	<ul style="list-style-type: none"> <li>Care coordination and practice support (CO)</li> <li>Physical health services (UT)</li> <li>Physical health services plus additional services (IL, ME, MN, NJ, OR, VT)</li> </ul>
5. How will the payment model be structured?	<ul style="list-style-type: none"> <li>Pay-for-performance (CO)</li> <li>Shared savings (NJ)</li> <li>Shared savings/risk (IL, ME, MN, VT)</li> <li>Capitation/global payments (OR, UT)</li> </ul>
6. How will quality be measured?	<ul style="list-style-type: none"> <li>Few metrics (&lt;20), all tied to payment (CO,<sup>17</sup> ME)</li> <li>Many metrics (&gt;20), some tied to payment (IL, OR, VT)</li> <li>Many metrics (&gt;20), all tied to payment (MN,<sup>18</sup> NJ)</li> <li>Many metrics (&gt;20), none tied to payment (UT)</li> </ul>
7. How will data be collected and analyzed?	<ul style="list-style-type: none"> <li>State and contractor collect and analyze data (CO, IL, ME, MN, NJ, OR, UT, VT)</li> </ul>
8. How will MCOs be involved?	<ul style="list-style-type: none"> <li>Leading ACOs (OR, UT)</li> <li>Required to share savings with ACOs (MN)</li> <li>Given option to enter into contracts with ACOs (IL, NJ)</li> <li>No role (CO, ME, VT)</li> </ul>

### *Who will lead the ACOs?*

A core decision in developing an ACO model is determining the entity that is financially responsible for on-the-ground care management and how that entity is governed. States that prioritize shifting accountability directly to providers may prefer a provider-led model, while those that prioritize risk management experience may want to have MCOs run ACOs. Most Medicaid ACO models are provider-led (Illinois, Maine, Minnesota, New Jersey, and Vermont), but these models have a variety of structures. For example, New Jersey requires its ACOs to be state-registered nonprofit organizations with strict governance requirements, while Minnesota and Vermont have broader governance definitions designed to attract a range of provider organizations. Oregon's CCOs are payers, but providers and community-based organizations are required to be part of the CCO's Boards of Directors. Colorado created Regional Care Collaborative Organizations (RCCOs), which help providers by offering care coordination support, supporting practice transformation efforts, and helping them navigate the Medicaid system. In addition to the ACO's primary lead organization, many states also include requirements on community and enrollee involvement, such as seats on the Board of Directors or formation of a Community Advisory Council.<sup>19</sup>

### *Whom will ACOs serve?*

In addition to the broad Medicaid population, Medicaid ACOs may also serve Medicare-Medicaid enrollees or a specific subset of Medicaid enrollees. The majority of Medicaid ACO programs have elected to exclude Medicare-Medicaid enrollees due to: the difficulty of achieving a return on investment since Medicare expenditures are not included; administrative complexities; the diverse needs of the population; and/or the presence of existing state programs to serve this population.<sup>20</sup> Only Colorado, Maine, and Oregon use Medicaid ACOs to serve Medicare-Medicaid enrollees. Colorado's program did not initially include Medicare-Medicaid enrollees, but these individuals were included once Colorado received approval for their Financial Alignment Demonstration.<sup>21</sup>

### *What services will the ACOs provide?*

While all states except Colorado provide physical health services through their Medicaid ACO programs,<sup>22</sup> many have also included other services such as behavioral health care, long-term services and supports (LTSS), oral health services, pharmacy services, and non-emergency transportation services. Broadening the scope of services to better serve enrollees can be a powerful tool for ACOs. For example, ACOs can encourage more meaningful collaboration between physical health and non-physical health providers. ACOs can be made accountable for these services by requiring ACO providers to offer these services, including them in the TCOC calculations or by including quality metrics for these conditions.

Important factors for states in considering whether to include non-medical services are: (1) existing relationships across medical and non-medical providers; (2) provider capacity to offer additional services; and (3) how the ACO may interact with existing programs that support integration. The state may also consider if these services are necessary to achieve program goals.

Exhibit 3 is a matrix of services included in payment calculations for active Medicaid ACOs. Six states have launched ACOs that include options beyond traditional physical health services.

Exhibit 3: Services Included in Medicaid ACO Payment Calculations

State	Services Included in Payment Calculation
Colorado	Care coordination and practice support
Illinois	Physical health, behavioral health
Maine	Physical health, behavioral health ( <i>optional</i> : LTSS and oral health)
Minnesota	Physical health, behavioral health, pharmacy ( <i>optional</i> : LTSS, oral health, non-emergency medical transport)
New Jersey <sup>23</sup>	Physical health ( <i>optional</i> : behavioral health, LTSS, oral health, pharmacy)
Oregon	Physical health, behavioral health, oral health
Utah	Physical health
Vermont	Physical health ( <i>optional</i> : pharmacy, non-emergency medical transport)

### *How will the payment model be structured?*

Many Medicaid ACO programs include financial risk for providers in their payment models to encourage greater accountability for their patient population. In doing so, states must assess whether their providers are ready to accept risk. This can be determined by examining key factors such as organizational size, services provided, data capacity, and experience with risk-based models. Phasing in risk gradually or offering upside-only models, as Maine, Minnesota, and Vermont have done, may be a palatable approach that acknowledges varying provider capacity. States may also opt to help providers with the upfront infrastructure investment required to begin an ACO program. Finally, the state will need to determine the amount of savings the ACO will receive and the amount the state would retain. This decision may be influenced by the need to demonstrate immediate savings due to budgetary issues or political factors.

The most prevalent payment model among active Medicaid ACO programs is shared savings arrangements. ACOs in five states (Illinois, Maine, Minnesota, New Jersey, and Vermont) are responsible for the TCOC for their attributed patients and receive a percentage of shared savings if cost savings are achieved and quality standards are met. Three of these state ACO models (Maine, Minnesota, and Vermont) also include downside risk, where providers are also accountable for exceeding cost benchmarks. Maine and Vermont offer the option for ACOs to select from an upside-only model or a model with downside risk that phases in shared risk over three years in exchange for greater potential savings. Minnesota assigns participating ACOs to an upside-only or upside/downside model based on the ACO's attributed population and provider makeup. Illinois' shared savings program goes a step further, transitioning payment to a capitated model over 36 months. States developing a shared savings payment must carefully determine methodological factors such as risk adjustment methods, a minimum savings rate, benchmarking criteria, and whether or not to remove high-cost patients from shared savings calculations.<sup>24</sup>

The two states with payer-led models, Oregon and Utah, have full-risk, capitated per member per month payments in place from day one. In capitated models, payments are naturally limited since ACOs are paid a flat fee, but states must determine how often this fee is rebalanced and how the population is risk-adjusted to ensure an effective model.<sup>25</sup>

### *How will patients be attributed?*

Patients are assigned to ACOs through retrospective or prospective attribution. The attribution model typically follows the payment model, though there are exceptions. Patients are attributed to ACOs retrospectively under shared savings or shared savings/risk arrangements, while prospective models are for capitated arrangements or global payments.

In retrospective attribution models, a patient is assigned to an ACO or provider (typically a primary care provider) based on actual utilization. This approach allows states to evaluate the ACO on the patients who received the majority of their care from ACO providers. However, this approach makes it difficult for ACOs to proactively identify patients and coordinate care. This could create perverse incentives, such as ACOs selectively treating low-cost patients who will save them money in a capitated payment model or focusing only on serving high-cost patients in a shared savings model. However, this model might be more palatable for providers who may be concerned about being held responsible for the costs and quality of care for patients who they may have served and who are assigned prospectively.

In prospective attribution models, patients can be assigned geographically (as in Oregon),<sup>26</sup> through patient selection (as in Utah), and could also be handled through algorithmic prospective assignment, where patients are assigned based on past utilization patterns, proximity to primary care providers, or other criteria. Under prospective attribution, ACO providers know at the outset for whom they are responsible. This arrangement may also encourage ACOs to invest in activities that support public health and the community. Given the prospective assignment process recently established by the Next Generation ACO model,<sup>27</sup> there may be more Medicaid programs looking into a prospective attribution option.

### *How will quality be measured?*

ACO quality measurement approaches vary greatly. States typically assess the following in constructing their quality measurement plan:

1. How many quality metrics to include;
2. What the mix of process, outcome, and patient experience metrics will be;
3. Which conditions to target;
4. Whether or not to tie some or all metrics to payment;
5. Whether quality performance is measured against attainment of a benchmark, improvement over time, or relative to other ACO performance; and
6. How to align metrics with other state programs and Medicare and commercial ACO models.

States have as few as three and up to as many as 33 metrics for ACOs, and some tie every metric to payment while others link only a subset.<sup>28</sup> It is just as important for states to create a set of

outcome, process, and patient experience metrics to accurately measure performance and the achievement of program goals. Ideally, states seek to identify a set of evidence-based quality metrics that accurately evaluates an ACO's performance, but that does not overburden providers with undue data reporting. Finding this balance is imperative and often requires an iterative process. For example, Minnesota has reduced the number of quality metrics, while Vermont has added measures. Maine, Minnesota, New Jersey, and Vermont give ACOs flexibility on the selection of some quality metrics.

States must also determine how to tie payment to quality. All states with active Medicaid ACO programs allow "pay-for-reporting" arrangements in the first year, and then evaluate ACOs on quality performance beginning in the second year. Some models also gradually increase either the percentage of payment tied to quality or the number of metrics tied to payment after the second year. States must also determine what triggers a payment. Exhibit 4 below shows the range of payment approaches.

Exhibit 4: Approaches for Quality Activation of Payment<sup>29</sup>

Method	Description	States Using Method
<b>Gate (Benchmark)</b>	ACO performance must meet or exceed a performance benchmark for ACO to receive payment.	Colorado, <sup>30</sup> Illinois, Minnesota, New Jersey
<b>Two Gate</b>	ACO performance must meet or exceed a baseline performance benchmark to receive payment. ACOs performing over an improvement target receive an enhanced payment.	Oregon
<b>Gate and Ladder</b>	ACO performance must meet or exceed a baseline performance benchmark to receive payment. If ACOs exceed the baseline, they receive a bonus payment tied to the percentage that they exceeded the benchmark.	Colorado, <sup>31</sup> Maine, Vermont

### *How will data be collected and analyzed?*

Data sharing and analysis – key components of care coordination and program evaluation – form the backbone of a successful Medicaid ACO program. Each ACO program must track quality and cost performance, and therefore will need to collect this data and analyze the data. Some states have also elected to provide reports and analysis at the patient and population level to help with care management activities. All states with Medicaid ACO programs have taken different approaches to working with a contractor to provide some of these functions. Colorado and New Jersey outsource much of their data collection and evaluation to a contractor, which requires less staff capacity and could be less expensive. Other states, such as Maine, Minnesota, Oregon, Utah, and Vermont, stay more actively involved in collection and evaluation and hire a contractor for limited and specific roles. For example, Oregon and Vermont hired an outside contractor to validate financial and quality performance findings. Minnesota uses a contractor to collect and validate quality data from physicians and medical groups. Maine uses its contractor to provide analytic support to its Accountable Communities. Utah offers its ACOs the option to collect data on their own or use a state contractor, but performs its own analysis.<sup>32</sup>

### *How will MCOs be involved?*

States with Medicaid managed care have taken varied approaches to involve MCOs in Medicaid ACOs, but a key factor is the state's satisfaction with the quality and cost outcomes that MCOs provide. If a state is satisfied with MCO results, the state may opt for a payer-led model, or incentivize providers and payers to collaborate to improve costs and quality. For example, New Jersey does not require its MCOs to participate in its model, and instead MCOs and ACOs are free to form their own contractual arrangements, including payment methodologies.<sup>33,34</sup> Minnesota does not allow MCOs to participate in its Integrated Health Partnerships program, but requires MCOs to share savings with ACOs if their patients are attributed to an ACO that has achieved savings. If MCOs are not performing to expectations, states may choose a provider-led model independent from managed care.<sup>35</sup> In its recent proposed rule for managed care regulations, CMS explicitly granted states the regulatory authority to require Medicaid MCOs to participate in statewide payment reform initiatives.<sup>36</sup> If this provision is included in the final rule, it could help facilitate state efforts to implement Medicaid ACOs in a managed care environment.

In a managed care environment, a state must also consider the role ACOs will play relative to MCOs. While MCOs traditionally have performed care management responsibilities, ACOs will likely take on that role in a state where both ACOs and MCOs exist. Other activities, including quality improvement, data sharing and analytics, establishing evidence-based guidelines, and utilization management, may also be delineated to ensure that ACOs and MCOs are not duplicating efforts.<sup>37</sup> As ACOs gain more experience, they may be expected to take on more of these responsibilities. However, states may also opt to give general guidance and allow ACOs and MCOs to figure out mutually beneficial arrangements on a case-by-case basis.

## A Final Consideration

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Medicaid ACOs are now a significant presence in state Medicaid programs, with additional states seeking to launch Medicaid ACO programs in the coming years. As these states begin to design Medicaid ACO models, they should be mindful of their state's health care environment, clearly define program objectives, and design program parameters to achieve these goals. In designing Medicaid ACO approaches, it is helpful to recognize that models will evolve over time. For example, Colorado and Minnesota, two of the earliest Medicaid ACO programs, are now seeking to update their programs to "Version 2.0" in 2017. Similarly, states that have shared savings payment models may consider transitioning into full risk capitation or global payments in the future to address the inevitably limited benefits of shared savings programs. Given the evolution of ACO programs, states designing Medicaid ACOs should not limit future possibilities by rigidly defining certain aspects of ACOs. By building in flexibility for evolving ACO models, states can realize greater success in the future through their Medicaid ACO programs.

## ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It 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

- <sup>1</sup> *Medicaid Accountable Care Organizations: State Update*. Center for Health Care Strategies, August 2015. Available at: <http://www.chcs.org/resource/medicaid-accountable-care-organizations-state-update/>.
- <sup>2</sup> *Ibid.*
- <sup>3</sup> Compilation of reported Medicaid ACO results to date. For more information on individual state performance, please see <http://www.chcs.org/resource/medicaid-accountable-care-organization-programs-state-profiles/>.
- <sup>4</sup> “Colorado Medicaid Program Continues Record Savings, Improved Outcomes.” Colorado Department of Health Care Policy and Financing. November 3, 2015. Available at: <https://www.colorado.gov/pacific/hcpf/news/colorado-medicaid-program-continues-record-savings-improved-outcomes>.
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- <sup>6</sup> Oregon Health Authority. Oregon’s Health System Transformation, 2015 Mid-Year Report. Available at: <http://www.oregon.gov/oha/metrics/pages/index.aspx>.
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- <sup>8</sup> Colorado Department of Health Care Policy and Financing, *op cit.*; Minnesota Department of Human Services, *op cit.*; Oregon Health Authority, *op. cit.*; and Vermont Governor’s Office, *op cit.*
- <sup>9</sup> *Medicaid Accountable Care Organizations: State Update*, *op cit.*
- <sup>10</sup> “Shared Savings Methodologies.” State Medicaid Letter from the Center for Medicaid & CHIP Services, SMDL# 13-005, October 2013. Available at: <http://www.medicare.gov/federal-policy-guidance/downloads/smd-13-005.pdf>.
- <sup>11</sup> “Integrated Care Models.” State Medicaid Letter from the Center for Medicaid & CHIP Services, SMDL# 12-001, July 2012. Available at: <http://www.medicare.gov/Federal-Policy-Guidance/Downloads/SMD-12-001.pdf>
- <sup>12</sup> “Policy Considerations for Integrated Care Models.” State Medicaid Letter from the Center for Medicaid & CHIP Services, SMDL# 12-002, July 2012. Available at: <http://www.medicare.gov/Federal-Policy-Guidance/downloads/SMD-12-002.pdf>
- <sup>13</sup> For more information about the Medicaid Accountable Care Organization Learning Collaborative, made possible by The Commonwealth Fund, see <http://www.chcs.org/project/medicaid-accountable-care-organization-learning-collaborative-phase-iii/>.
- <sup>14</sup> R. Houston and T. McGinnis. “Adapting the Medicare Shared Savings Program to Medicaid Accountable Care Organizations.” Center for Health Care Strategies, March 2013. Available at: <http://www.chcs.org/resource/adapting-the-medicare-shared-savings-program-to-medicaid-accountable-care-organizations/>.
- <sup>15</sup> Summary: Oregon’s 1115 Medicaid Demonstration, Accountability Plan and Expenditure Trend Review. Office of the Director, Oregon Health Authority. Available at: <http://www.oregon.gov/oha/OHPB/Pages/health-reform/cms-waiver.aspx>.
- <sup>16</sup> Oregon’s model also allows patients to choose a CCO if their geographic area is served by more than one CCO.
- <sup>17</sup> Colorado tracks metrics on RCCO performance in addition to measures collected for its Accountable Care Collaborative (ACC) program. For more information, see ACC 2015 Annual Report: <https://www.colorado.gov/pacific/sites/default/files/Supporting%20a%20Culture%20of%20Coverage%20Accountable%20Care%20Collaborative%202014-15%20Annual%20Report.pdf>.
- <sup>18</sup> Minnesota’s 32 quality metrics are grouped into and scored as nine aggregate metrics.
- <sup>19</sup> “Comparing State Medicaid Accountable Care Organization Governance Models.” Center for Health Care Strategies, July 2015. Available at: <http://www.chcs.org/resource/comparing-state-medicaid-accountable-care-organization-governance-models/>.
- <sup>20</sup> R. Houston and M. Soper. “Exploring the Feasibility of Including Medicare-Medicaid Enrollees in Medicaid Accountable Care Organizations.” Center for Health Care Strategies, April 2015. Available at: <http://www.chcs.org/resource/exploring-feasibility-including-medicare-medicare-enrollees-medicare-accountable-care-organizations/>.
- <sup>21</sup> For more information on Colorado’s Financial Alignment Demonstration, visit <https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/Colorado.html>.
- <sup>22</sup> Colorado’s RCCOs do not provide nor are accountable for direct services to patients, but rather support providers with a combination of care coordination and practice support. These services are paid for by a per member per month fee and an opportunity to receive bonuses if providers in the RCCO’s geographic area meet or exceed quality standards.
- <sup>23</sup> New Jersey’s program assumes a broad total cost of care, but ACOs and MCOs negotiate their own agreements.

- <sup>24</sup> R. Houston and T. McGinnis. “Adapting the Medicare Shared Savings Program to Medicaid Accountable Care Organizations.” Center for Health Care Strategies, March 2013. Available at: <http://www.chcs.org/resource/adapting-the-medicare-shared-savings-program-to-medicare-accountable-care-organizations/>.
- <sup>25</sup> J. Lloyd, R. Houston, and T. McGinnis. “Medicaid Accountable Care Organization Programs: State Profiles.” Center for Health Care Strategies, October 2015. Available at: <http://www.chcs.org/resource/medicaid-accountable-care-organization-programs-state-profiles/>.
- <sup>26</sup> Oregon’s model also allows patients to choose a CCO if their geographic area is served by more than one CCO.
- <sup>27</sup> For information on the ACO Next Generation Model, visit <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model>.
- <sup>28</sup> J. Lloyd, et al., op. cit.
- <sup>29</sup> “Quality Measurement Approaches of State Medicaid.” Center for Health Care Strategies, September 2014. Available at: <http://www.chcs.org/resource/quality-measurement-approaches-medicare-accountable-care-organizations/>.
- <sup>30</sup> Colorado uses “gate” incentives for certain metrics and “gate and ladder” incentives for others.
- <sup>31</sup> Ibid.
- <sup>32</sup> J. Lloyd, et al., op. cit.
- <sup>33</sup> Ibid.
- <sup>34</sup> A recommended gainsharing methodology produced by the Rutgers Center for State Health Policy can be found here: <http://www.cshp.rutgers.edu/Downloads/9290.pdf>
- <sup>35</sup> T. McGinnis, R. Houston, and D. Brown. “The Balancing Act: Integrating Medicaid Accountable Care Organizations into a Managed Care Environment.” Center for Health Care Strategies, November 2013. Available at: <http://www.chcs.org/resource/the-balancing-act-integrating-medicare-accountable-care-organizations-into-a-managed-care-environment/>.
- <sup>36</sup> “Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Proposed Rules” Federal Register. Vol 80, No 104. June 1, 2015. Available at: <https://www.gpo.gov/fdsys/pkg/FR-2015-06-01/pdf/2015-12965.pdf>.
- <sup>37</sup> T. McGinnis, et al., op. cit.