Accountable Care Organizations and Work Requirements

When Provider Accountability Meets Eligibility Instability

Accountable Care Organizations represent a fundamentally different organizational model than the managed care organizations examined in Articles 3A through 3C. ACOs are provider-led entities that assume financial accountability for quality and cost of care for defined populations. They typically operate through shared savings arrangements rather than capitated payments. When Medicaid expansion adults face work requirements beginning December 2026, ACOs confront a structural dilemma. Their accountability model depends on population stability and longitudinal care continuity. Work requirements create exactly the opposite.

Understanding how ACOs differ from MCOs matters for implementation. MCOs are insurance entities managing benefits and paying claims. ACOs are provider collaborations managing actual care delivery while sharing financial risk. MCOs already have eligibility systems, member services infrastructure, and institutional experience with enrollment volatility. ACOs have clinical care coordination capabilities and deep provider relationships, but limited experience with administrative eligibility management. The distinction shapes what each organization can realistically accomplish and where their unique value lies.

The ACO Model and Its Core Assumptions

ACOs consist of groups of doctors, hospitals, and other providers who voluntarily coordinate care for defined populations. Payments link to quality improvement and cost reduction measured over multi-year periods. Under Medicare Shared Savings Program rules, ACOs must cover at least 5,000 beneficiaries, maintain sufficient primary care capacity, implement evidence-based medicine processes, and participate for minimum three-year terms.

The model assumes population stability. ACOs invest in care coordination infrastructure, develop longitudinal relationships with patients, implement prevention programs, and coordinate across care settings. These investments pay off over time through reduced emergency utilization, better chronic disease management, and avoided complications. Return on investment calculations assume members remain attributed to the ACO long enough to realize health improvements that generate savings.

State Variation in Medicaid ACO Models

Medicaid ACO programs vary dramatically across states in structure, payment models, and operational requirements. This variation matters for work requirement implementation because ACO capabilities and constraints differ based on state program design.

Massachusetts operates the most mature Medicaid ACO program through its MassHealth accountable care organization initiative. Seventeen ACOs serve approximately 800,000 MassHealth members. The state uses a two-sided risk model where ACOs share both savings and losses. Payment includes risk-adjusted per-member-per-month care coordination fees alongside

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

shared savings opportunities. Massachusetts ACOs have sophisticated care management infrastructure and established relationships with community-based organizations. Work requirements would overlay on relatively mature ACO operations with existing social determinants capabilities.

Oregon takes a different approach through Coordinated Care Organizations that function as Medicaid ACOs covering both physical and behavioral health. CCOs receive global budgets and accept full risk for their attributed populations. The state emphasizes community governance and flexible benefit packages addressing health-related social needs. Oregon's CCO model already integrates non-medical support services into care coordination, providing natural infrastructure for work requirement navigation. However, global budgets create financial pressure where work requirement administrative costs compete with clinical care spending.

Colorado's Regional Accountable Entities serve Medicaid members with behavioral health needs. RAEs operate under performance-based contracts combining care coordination payments with quality incentives. The focus on behavioral health populations means RAE attributed members likely face higher rates of work requirement exemptions for mental health and substance use conditions. Documentation of functional limitations and exemption support become central RAE functions rather than peripheral additions.

New Jersey integrated ACOs into Medicaid managed care through the Medicaid ACO Demonstration. Health plans contract with ACO-like provider organizations that accept risk-sharing arrangements. This creates a three-party relationship where the state contracts with MCOs, MCOs contract with ACO provider organizations, and work requirement administration flows through all three entities. Coordination complexity increases but financial responsibility is clearer than in direct ACO-state contracting.

Several states including Arkansas, Ohio, and Georgia that are implementing or proposing work requirements do not have established Medicaid ACO programs. In these states, Medicaid managed care organizations bear primary responsibility for care coordination and work requirement support. Provider organizations may participate in MCO-sponsored ACO-like arrangements, but they lack the direct state contracts and defined accountability that characterize formal Medicaid ACO programs.

The payment model variations create different incentive structures for work requirement response. ACOs in shared savings models with upside-only risk face weaker incentives to invest in work requirement support than ACOs in two-sided risk models or global budget arrangements. ACOs receiving prospective care coordination payments have more stable revenue for navigation infrastructure than ACOs relying solely on retrospective shared savings. These payment differences affect how aggressively ACOs will invest in preventing coverage loss versus accepting attribution volatility.

Attribution methodologies also vary by state. Some states use prospective attribution assigning members to ACOs at the beginning of coverage periods based on prior utilization patterns. Others use retrospective attribution assigning members after the performance year based on where they actually received care. Prospective attribution gives ACOs earlier awareness of their attributed population for proactive outreach but creates mismatches when members switch providers. Retrospective attribution ensures members are attributed to where they actually received care but

provides no advance population for care coordination planning. Work requirements affect these models differently in timing of ACO awareness and ability to intervene before coverage loss.

Minimum enrollment thresholds and attribution stability requirements also vary. Some states require members to have six months of continuous enrollment before counting toward ACO performance measures. Others have shorter or no minimum enrollment periods. These thresholds interact with work requirement redetermination cycles to determine which coverage disruptions affect ACO accountability and which fall outside measurement periods.

The payment model matters enormously. Medicare ACOs receive fee-for-service payments with retrospective shared savings if they meet quality targets and reduce spending growth. Most earn shared savings without downside risk in initial years. Medicaid ACOs may operate similarly, or they may receive prospective primary care payments, care coordination fees, or risk-adjusted capitation. The payment structure determines financial exposure to enrollment volatility created by work requirements.

Work Requirements and Attribution Disruption

ACO attribution assigns beneficiaries based on where they receive primary care services. Attribution methodologies typically look at patterns of primary care utilization over defined periods. Someone who loses Medicaid coverage due to work requirement non-compliance disappears from attribution. When they regain coverage weeks or months later, they may be attributed back to the same ACO, or they may have switched providers and be attributed elsewhere.

This creates investment loss. An ACO invests in care coordination for someone with diabetes, developing care plans, coordinating specialist visits, managing medications, and supporting lifestyle changes. Six months later, that person loses coverage for work requirement non-compliance. The ACO loses attribution and potential shared savings from that member's improved outcomes. When coverage returns, the health gains may have eroded and the cycle restarts.

Quality metric disruption follows. ACO performance is measured through HEDIS-style quality measures requiring continuous measurement periods. Diabetes control measured through quarterly HbA1c tests. Appropriate medication adherence tracked monthly. Cancer screening completion within annual windows. When members churn in and out of coverage, these continuous measurement periods break. The ACO cannot demonstrate quality improvement for populations who are not stably enrolled long enough for interventions to produce measurable outcomes.

Risk adjustment problems compound the attribution loss and quality disruptions. ACOs operating under prospective payment or shared savings models rely on accurate risk adjustment reflecting member health status and expected costs. Someone loses coverage, develops uncontrolled conditions while uninsured, returns sicker, and generates higher costs than their risk score predicted. The ACO absorbs those costs without corresponding payment adjustment because the risk score was calculated before the coverage gap and health deterioration.

The Dual-Eligible Population Complication

Approximately 13.7 million Americans are dually eligible for both Medicare and Medicaid, representing a substantial portion of many ACO attributed populations. In 2024, 35% of dual-

eligible beneficiaries in traditional Medicare were attributed to ACO-participating providers, with the majority in Medicare Shared Savings Program ACOs. This population creates unique challenges under work requirements because Medicare and Medicaid coverage operate independently with different rules and accountability structures.

Dual-eligible individuals fall into two categories. Full-benefit duals receive comprehensive Medicaid coverage including long-term services and supports alongside Medicare benefits. Partial-benefit duals receive Medicaid assistance only with Medicare premiums, deductibles, and cost-sharing through Medicare Savings Programs. Work requirements affect only the Medicaid portion of coverage, creating asymmetric coverage scenarios that ACOs have never confronted systematically.

When a dual-eligible person loses Medicaid due to work requirement non-compliance, they retain Medicare coverage and remain attributed to their Medicare ACO. The ACO continues bearing financial accountability for Medicare Part A and Part B spending. However, the person loses Medicaid coverage for Medicare cost-sharing, prescription drug assistance beyond Medicare Part D, non-emergency medical transportation, and long-term services and supports. The financial and care coordination implications are substantial.

Consider someone with diabetes and mobility limitations who receives home health services through Medicaid. They lose Medicaid coverage for work requirement non-compliance but retain Medicare. Medicare covers skilled nursing visits but not the personal care services that help with medication management, meal preparation, and activities of daily living. Without those supports, medication adherence declines, blood sugar control deteriorates, and emergency department visits increase. The ACO faces increased Medicare costs from preventable complications while losing the Medicaid-funded support services that were preventing those complications.

The care coordination infrastructure breaks down. ACO care coordinators traditionally work with members' Medicare and Medicaid benefits in integrated ways. They arrange transportation through Medicaid non-emergency medical transportation for Medicare-covered specialist appointments. They coordinate skilled nursing facility discharge planning considering both Medicare rehabilitation coverage and Medicaid long-term care eligibility. They manage medication regimens combining Medicare Part D coverage with Medicaid supplemental assistance for beneficiaries reaching the coverage gap. When Medicaid coverage terminates but Medicare continues, care coordinators lose critical tools while retaining accountability for outcomes.

Attribution remains unchanged despite fundamental shifts in care coordination capacity. Medicare ACO attribution is based on primary care utilization patterns and does not adjust when someone loses Medicaid coverage. The dual-eligible person remains attributed to the ACO for Medicare shared savings calculations. The ACO continues being measured on quality metrics that depend on services and supports no longer available. Diabetic retinopathy screening requires transportation the person no longer has Medicaid coverage for. Medication adherence requires prescription assistance that disappeared with Medicaid termination. The quality metrics hold constant while the infrastructure enabling quality performance collapses.

The financial incentive misalignment intensifies. ACOs are not at risk for Medicaid spending, only Medicare spending. When dual-eligible individuals lose Medicaid coverage, ACOs might theoretically benefit if those individuals were generating high Medicaid costs that affected overall

wellbeing and indirectly drove Medicare utilization. However, the reverse is more common. Loss of Medicaid support services leads to Medicare cost increases through emergency department visits, inpatient admissions, and preventable complications. The ACO absorbs increased Medicare costs without corresponding payment adjustment and without the Medicaid tools that previously prevented those costs.

State variation in Medicaid benefits for dual-eligible populations compounds implementation complexity. Some states provide robust home and community-based services that enable community living for people with significant disabilities. Other states have more limited Medicaid benefits. Work requirements affect these state benefits differentially. ACOs operating in multiple states must navigate different impacts on their dual-eligible attributed populations based on what Medicaid services those states provide and how work requirements interact with disability exemptions and long-term services eligibility.

The Medicare-Medicaid ACO model that CMS piloted specifically aimed to create accountability for both programs. These integrated ACOs accepted financial responsibility for total Medicare and Medicaid costs for dual-eligible populations. Work requirements would affect these integrated ACOs differently than traditional Medicare-only ACOs. An integrated ACO at risk for Medicaid costs has direct financial incentive to prevent Medicaid coverage loss through work requirement support. However, most dual-eligible individuals are not in integrated ACO models. They are in traditional Medicare ACOs that bear no Medicaid financial risk.

The policy question becomes whether work requirements should trigger different attribution rules for dual-eligible beneficiaries. Should someone who loses Medicaid coverage remain attributed to their ACO for Medicare accountability purposes? Should quality measures adjust when dual-eligible individuals lose the Medicaid supports that enable performance on those measures? Should risk adjustment account for loss of Medicaid benefits even though ACOs are not at risk for Medicaid spending? These technical questions have significant financial implications for ACOs serving high percentages of dual-eligible populations.

Safety-net ACOs serving predominantly low-income populations typically have higher percentages of dual-eligible attributed beneficiaries than commercially-oriented ACOs. Federally Qualified Health Centers serving as ACO participants often have 30-50% of their Medicare patients who are also Medicaid beneficiaries. Work requirements will affect these ACOs disproportionately compared to ACOs serving primarily non-dual Medicare populations. The attribution volatility, care coordination disruptions, and financial risks concentrate in organizations already operating on thin margins serving vulnerable populations.

Care Coordination Infrastructure Without Eligibility Authority

ACOs excel at care coordination. Physician practices, hospitals, and post-acute facilities develop integrated workflows sharing clinical information and coordinating transitions. Care teams manage complex conditions, connect patients to community resources, and coordinate across specialties. This infrastructure is valuable for work requirement navigation, but ACOs lack the eligibility systems and administrative capacity that MCOs possess.

An MCO has member services departments, eligibility and enrollment teams, IT systems connected to state Medicaid agencies, and institutional experience managing coverage transitions.

An ACO has clinical care coordinators, case managers, and patient navigators focused on health management. These are different skill sets operating with different infrastructure. Asking ACO care coordinators to manage work requirement verification is similar to asking MCO eligibility workers to manage diabetes care plans. The competencies do not match organizational capabilities.

Integration with MCOs offers a potential solution. In states where Medicaid managed care is the payment mechanism, ACOs typically contract with MCOs rather than directly with state agencies. The MCO handles eligibility, enrollment, and member services. The ACO handles care delivery and coordination. This division of labor could work for work requirements if properly structured with clear roles and bidirectional information flows.

The MCO would manage work requirement verification systems, member communications about requirements, coordination with state portals, and coverage reinstatement processes. The ACO would integrate work requirement status into care coordination workflows, flag members at risk of losing coverage, coordinate exemption documentation through provider networks, and maintain care continuity during coverage gaps when possible.

This requires bidirectional information flow. ACOs need real-time visibility into member verification status, upcoming deadlines, and exemption eligibility. MCOs need ACO input on medical exemptions, functional assessments, and care coordination impacts of coverage loss. Without integration, ACOs operate blind to eligibility changes until members miss appointments and staff discover coverage has terminated. The discovery happens too late to prevent health deterioration or facilitate timely coverage reinstatement.

Provider Networks and Medical Exemption Infrastructure

ACOs have an advantage MCOs lack. They maintain direct relationships with the providers who must document medical exemptions. When someone needs disability documentation, chronic condition assessment, or functional capacity evaluation, ACO-affiliated providers are already providing that clinical care. The challenge is translating clinical documentation into exemption attestations without overwhelming providers.

Article 2B examined provider bottlenecks in exemption systems. Safety-net clinics serving high Medicaid populations face waves of exemption documentation requests. Appointment availability becomes the limiting factor. Wait times extend. People lose coverage waiting for appointments to obtain exemption letters. ACOs coordinating care across provider networks can implement systematic solutions that isolated providers cannot.

Four specific exemption categories reveal where ACOs possess structural advantages through their provider relationships and clinical infrastructure. These are not the only exemption categories, but they represent domains where ACO capabilities align with documentation requirements in ways that benefit both members and system efficiency.

Medical frailty exemptions require provider attestation that someone cannot consistently meet work requirements due to health conditions. Traditional approaches ask: does this person have a qualifying diagnosis? The better question is: can this person reliably work 80 hours monthly given their health status and available support systems? That functional assessment is precisely what ACO care coordinators and primary care providers conduct routinely. Someone with diabetes, arthritis, and depression might work full-time with proper medication, stable housing, and

employer flexibility. The same person cannot work when insulin access is disrupted, housing is unstable, or the employer refuses accommodations. ACO providers already document functional status for care planning purposes. Extending that documentation to exemption attestations requires process standardization, not additional clinical assessment.

Standardized exemption templates integrated into electronic health records reduce provider burden dramatically. A primary care provider treating someone with severe arthritis clicks a template during a routine visit, answers functional assessment questions about ability to stand, lift, and maintain consistent schedules, and generates an exemption attestation in five minutes. The template feeds directly to the state exemption portal through provider integration infrastructure. What previously required a 30-minute letter written weeks after the appointment becomes a streamlined workflow component.

Pregnancy and postpartum exemptions typically require provider verification of pregnancy status and expected delivery dates, with most states extending exemptions six to twelve months postpartum. ACO obstetric providers and primary care physicians already document these facts for prenatal and postpartum care. The information exists in medical records. The challenge is transmission to exemption systems. ACO care coordinators can flag pregnant members approaching redetermination cycles, prompt providers to complete exemption attestations during prenatal visits, and coordinate exemption renewal timing with postpartum checkups. The member never makes a separate trip for exemption documentation. It happens integrated with existing care touchpoints.

Substance use disorder treatment exemptions protect people actively engaged in treatment programs from work requirements that would conflict with treatment participation. Residential treatment, intensive outpatient programs, and recovery support services consume significant time and mental energy. ACOs with integrated behavioral health services already track treatment engagement for care coordination purposes. A behavioral health clinician documenting treatment participation can simultaneously generate exemption attestations. For ACOs operating medication-assisted treatment programs, the weekly or monthly clinic visits for medication management become natural opportunities for exemption documentation without additional patient burden.

Caregiver exemptions for parents of young children or for adults caring for disabled family members create documentation challenges because the care recipient's needs must be verified, not just claimed. A parent of a child under six requires birth certificate documentation that the child exists and falls within the age range. A parent of a disabled child requires documentation of the child's disability and care needs. An adult caring for an elderly parent with dementia needs verification of the parent's functional limitations. ACOs treating both the caregiver and the care recipient have access to both sets of medical information. A pediatrician treating a severely autistic child documents care needs that support the parent's caregiver exemption. A geriatrician treating a parent with advanced dementia provides functional assessments supporting the adult child's caregiver exemption. This works only with appropriate consent and privacy protections, but the clinical information exists within the ACO provider network without requiring external verification.

Proactive exemption screening during routine care prevents last-minute scrambles. ACO care coordinators reviewing appointment schedules identify members approaching redetermination

deadlines who may qualify for medical exemptions. They flag these members for providers, who complete assessments during scheduled visits rather than through separate exemption appointment requests. This anticipatory approach reduces the likelihood that someone loses coverage while waiting weeks for an exemption documentation appointment.

Coordinated multi-provider documentation handles complex cases smoothly. Someone with multiple chronic conditions may need attestations from primary care, cardiology, and endocrinology regarding how their combined conditions affect work capacity. Someone caring for a disabled child may need documentation from the child's pediatric specialists while also documenting their own health conditions that limit their caregiving capacity. ACO care coordination facilitates these multi-provider attestations through established referral relationships and shared care planning processes. The coordination infrastructure that enables integrated clinical care also enables integrated exemption documentation.

The Attribution Paradox and Perverse Incentives

ACOs face a perverse incentive structure under work requirements. Members who successfully maintain coverage and meet work requirements remain attributed, contributing to quality metrics and potential shared savings. Members who lose coverage due to non-compliance disappear from attribution, removing their costs and quality measures from ACO calculations.

If ACOs invest heavily in work requirement support, they spend resources helping members maintain coverage who may generate costs without corresponding clinical need for services. Someone employed and healthy requires minimal clinical intervention, so keeping them attributed generates little opportunity for cost savings through care coordination. Meanwhile, someone with chronic conditions who loses coverage removes high-cost cases from the ACO's book of business.

This creates cream-skimming pressure. The rational economic strategy would be minimal investment in work requirement support, allowing healthier members to maintain coverage through their own resources while unhealthier members churn out. This maximizes the ACO's ratio of low-cost to high-cost attributed members, improving financial performance measures that determine shared savings eligibility.

The incentive structure differs from MCOs. MCOs receive per-member-per-month payments covering all enrolled members regardless of health status. They lose revenue when members lose coverage, creating financial incentive to prevent churn. ACOs in shared savings arrangements do not lose direct payment when members lose attribution. They lose opportunities for care coordination that could generate shared savings, but those opportunities are most valuable for high-utilizing members who are also most likely to face work requirement barriers.

Medicaid ACO payment models that include prospective care coordination payments create different incentives. If ACOs receive monthly payments for attributed members similar to MCO capitation, they have direct financial incentive to maintain attribution through work requirement support. If they operate purely on retrospective shared savings without prospective payments, the incentive is weaker and potentially misaligned.

Risk adjustment that accounts for social determinants could partially address the incentive misalignment. If ACO risk scores and savings benchmarks adjust for members facing work requirement barriers, ACOs would be rewarded for successfully managing complex social needs

rather than penalized for serving harder-to-maintain populations. This requires sophisticated modeling linking social factors to expected costs and quality outcomes, which most state Medicaid programs have not yet developed.

Population Health Management Under Instability

ACO core competency is population health management. They stratify attributed populations by risk, target interventions to high-need subgroups, implement registry-based outreach for preventive services, and track outcomes across the full population. Work requirements undermine this capability by making the population unstable and attribution unpredictable.

Population health management requires knowing who is in your population. ACOs receive attribution lists showing which beneficiaries are assigned based on primary care utilization patterns. These lists update periodically as people move or change providers. Under work requirements, attribution changes will accelerate dramatically. Someone attributed in January may be gone in March due to coverage loss and reattributed in May to a different ACO after coverage reinstatement and provider changes.

The churn makes prospective population health interventions difficult. An ACO identifies members due for diabetic retinopathy screening and schedules outreach. By the time outreach occurs, some members have lost coverage and are no longer attributed. The ACO invests in outreach to people no longer in their population. Staff time is wasted. Data systems show incomplete screening rates, but the ACO cannot screen people who are not attributed during the measurement period.

Preventive care campaigns that span months become impossible with enrollment volatility. Smoking cessation programs lasting three months. Weight management interventions over six months. Chronic disease self-management education over twelve weeks. These extended engagements depend on continuous coverage and attribution. When people cycle in and out, ACOs cannot sustain multi-month interventions. They shift toward acute episodic interventions that can be completed in single encounters because longer programs lose participants to coverage gaps.

This moves ACOs away from population health and toward individual clinical episodes, which undermines the ACO model's fundamental value proposition. ACOs were created to shift from episodic sick care to proactive population health management. Work requirements push them back toward episodic approaches because population-based longitudinal interventions do not work with unstable attribution. The organizational model designed to transform healthcare delivery gets forced back into traditional reactive patterns by administrative eligibility rules.

Safety-Net ACOs and Community Health Centers

Community health centers and other safety-net providers form many Medicaid ACOs. Medicare regulations explicitly allow community health centers and rural health clinics to lead ACOs, and special provisions support safety-net provider participation. These organizations serve populations most likely to face work requirement barriers. Low-income adults, people with limited English proficiency, individuals experiencing homelessness, and others with complex social needs concentrate in safety-net provider panels.

Safety-net ACOs face intensified challenges. Their attributed populations have higher rates of unemployment, unstable housing, chronic conditions that limit work capacity, and limited digital literacy for verification systems. The populations most valuable for ACOs to serve through intensive care coordination are the populations most likely to lose coverage under work requirements. The mission-driven imperative to serve vulnerable populations conflicts with the economic reality that these populations will experience the highest attribution volatility.

Community health centers already provide non-clinical support services that could extend to work requirement navigation. Many have benefits counselors helping patients access SNAP, housing assistance, and other programs. These counselors could add work requirement support to their scope. Many have care coordinators who already address social determinants. Work requirement status becomes another social determinant to manage within existing workflows and relationships.

However, safety-net ACOs operate on thin financial margins. They rely on enhanced Medicaid payment rates, 340B drug pricing, and federal grants to cover costs of serving high-need populations. They cannot afford to build sophisticated work requirement support infrastructure from existing resources without displacement of other essential services. They need either additional payment for this function or they need MCO or state-provided infrastructure they can integrate into their existing workflows.

The pre-payment provisions in Medicare's safety-net ACO policies offer a model. Medicare provides advance payments of shared savings to safety-net ACOs to support infrastructure investment. Medicaid could adopt similar provisions, giving safety-net ACOs advance payment for care coordination infrastructure that includes work requirement support. This recognizes that serving vulnerable populations requires investment before savings materialize and that retrospective shared savings models disadvantage organizations serving populations with high social needs.

Data Infrastructure and State System Integration

ACOs have sophisticated clinical data infrastructure. Electronic health records, health information exchanges, care management platforms, and quality reporting systems enable coordinated care. They lack the eligibility and enrollment data infrastructure that MCOs maintain. Integrating these systems is essential for ACOs to effectively support work requirement compliance while managing care delivery.

Real-time eligibility data feeds from state Medicaid systems to ACO care management platforms allow care coordinators to see verification status, upcoming deadlines, and exemption eligibility alongside clinical information. A care coordinator reviewing a patient's care plan sees that they are due for diabetic retinopathy screening and that their work requirement verification is due in three weeks. Both needs can be addressed in coordinated outreach rather than separate contacts that burden members and waste staff time.

Bidirectional data flow between provider EHRs and state exemption systems streamlines medical exemption processes discussed in Article 2B. Providers document functional assessments during clinical encounters. That documentation flows automatically to state exemption determination systems. States provide confirmation of exemption status back to providers and ACOs. This

closed-loop process prevents exemption requests from falling into administrative black holes where neither providers nor members know the status until coverage terminates.

Attribution data that accounts for coverage gaps enables ACOs to maintain care relationships during disenrollment. Someone loses coverage but remains in the ACO's tracking system as a formerly attributed member. The ACO can provide gap engagement support, facilitate re-enrollment, and resume care coordination when coverage returns. This maintains continuity even through coverage disruptions, preventing the complete relationship loss that otherwise occurs.

Quality measure denominator adjustments must account for coverage gaps. Current quality measures assume continuous enrollment. Someone enrolled for eight months of a measurement year who loses coverage for four months gets excluded from quality metrics or counted as missing expected care. ACOs serving populations with work requirement churn need quality measurement methodologies that fairly assess performance given enrollment instability. Without these adjustments, ACOs serving vulnerable populations appear to perform poorly compared to ACOs serving stable populations, even if care quality during periods of attribution is identical.

Financial Sustainability Under Shared Savings

ACOs must demonstrate savings above a minimum threshold before earning shared savings, and participation requires multi-year commitments. This payment structure creates financial risk when member attribution becomes unstable. An ACO invests in infrastructure and care coordination expecting three years of attribution continuity to generate measurable savings. Work requirement churn disrupts those savings calculations fundamentally.

Consider a simplified scenario. An ACO invests in intensive care coordination for 1,000 high-utilizing Medicaid expansion adults. The investment costs $500 per member annually. Historical data suggests this coordination can reduce emergency department utilization and inpatient admissions by enough to generate $750 per member in savings, leaving $250 per member in net savings for shared savings distribution.

Under stable enrollment, the ACO invests $500,000 in year one and realizes $750,000 in savings for net positive $250,000. Over three years, cumulative savings compound as care improvements prevent complications and build on previous gains. The business case is straightforward. The investment returns exceed costs and the ACO shares in savings with the Medicaid program.

Under work requirement churn with 25% annual turnover, the calculus changes. The ACO invests $500,000 in year one but loses attribution for 250 members by year end. Those 250 members' care coordination investments do not generate savings for the ACO because they are no longer attributed. Another 250 newly attributed members join, but they have not received the care coordination yet. Effective savings only accrue from the 500 stably attributed members, generating $375,000 in savings for $125,000 net loss in year one.

By year three, if churn continues at similar rates, the ACO may never achieve cumulative savings above the benchmark threshold required for shared savings distribution. The investments exceed the savings that can be attributed to the ACO. The financial model breaks. The more the ACO invests in care coordination, the worse its financial performance becomes under attribution volatility.

This creates difficult strategic choices. ACOs can reduce care coordination investment to match expected attribution stability, but this undermines care quality and contradicts the ACO model's purpose. They can invest only in members predicted to maintain coverage, but this creates inequitable tiering where vulnerable populations receive less support. They can advocate for payment model changes recognizing instability, but states may be unwilling to adjust benchmarks without data demonstrating the impact. Or they can exit Medicaid ACO participation, leaving vulnerable populations without coordinated care options.

Alternative Payment Models for Unstable Populations

The shared savings model may be fundamentally incompatible with work requirement enrollment volatility. ACOs serving Medicaid expansion populations may need different payment structures that recognize attribution instability while maintaining accountability for quality and appropriate resource use.

Prospective care coordination payments provide stable revenue regardless of attribution changes. An ACO receives monthly per-member payments for care coordination services delivered to currently attributed members. When someone loses attribution, payments stop, but the ACO has not made long-term investments expecting multi-year returns. When someone gains attribution, payments start immediately. This matches payment to current service delivery rather than expected future savings that may never materialize under unstable attribution.

Some Medicaid ACO models already use shared savings combined with care coordination fees or risk-adjusted prospective payments rather than pure retrospective shared savings. These hybrid models could work better under instability. Base payment covers care coordination costs regardless of savings generation. Shared savings provide upside for ACOs that successfully reduce utilization, but the base payment prevents financial losses from attribution volatility. The downside protection matters when serving populations with high churn risk.

Episode-based payments for specific care coordination interventions create accountability without requiring long-term attribution. An ACO receives a bundled payment for managing someone through a diabetes education program, a smoking cessation intervention, or transitional care after hospital discharge. Payment is tied to completing the episode successfully regardless of whether the member remains attributed long-term. This works for discrete interventions but does not support ongoing longitudinal population health management.

Quality-based bonuses rather than savings-based bonuses maintain performance accountability while recognizing that savings may not be measurable with unstable populations. An ACO earns bonuses for achieving clinical quality metrics, patient experience scores, and preventive care completion rates among currently attributed members. These metrics can be measured even with shorter attribution periods. However, quality bonuses without savings requirements may not generate sufficient total payment to sustain ACO operations.

The payment model must balance several objectives. Maintaining ACO financial sustainability. Creating incentives for quality improvement and appropriate resource use. Recognizing the reality of attribution instability. Ensuring adequate care coordination investment for vulnerable populations. No single payment model perfectly achieves all objectives simultaneously, but hybrid

approaches combining base payments with performance incentives can come closer than pure shared savings models designed for stable populations.

The Governance Question: Who Should Lead?

ACOs are provider-led by design. Clinical leadership makes decisions about care delivery, resource allocation, and quality improvement priorities. This governance structure works for clinical care coordination but may not work for work requirement implementation. Should ACO boards and leadership take responsibility for work requirement compliance systems, or should this remain with MCOs, state agencies, or separate administrative entities?

The argument for ACO leadership starts with health outcomes. Work requirements affect health outcomes, so they fall within the ACO's accountability scope. Coverage loss leads to missed care, worse chronic disease control, and preventable complications. ACOs accountable for quality and cost should have authority and resources to prevent coverage loss that undermines health. The integration of work requirement support into care coordination makes clinical sense.

The argument against ACO leadership emphasizes organizational competency. Work requirements are administrative eligibility functions, not clinical care functions. ACOs lack expertise in eligibility systems, state policy compliance, and benefits administration. Asking clinically-led organizations to build administrative infrastructure diverts resources from care coordination and distorts organizational mission. Physicians and nurses became providers to deliver healthcare, not to manage government benefit compliance.

The pragmatic middle ground likely involves shared responsibility with clear role delineation. State Medicaid agencies maintain ultimate authority over eligibility determination and build core verification infrastructure. MCOs manage member services, communications, and initial support. ACOs integrate work requirement status into care coordination, facilitate medical exemptions through provider networks, and provide clinical documentation for exemption processes. Each entity focuses on its core competencies.

This division leverages organizational strengths. States do policy and systems. MCOs do member administration. ACOs do care coordination and provider engagement. The coordination among these entities becomes critical. Governance structures that include representatives from all three stakeholder groups can facilitate aligned approaches rather than fragmented parallel systems that confuse members and waste resources.

SDOH Platforms as Intermediary Infrastructure

A different strategic option emerges when examining the capabilities ACOs lack and MCOs possess imperfectly. SDOH and health-related social needs platforms and organizations already operate at the intersection of healthcare delivery and social service coordination. These entities could serve as the intermediary layer managing work requirements, redetermination support, and coverage gap engagement on behalf of both ACOs and MCOs.

The existing SDOH infrastructure addresses precisely the domains work requirements implicate. Specialized platforms coordinate community resource referrals, track member needs across multiple social determinants, connect members to employment services and job training programs, facilitate transportation to appointments, and maintain engagement through coverage

transitions. Article 3B identified SDOH vendor partnerships as essential MCO infrastructure. For ACOs lacking administrative capacity, outsourcing the entire work requirement management function to specialized SDOH entities could prove more effective than attempting to build internal capabilities or relying solely on MCO partnerships.

Full-service SDOH entities operating on behalf of ACOs would handle member communications about work requirements and deadlines, coordinate verification submission through employer and educational institution partnerships, navigate exemption processes including documentation gathering, maintain member engagement during coverage gaps, facilitate re-enrollment when coverage reinstates, and coordinate with both MCO administrative systems and ACO clinical systems. The SDOH entity becomes the connective tissue between clinical care delivery, insurance administration, and social service coordination.

This model works because SDOH organizations already maintain the community relationships ACOs need but lack resources to build. They have established partnerships with employers, educational institutions, workforce development programs, volunteer coordinators, and community-based organizations. When someone needs to find qualifying volunteer opportunities, the SDOH entity connects them through existing community partnerships rather than ACOs building separate volunteer coordination infrastructure. When someone needs transportation to verification appointments, the SDOH entity coordinates through transportation networks already serving that member for medical appointments.

The technology integration ACOs require for work requirement visibility exists in mature SDOH platforms. These systems already integrate with MCO care management platforms, provider EHR systems through health information exchanges, state eligibility systems for Medicaid enrollment data, employer verification systems, and community organization referral networks. Adding work requirement status tracking, verification deadline alerts, and exemption documentation workflows to existing SDOH platforms extends current functionality rather than building from scratch.

Coverage gap engagement represents a domain where SDOH entities possess structural advantages over both MCOs and ACOs. When someone loses Medicaid coverage, MCOs lose financial relationship and attribution ends for ACOs. SDOH entities serving communities rather than covered populations can maintain engagement. A community health worker employed by an SDOH organization continues supporting someone during coverage gaps, facilitating access to safety-net services, providing health self-management education, maintaining care continuity to the extent possible without insurance, and helping navigate re-enrollment when the person becomes eligible again.

This continuity matters enormously for people with chronic conditions who cycle through coverage. Someone with diabetes loses Medicaid, cannot afford insulin, develops uncontrolled blood sugar, ends up in the emergency department, and returns to coverage sicker and more expensive to manage. An SDOH entity maintaining engagement during the gap connects them to community health centers offering sliding-scale insulin access, coordinates with charitable prescription programs, monitors symptoms to catch deterioration early, and facilitates rapid re-enrollment before health crisis occurs. The ACO regains attribution to a member whose health status deteriorated less than it would have without gap support.

The financial model for SDOH intermediaries requires clarity about who pays for what. MCOs could contract with SDOH entities for comprehensive work requirement support, paying per-member-per-month fees for attributed members plus episode payments for specific interventions. ACOs could share payment responsibility, contributing to SDOH entity funding based on members served. States could provide administrative funding recognizing that SDOH entities reduce state administrative burden by handling complex navigation cases. Philanthropic funding could support gap engagement services for disenrolled members where neither MCOs nor ACOs have financial responsibility.

Hybrid payment models work best. Base per-member fees cover ongoing verification support and routine navigation. Outcome-based bonuses reward successful coverage maintenance, exemption facilitation, and rapid re-enrollment. Enhanced payments for multiply-burdened members requiring intensive support ensure SDOH entities serve high-need populations rather than focusing on easier cases. This blended approach aligns financial incentives with desired outcomes while providing revenue stability.

The vendor-agnostic consideration matters here. Some health plans and ACOs may prefer contracting with established SDOH platform vendors who can rapidly deploy technology infrastructure and scale quickly. Others may prefer partnerships with local community-based organizations providing SDOH services who have deeper community relationships but less sophisticated technology. Both models work. The platform vendors offer standardization and scale. The community organizations offer cultural competence and trust. Many implementations will combine both, with platform vendors providing technology backbone and local organizations delivering direct member services.

Data sharing arrangements require careful structure. SDOH entities need access to ACO clinical data for exemption documentation, MCO eligibility data for verification status, state redetermination schedules and requirements, and member authorization for comprehensive support. Privacy protections must prevent inappropriate disclosure while enabling coordinated care. HIPAA business associate agreements, data use agreements limiting information to specified purposes, member consent processes explaining what information shares with whom, and regular audits ensuring compliance become essential infrastructure components.

The governance model determines whether SDOH intermediaries truly serve both ACO and MCO interests or become captive to one stakeholder. Independent SDOH entities with diverse funding sources and accountability to community interests alongside payer interests can maintain balanced approaches. SDOH entities wholly owned by MCOs may prioritize insurer interests over clinical care continuity. SDOH entities funded exclusively by ACOs may lack administrative sophistication for insurance coordination. Tri-partite governance including ACO, MCO, and community representation offers optimal structure.

Quality measurement for SDOH intermediary performance requires metrics that matter. Coverage retention rates for members receiving support. Time from initial contact to successful verification completion. Exemption documentation success rates and processing times. Member satisfaction with support received. Health outcomes during and after coverage gaps for members receiving gap engagement. Re-enrollment rates and speed for formerly covered members. Cost-effectiveness

compared to alternative support models. These metrics inform both payment structures and continuous improvement processes.

The scalability question looms large. Can SDOH entities absorb work requirement management for 18.5 million expansion adults while maintaining quality? The December 2026 timeline means SDOH organizations have 14 months to build capacity, train staff on work requirements and exemptions, develop technology integrations, establish stakeholder partnerships, implement quality measurement systems, and pilot approaches before full implementation. Organizations already operating at capacity serving current SDOH needs cannot simply add work requirements without displacement of other services or significant expansion funding.

Phased implementation allows capacity building. ACOs and MCOs could begin by referring their highest-risk members to SDOH entities, testing processes with manageable volumes before expanding to broader populations. Initial contracts could cover 10-20% of attributed members, scaling based on demonstrated capacity and quality. This protects members from service failures while giving SDOH entities time to mature capabilities. However, phased approaches must avoid cream-skimming where SDOH entities serve easier cases while complex cases remain unsupported.

The strategic advantage for ACOs in outsourcing to SDOH intermediaries is focus. ACO leadership and resources can concentrate on clinical care coordination, quality improvement, and provider integration rather than diverting to administrative eligibility management. The SDOH entity handles the administrative complexity that falls outside ACO core competency. When someone needs medical exemption documentation, the SDOH entity coordinates with ACO providers to facilitate the clinical attestation while handling all administrative submission and follow-up. The ACO does what it does well while the SDOH entity fills capability gaps.

Looking Forward: ACO Adaptation Strategies

Medicaid ACOs have 14 months until December 2026 to prepare for work requirement implementation. Strategic adaptation requires understanding which functions ACOs can realistically perform versus which require partnership with MCOs, SDOH intermediaries, or state agencies.

ACOs can own integration of work requirement status into care coordination platforms. They can train care coordinators on exemption processes and implement proactive exemption screening during routine care. They can streamline provider exemption documentation through EHR templates and maintain care continuity during coverage gaps for high-need members. They can track health outcomes related to coverage instability and advocate for payment models that account for enrollment volatility. These functions leverage existing ACO capabilities in care coordination, provider relationships, and clinical data management.

Functions potentially outsourced to SDOH intermediaries include comprehensive work requirement navigation and member support, verification submission coordination with employers and educational institutions, exemption documentation gathering and processing, coverage gap engagement maintaining relationships during disenrollment, re-enrollment facilitation when coverage reinstates, and coordination between ACO clinical systems and MCO administrative systems. This outsourcing option allows ACOs to maintain clinical focus while ensuring members

receive necessary support through specialized entities with community relationships and administrative expertise.

Functions requiring MCO partnership for ACOs not using SDOH intermediaries include member communications about work requirements, verification portal access and technical support, connection to state eligibility systems, and member services for general questions. MCOs also handle coordination with employers and community organizations not already partnered with SDOH entities, gap coverage arrangements during transitions, and re-enrollment facilitation after coverage loss. These administrative functions fall outside ACO core competencies but are essential for comprehensive member support.

Functions requiring state leadership include verification system infrastructure, exemption policy design, provider portal development, and data integration standards. States must provide real-time eligibility feeds, quality measure adjustments for enrollment instability, and payment model modifications accounting for attribution volatility. Only state Medicaid agencies have authority to implement these system-level changes.

ACOs face a strategic choice about their work requirement approach. Build internal capacity for comprehensive support, stretching organizational capabilities and resources beyond core clinical competencies. Partner directly with MCOs for administrative functions while maintaining clinical focus, requiring strong coordination and clear role delineation. Contract with SDOH intermediaries for full-service work requirement management, outsourcing the entire function to specialized entities. Or implement hybrid approaches combining internal clinical capabilities with external partnerships for administrative complexity.

The SDOH intermediary option offers particular promise for safety-net ACOs and community health center-led ACOs serving vulnerable populations. These organizations have strong clinical relationships and community trust but limited administrative infrastructure and tight financial margins. Outsourcing work requirement management allows them to leverage their clinical strengths while accessing specialized administrative capabilities through partnerships. The financial model must account for these partnerships, with payment flowing from ACOs and MCOs to SDOH entities covering actual support costs.

ACOs that clearly define their role scope, build partnerships for functions outside their competency, and focus resources on what they do best will navigate work requirements most effectively. Those that try to own all functions will be overwhelmed by scope beyond their organizational capabilities. Those that ignore work requirements as outside clinical scope will watch their attributed populations destabilize and their quality metrics deteriorate. The ACO model has value for vulnerable populations, but only if adapted to operate in an environment of eligibility instability that the model was never designed to accommodate.

The philosophical question remains unresolved. Should provider organizations built for longitudinal care coordination also function as administrative compliance monitors for government benefit conditions? The answer shapes what ACOs become. ACOs that embrace the full social determinants responsibility, including work requirement support whether delivered internally or through SDOH partnerships, evolve toward community-centered comprehensive care organizations addressing both medical and social needs. ACOs that maintain focus on clinical care coordination while partnering for administrative functions preserve their clinical identity but require

strong partnerships to serve members effectively. Either path can work, but neither is simple, and both require resources, time, and coordination that 14 months barely provides. The choices being made now will determine whether ACOs serving vulnerable populations survive work requirements or whether the accountability model proves incompatible with eligibility instability.

Appendix: ACO Attribution Methodology

Understanding how ACO attribution works is essential for grasping how work requirements disrupt population stability. Attribution methodologies differ substantially between Medicare and Medicaid ACOs and across state Medicaid programs.

Medicare ACO Attribution

Medicare Shared Savings Program uses a two-step attribution methodology. Preliminary prospective attribution occurs at the start of the performance year based on prior year primary care utilization. Final retrospective attribution occurs after the performance year based on actual utilization during the measurement period. Beneficiaries are attributed to the ACO where they received the plurality of their primary care services, measured by allowed charges for evaluation and management visits with primary care physicians.

Step one examines whether the beneficiary received primary care services from a primary care physician. If yes, the beneficiary attributes to the ACO that includes the primary care physician who provided the plurality of primary care services by allowed charges. Step two applies if the beneficiary had no primary care physician visits. The methodology then looks at specialist evaluation and management visits and attributes based on plurality of those services.

This retrospective component means ACOs do not know their final attributed population until after the performance year. Medicare provides quarterly reports showing preliminarily attributed beneficiaries, but final accountability depends on where beneficiaries actually received care. Work requirements create attribution instability both within performance years as members lose and regain coverage and across performance years as members switch providers during coverage gaps.

Medicaid ACO Attribution Variations

Medicaid attribution methodologies vary significantly by state program design. Common approaches include:

Prospective attribution assigns members to ACOs at the start of the measurement period based on prior utilization patterns, member selection of primary care provider, or MCO assignment rules. Members remain attributed for the full measurement period regardless of subsequent utilization changes. This provides ACOs with advance knowledge of their attributed population for care coordination planning but creates mismatches when members switch providers or lose coverage.

Retrospective attribution assigns members after the measurement period based on actual utilization during that period, similar to Medicare methodology. ACOs do not know their final attributed population until after performance measurement concludes. This ensures attribution reflects actual care patterns but prevents proactive population health management.

Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*

Hybrid attribution combines prospective assignment for care coordination purposes with retrospective adjustment for performance measurement and payment. ACOs receive preliminary attributed populations for care management but final accountability and shared savings calculations depend on retrospective attribution.

Voluntary alignment allows members to select or be assigned to an ACO but does not restrict their ability to seek care from non-ACO providers. Attribution typically follows utilization patterns rather than enrollment designation. This differs from Medicare Advantage or Medicaid managed care where members enroll in specific plans with network restrictions.

Minimum Utilization and Enrollment Requirements

Most ACO models require minimum utilization levels for attribution. A beneficiary must have at least one primary care visit during the measurement period. Some Medicaid programs require multiple visits or minimum enrollment duration such as six months of continuous coverage. These requirements interact with work requirement redetermination cycles.

If redetermination occurs every six months and minimum enrollment requires six months of continuous coverage, members who lose coverage at five months do not count toward ACO performance measures. The ACO invested in care coordination but receives no attribution for that member. Conversely, if minimum enrollment is three months, members who lose coverage at four months count toward measures but subsequent coverage gaps disrupt quality measurement.

Attribution During Coverage Gaps

When someone loses Medicaid coverage, attribution rules vary by program. In Medicare ACOs, attribution continues if the member maintains Medicare coverage regardless of Medicaid status. In Medicaid-only ACOs, attribution terminates when coverage ends. Some states maintain ACO assignment during brief coverage gaps expecting re-enrollment, while others immediately de-attribute members upon coverage termination.

For dual-eligible beneficiaries in Medicare ACOs, Medicaid coverage loss does not affect Medicare attribution. The member remains attributed to the Medicare ACO for Medicare accountability purposes while losing Medicaid benefits. This creates the asymmetric coverage scenario where ACO accountability continues but support services disappear.

Minimum Population Size Requirements

Medicare ACOs must maintain at least 5,000 attributed beneficiaries. Medicaid ACO minimum size requirements vary by state, typically ranging from 1,000 to 5,000 members. Work requirement attribution volatility affects whether ACOs maintain minimum population thresholds. An ACO with 5,500 attributed members that loses 15% to work requirement non-compliance drops to 4,675 members, falling below Medicare minimum requirements.

States typically allow ACOs to fall below minimum size temporarily but require corrective action if populations remain below thresholds for extended periods. This creates strategic questions about whether ACOs serving predominantly expansion populations remain viable under work requirement instability or whether they must shift focus to non-expansion populations to maintain size requirements.

Performance Measurement Denominators

Quality measure denominators use different rules depending on measure specifications. Some measures require continuous enrollment throughout the measurement period. A member enrolled for eight months who loses coverage for four months gets excluded from measures requiring twelve-month continuous enrollment. Other measures allow gaps up to specific thresholds, such as 45 days.

Work requirements with monthly or quarterly verification create systematic gaps in enrollment that may disqualify members from quality measure denominators even if care coordination occurred during coverage periods. ACOs serving populations with high work requirement churn see their quality measure denominators shrink and become less representative of members they actually served.

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Syam Adusumilli, Chief Evangelist, *syam.a@groundgame.health*