Medicaid ACO Models and Work Requirements

Value-Based Care Meets Eligibility Instability: Payment Architecture Under OB3

The executive director of a Portland-area Coordinated Care Organization stared at the 2027 financial projections spread across her conference table. Oregon's CCO model had delivered remarkable results since 2012: per capita spending growth held to 3.4% annually, emergency department visits down 22% from baseline, behavioral health integration proceeding on schedule. The global budget arrangement gave her organization flexibility to invest in housing navigation, food security programs, and community health workers. Returns on these upstream investments typically materialized over three to five years.

Then came December 2026.

The One Big Beautiful Bill Act would subject Oregon's 520,000 Medicaid expansion adults to work requirements beginning that month. Her CCO's global budget assumed population stability that work requirements would shatter. Quality metrics requiring twelve-month continuous enrollment would break for precisely the chronic disease population the CCO invested most heavily in managing. The behavioral health integration her team had spent years building served disproportionately members whose mental health conditions made navigating compliance systems most difficult.

She understood the fundamental collision before her. ***CMS demanded value-based care transformation*** while OB3 created structural conditions that undermined it. The irony was not lost on her: federal policy simultaneously pushed states toward accountable care models requiring longitudinal relationships and imposed eligibility instability making those relationships impossible to maintain.

The Collision of Policy Trajectories

CMS has pushed aggressively for Medicaid managed care organizations to move payments toward value-based arrangements. The 2024 Managed Care Access, Finance, and Quality Rule reinforced quality expectations and required states to demonstrate network adequacy through appointment wait time standards and secret shopper surveys. States increasingly require MCOs to place 40 to 60 percent of provider payments in Alternative Payment Models. Oregon mandates that by 2024, no less than 70 percent of CCO provider payments must take the form of value-based arrangements at LAN Category 2C or higher, with at least 25 percent including downside risk.

This trajectory assumes conditions that value-based care requires: ***stable attribution, longitudinal relationships, and multi-year investment horizons***. ACO payment models reward organizations for keeping populations healthy over time. Prevention investments generate returns when the same people remain in the same accountable relationship long enough for those investments to pay off.

Work requirements inject systematic enrollment volatility into precisely the population states target for accountable care transformation. The 18.5 million expansion adults subject to OB3 requirements represent the core population Medicaid ACO programs were designed to serve.

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Semi-annual redetermination cycles, documentation requirements, and compliance verification create churning patterns incompatible with value-based payment logic.

The policy collision reflects competing theories of how to improve health outcomes. Work requirements theory posits that behavioral incentives create self-sufficiency and reduce dependency. Value-based care theory posits that coordinated longitudinal care management improves outcomes and reduces costs. These theories require different infrastructure, different investment horizons, and different assumptions about population stability.

Taxonomy of Medicaid ACO Payment Models

Medicaid ACO programs have proliferated across states, though they vary dramatically in structure, risk arrangements, and operational requirements. Understanding these variations matters because different payment architectures create different vulnerabilities to enrollment instability.

Oregon's Coordinated Care Organizations represent the most integrated model nationally. Sixteen CCOs serve approximately 1.4 million Medicaid members, with an estimated 520,000 expansion adults. CCOs operate under global budgets covering physical, behavioral, and oral health services. They accept full financial risk for their assigned populations. Community advisory councils provide local governance. The model's flexibility allows CCOs to invest in upstream services including housing, nutrition, and social supports.

Massachusetts MassHealth ACOs number seventeen organizations serving roughly 1.3 million members, including approximately 255,000 expansion adults. The program operates two tracks: Accountable Care Partnership Plans partner with MCOs to create integrated networks, while Primary Care ACOs maintain fee-for-service arrangements with shared savings. All MassHealth ACOs bear two-sided risk, meaning they share both savings and losses based on total cost of care targets. The program emphasizes health equity through its ACO Quality and Equity Incentive Program requiring disability competent care training and health disparity interventions.

Minnesota's Integrated Health Partnerships include 25 participating organizations covering more than 505,000 beneficiaries as of July 2024, with approximately 195,000 expansion adults. The program operates two tracks: Track 1 emphasizes virtual integration among providers, while Track 2 enables partnerships with community-based organizations addressing social determinants. IHPs receive quarterly population-based payments supporting care coordination infrastructure alongside shared savings arrangements. Minnesota saved nearly $156 million in the program's first three years while reducing inpatient admissions by 14 percent.

Colorado's Regional Accountable Entities number seven organizations covering the state's 1.5 million Medicaid members geographically, including approximately 450,000 expansion adults. RAEs emphasize behavioral health integration and operate performance-based payment arrangements. They coordinate physical and behavioral health services across regions but do not assume full global budget risk like Oregon's CCOs.

Other states operate various Medicaid ACO arrangements. New Jersey's demonstration program serves approximately 400,000 members through twelve organizations using a three-party model where the state contracts with MCOs that then delegate to ACOs. Rhode Island's three Accountable Entities cover 180,000 members under shared savings arrangements. Vermont operates a unique all-payer ACO model through OneCare Vermont, integrating Medicare, Medicaid, and commercial populations under a single global budget framework.

Payment Model Variants and Stability Assumptions

Different ACO payment structures carry different sensitivity to enrollment volatility. Understanding these distinctions clarifies why work requirements pose existential rather than incremental challenges to value-based care.

Shared savings only models place ACOs at upside risk alone. Organizations share in savings they generate but bear no downside if costs exceed benchmarks. These models assume high population stability because investment payoff requires members remaining attributed long enough for prevention and care management to demonstrate results. Return on investment calculations typically assume eighteen to thirty-six month horizons. Work requirements creating six-month churning cycles systematically prevent investment recovery.

Two-sided risk models expose ACOs to both savings and losses. Organizations that reduce costs below benchmarks share gains; those exceeding benchmarks share losses. These models carry higher vulnerability to enrollment instability because they combine investment loss from member departure with potential liability for costs incurred before departure. A high-cost member generating losses who then disappears may leave the ACO both having absorbed the loss and unable to recoup it through subsequent care management.

Global budget models like Oregon's CCOs represent maximum financial exposure to enrollment loss. Unlike shared savings models where the state bears base cost, global budget ACOs receive fixed payments and bear full risk. A 15 percent population loss creates immediate budget crisis because infrastructure costs remain fixed while revenue declines proportionally. CCOs cannot simply reduce staffing and care coordination capacity in response to monthly enrollment fluctuations.

Hybrid payment structures combining guaranteed base payments with performance incentives may prove more resilient. Care coordination per-member-per-month payments provide stable revenue for current attributed population regardless of savings. Quality bonuses create performance accountability without requiring savings demonstration. Episode payments for discrete interventions such as care transitions or condition management programs can complete within coverage periods rather than requiring multi-year relationships.

Attribution Mechanics and Coverage Instability

ACO performance depends fundamentally on which members get assigned to which organizations and for how long. Work requirements disrupt both dimensions of the attribution question.

Prospective attribution assigns members at period start based on prior utilization. Members who received most primary care from a particular provider group get attributed to that group's ACO for the coming performance period. This approach enables ACOs to plan care coordination activities, knowing which members they will be accountable for managing. However, ***prospective attribution creates stranded investment*** when work requirements cause members to lose coverage mid-period. The ACO invested in care coordination for members who may disappear before investments generate returns.

Retrospective attribution assigns members after period end based on actual care received. This approach avoids prospective attribution's stranded investment problem but creates different challenges. ACOs cannot plan care coordination for unknown populations. Members appearing

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during brief enrollment periods may generate outlier attribution patterns. High-utilization members during short enrollment windows create disproportionate impact on performance metrics.

Minimum enrollment thresholds compound attribution challenges. Many ACO models require minimum continuous enrollment periods for quality metric denominators. HEDIS specifications typically require 12-month continuous enrollment for chronic care measures like diabetes A1c control and blood pressure management. Work requirement redetermination cycles systematically break these continuity requirements. Members who would have demonstrated quality improvement disappear from denominators before measurements occur.

Population size floor problems emerge for ACOs concentrated in expansion populations. Medicare's Shared Savings Program requires 5,000 attributed beneficiaries minimum. State Medicaid ACO programs maintain similar thresholds. An ACO with 6,000 expansion adult members losing 20 percent to work requirement non-compliance falls below minimum requirements. Strategic question: must expansion-focused ACOs shift toward non-expansion populations to maintain viability?

Quality Measurement Denominator Effects

Work requirements create systematic distortion in the quality metrics that drive ACO performance accountability. Understanding these effects matters because quality scores directly determine ACO payments under value-based arrangements.

HEDIS-style measures requiring continuous enrollment become progressively unreliable as churning increases. Most chronic care quality measures require twelve-month enrollment periods. A diabetic member who loses coverage in month eight never appears in the diabetes control denominator, regardless of care quality during covered months. An ACO managing blood pressure excellently for ten months loses credit when the member disappears before year-end measurement.

The paradox of apparent improvement emerges when sickest members disproportionately lose coverage. Members facing the greatest compliance barriers often have the most complex health conditions creating documentation and verification challenges. If these members churn off coverage at higher rates than healthier members, ACO quality scores may improve even as population health deteriorates. The survivors are healthier than the departed. This creates perverse incentives against retention investment for members whose care most challenges quality metrics.

Process measures show less sensitivity to churn than outcome measures because they can complete during shorter enrollment periods. Screening rates for cancer or depression can demonstrate during any covered period. However, outcome measures requiring sustained management suffer maximum disruption. Controlled diabetes or managed heart failure require continuous care that coverage volatility interrupts.

The benchmark problem creates additional distortion. ACO benchmarks typically use historical utilization to project expected costs. If historical data includes populations that will churn under work requirements, benchmarks systematically overstate expected costs for remaining populations. ACOs appear to generate savings simply because high-cost members disappeared rather than because care improved. Performance measurement becomes noise rather than signal.

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Payment Model Adaptations for Unstable Populations

Pure shared savings models are fundamentally incompatible with systematic enrollment volatility. States and ACOs must consider payment architecture modifications enabling value-based care despite instability.

Hybrid payment structures combining guaranteed elements with performance incentives offer more resilience. Care coordination PMPM payments provide stable revenue for current attributed population regardless of whether savings materialize. Quality bonuses create accountability without requiring savings demonstration over periods too short to generate savings. Episode payments for discrete care management programs can complete within coverage periods rather than requiring multi-year attribution.

Risk corridor redesign becomes necessary when standard actuarial assumptions fail. Traditional risk corridors assume random variation around actuarial projections. Work requirements introduce systematic, non-random membership changes that violate corridor design assumptions. Adapted corridors might exclude work requirement churn from corridor calculations, create specific population stability adjustments, or tier corridor thresholds by expansion adult enrollment concentration.

Attribution rule modifications could reduce volatility impact without abandoning value-based payment. States could maintain ACO attribution during coverage gaps for quality measurement purposes, even when members are not enrolled for service delivery. Look-back attribution capturing members who would have been attributed absent coverage loss could preserve quality denominator integrity. Weighted attribution based on coverage months rather than binary annual assignment could proportionally credit ACOs for partial-year care.

Performance period adjustments might align measurement with realistic enrollment duration expectations. Instead of twelve-month performance periods, ACO contracts could use rolling six-month periods matching work requirement redetermination cycles. Shorter periods would reduce the duration over which population stability must be maintained but would also reduce the time horizon over which prevention investments can demonstrate returns.

Oregon's CCO Model as Stress Test

Oregon's CCOs represent the most integrated Medicaid ACO model nationally. If any payment architecture can absorb work requirement disruption, CCOs should. Their experience will signal possibilities for other states.

CCO structural characteristics create both resilience and vulnerability to work requirements. CCOs already integrate non-medical services into care coordination, positioning them to help members navigate compliance requirements. Community governance through advisory councils creates local accountability and relationships with community organizations. Behavioral health integration means CCOs serve populations disproportionately affected by work requirements. Flexibility to invest in social determinants enables upstream interventions.

However, ***global budget arrangements create maximum financial exposure*** to enrollment loss. Unlike shared savings models where the state bears base cost, CCOs receive fixed budgets and bear full risk. If 15 percent of expansion adult members lose coverage, CCO revenue declines 15 percent while infrastructure costs remain fixed. Care coordination staff, community health

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workers, and administrative systems cannot scale down monthly in response to enrollment fluctuations.

Oregon's political context adds uncertainty. Oregon has not announced work requirement implementation plans as of mid-2025. As a progressive state, Oregon may pursue maximum exemptions and good cause provisions. But federal requirements apply regardless of state preferences. The December 2026 deadline approaches whether Oregon prepares or not.

CCOs already operating on thin margins face particular vulnerability. Oregon Health Authority data for 2024 showed CCOs collectively achieved a net operating margin of just 0.001% statewide, with seven of sixteen CCOs operating at losses. The 2025 data through June showed margins of only 0.02% with CCOs spending 91.9% of revenue on member services. The Oregon Legislature provided a one-time $30 million increase for 2025 capitation rates recognizing financial pressures.

The Dual-Eligible ACO Complication

Dual-eligible beneficiaries present unique challenges when work requirements affect Medicaid coverage but not Medicare coverage. The asymmetric coverage effect creates complications no single payment model addresses.

Dual-eligible members remain attributed to Medicare ACOs even when Medicaid coverage terminates for work requirement non-compliance. This creates Medicare accountability without Medicaid support services. The Medicare ACO bears responsibility for cost and quality outcomes while Medicaid-funded wraparound services disappear. Care coordination infrastructure gaps emerge when Medicaid-funded transportation, care management, and social support services end.

Financial exposure increases when Medicare ACOs cannot rely on Medicaid cost sharing. Medicare pays primary for medical services, but Medicaid covers cost-sharing that Medicare beneficiaries cannot afford. When Medicaid terminates, dual-eligible members face cost-sharing barriers to accessing Medicare-covered services. Their utilization patterns change, often toward emergency services rather than preventive care. Medicare ACOs absorb costs that Medicaid wraparound would have offset.

Integrated dual-eligible ACO models would have direct financial incentive to prevent Medicaid coverage loss. Demonstrations testing integrated Medicare-Medicaid accountability show promise for coordinating care across both programs. Under integrated models, the ACO's interest in maintaining Medicaid coverage aligns with its interest in controlling Medicare costs. However, most dual-eligible beneficiaries are not in integrated models. They experience coverage asymmetry that integrated approaches would resolve.

Safety-net ACO concentration of dual-eligible populations creates differential impact across ACO types. FQHC-based and public hospital-led ACOs serve disproportionate dual-eligible populations. Work requirements will affect these ACOs more severely than commercially-oriented ACOs serving primarily non-dual Medicare beneficiaries. Financial stress concentrates in organizations already operating on thin margins.

MCO-ACO Integration Dynamics

In states where MCOs contract with ACO provider organizations, work requirements create three-party coordination challenges that current arrangements inadequately address.

The layered accountability problem emerges when eligibility, insurance, and care delivery operate in separate organizations. The state sets eligibility policy and verification requirements.

The MCO manages member services, communications, and compliance support. The ACO manages care delivery and provider network engagement. Information must flow bidirectionally across all relationships. Without integration, ACOs operate blind to eligibility changes until members miss appointments.

Contractual flow-through requirements must address work requirement coordination explicitly. MCO contracts with ACOs should specify work requirement status data sharing, exemption documentation responsibilities, attribution adjustment provisions for coverage volatility, and shared investment in retention infrastructure. Current contracts rarely address these elements because work requirements have not previously applied to expansion populations.

Financial alignment and misalignment between MCOs and ACOs determine whether organizations pursue compatible or competing strategies. MCOs have direct financial interest in member retention through capitation. Every member retained generates premium revenue. ACOs have indirect interest in retention through shared savings that may never materialize if members depart before savings accrue. Creating aligned incentives requires explicit contractual provisions rather than assuming natural alignment.

The payment flow structure matters. If the state pays the MCO, which then pays the ACO, investment in retention competes with other priorities within the MCO's budget. If retention investment requires ACO action, the MCO must create incentive structures motivating ACO behavior. Misaligned incentives could result in neither organization investing adequately because each expects the other to act.

CMS Policy Tensions

Federal policy simultaneously pushes states toward value-based care transformation and approves work requirement waivers that undermine transformation prerequisites. This tension reflects different policy priorities across CMS components rather than a coherent strategy.

The 2024 Managed Care Access Rule reinforced CMS expectations for quality improvement, network adequacy, and value-based payment progression. States must demonstrate appointment wait time compliance through secret shopper surveys. MCOs must report payment analyses comparing rates to Medicare benchmarks. Quality rating systems must enable beneficiary comparison across plans. These requirements assume stable populations enabling meaningful quality measurement.

Section 1115 waiver authority for work requirements operates through a different CMS review process with different policy priorities. Waiver approvals focus on state flexibility and program integrity rather than value-based care compatibility. CMS does not require states to demonstrate how work requirements will affect ACO programs or quality measurement validity. The siloed approval process ignores cross-cutting implementation effects.

State plan amendment interactions create additional coordination challenges. States implementing work requirements must simultaneously manage Section 1115 waivers for work requirements, state plan amendments for ACO payment models, quality strategy updates reflecting changed measurement capacity, and rate certifications accounting for population volatility. Each approval process proceeds independently. CMS provides no mechanism for evaluating how changes interact.

The quality strategy dilemma forces states toward uncomfortable choices. State Medicaid quality strategies increasingly emphasize value-based care metrics measuring chronic disease

management, care coordination, and prevention. Work requirements will systematically degrade performance on these metrics through denominator effects as complex members disappear from measurement populations. States face a choice: adjust expectations acknowledging work requirement impacts, or maintain standards that become unachievable for structural rather than quality reasons.

Investment Horizon Mismatch

ACO payment models assume investment in population health generates returns over periods longer than work requirements permit. This fundamental mismatch undermines value-based care logic.

Traditional ACO investment logic under stability works as follows: Spend $500 per member on care coordination infrastructure including health coaches, community health workers, and care managers. Generate $200 per member annual savings through reduced emergency department visits, avoided hospitalizations, and improved chronic disease control. By year two, cumulative savings exceed investment. By year three, net return reaches $100 per member.

Work requirements compress investment horizons beyond recovery capability. If 20% of members lose coverage within six months of investment, those members generate no savings return. The $500 investment in their care coordination is lost entirely. Savings from remaining members must compensate for investment losses among departed members. The math quickly becomes unfavorable.

Prevention investments face particular vulnerability because prevention returns materialize over the longest timeframes. Lifestyle coaching for pre-diabetic members may prevent diabetes onset over five to ten years. Medication adherence support reduces cardiovascular events over three to five years. Smoking cessation programs show hospitalization reduction over two to four years. Work requirement churning truncates these return periods before returns accrue.

Care management investment faces analogous challenges with shorter timeframes. Intensive care management for members with heart failure typically shows reduced hospitalization within twelve to eighteen months. Complex care coordination for members with multiple chronic conditions demonstrates returns within eighteen to twenty-four months. Even these relatively short investment horizons exceed the six-month windows work requirement redetermination cycles create.

Adaptive Strategies for Medicaid ACOs

ACOs cannot wait for federal policy reconciliation that may never occur. Organizations must develop adaptive strategies enabling value-based care despite enrollment instability.

Concentrate retention investment on highest-value members where the financial case is clearest. Members with risk scores of 2.5 or higher generate substantially higher capitation payments, often $8,000 to $12,000 annually. Investment of $500 to $800 in navigator services, exemption documentation support, and compliance assistance delivers returns of 10:1 to 15:1 if it prevents coverage loss. The chronic disease population most vulnerable to work requirement non-compliance is also most financially valuable to retain.

Integrate eligibility navigation into clinical workflows rather than treating it as separate administrative function. Care coordinators managing diabetes can simultaneously document medical exemptions. Behavioral health counselors treating depression can ensure mental health

exemption documentation reaches the state. Clinical encounters become opportunities for compliance support.

Develop rapid reattribution protocols enabling ACOs to recapture members quickly when coverage resumes. Members who lose and regain coverage within sixty or ninety days should return to the same ACO rather than requiring new attribution. Continuity of care relationship preserved through rapid reattribution enables care management continuation rather than restart.

Advocate for attribution rule modifications at the state level. ACOs should engage in waiver development processes to propose attribution mechanics that account for work requirement volatility. Weighted attribution, shadow attribution during coverage gaps, and look-back provisions could preserve value-based payment viability while accommodating coverage instability.

Consider population diversification reducing concentration in expansion adult populations. ACOs heavily concentrated in populations subject to work requirements face existential risk if those populations churn substantially. Diversifying toward children, elderly, disabled, and other populations not subject to work requirements could stabilize overall attribution even as expansion adult attribution fluctuates.

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