

Control Versus Administrative Discretion in Negotiating Voluntary P4P Networks: The Case of Medicaid Accountable Care Organizations

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Abstract

Government sponsored pay-for-performance systems (P4P) have emerged in many contexts, including those featuring third-party federalism such as Medicaid. In this vein, voluntary networks called Medicaid accountable care organizations (ACOs) seek to achieve health care savings while boosting the quality of care. Drawing on evidence from four states, this study probes how collaborative governance strategies that downplay formal democratic controls and enhance administrative flexibility shaped the response to two implementation problems. We find that administrative flexibility, combined with signals of support from political principals, helped galvanize ACO formation but undermined efforts to tailor performance metrics to the needs of Medicaid enrollees.

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Government sponsored pay-for-performance systems (P4P) targeted at organizations or networks have emerged in a range of principal-agent and policy contexts. Studies of P4P have focused on its dynamics and implications within a public organization (e.g., schools per Lavy, 2002; Marsh et al., 2011), in contracts with private implementing agents (e.g., Dias & Maynard-Moody, 2007), and in intergovernmental settings where one level of government relies on another to implement its programs (e.g., Frederickson & Frederickson, 2006; Heinrich, 2007). The P4P literature has also noted the different fortunes of these initiatives in various substantive policy spheres. For instance, Perry, Engbers, and Jun (2009, pp. 44, 47) generally offer a pessimistic assessment of the efficacy of P4P, but observe that research “conducted in health care settings” tends to cast the approach in a more favorable light. More recently, Gerrish (2016, p. 59) in a meta-analysis concluded that performance management systems in the health arena exhibited higher achievement than those in other policy spheres, such as education and employment services. Other studies of P4P in the health care sector tend to support this view (e.g., Weissert & Frederick, 2013, p. S145; Kelman & Friedman, 2009). While some analyses raise cautionary flags about the efficacy of P4P in this sector (e.g., Miller, Doherty, & Nadash, 2013; Pronovost & Lilford, 2011; Werner, Kolstad, Stuart, & Polsky, 2011), those who seek to build a more general theory of P4P need to take into account the health care experience.

Drawing on evidence from Medicaid, the largest federal grant program to the states, this research seeks to advance knowledge of the challenges involved in implementing a P4P initiative under third-party federalism. Such federalism features the national government providing grants to states or localities, which in turn rely on private agents to implement national policy (Terman & Feiock, 2015). More specifically, this study focuses on the potential and limits of state collaborative governance strategies that prioritize administrative flexibility as opposed to formal democratic control in meeting these challenges. The Affordable Care Act (ACA) of 2010 and the steadfast commitment of the Obama Administration fueled momentum for P4P in the health arena. Under the banner of “value-based purchasing,” P4P has become a pivotal tool in the federal government’s efforts to stem the growth in health care costs while boosting the quality of care. Government’s historic reliance on fee for service has, of course, long meant that payments to health care

providers were linked to their outputs. Value-based purchasing strives to go beyond this to reward providers for services deemed to be efficient and of high quality. Congress¹ and the Trump administration seem likely to continue this focus.

One prong of government's value-based initiative has stressed the development of accountable care organizations (ACOs) based on shared savings. At its core, the ACO represents a voluntary *network-inducement model* of P4P featuring a three-step process. Government (a) invites an array of service providers and other stakeholders to *voluntarily* assemble formal collaborative networks to deliver care, (b) decides which of the applicants meet its ACO standards, and (c) enters into P4P arrangements (e.g., contracts) with those that do. These arrangements specify that if the ACO achieves a certain level of savings in the delivery of care to a defined set of patients and performs well on key quality metrics, a portion of the savings will be shared with the ACO. This money can then be distributed among network members (gain-sharing) or otherwise invested in the ACO.

The ACO model has gained considerable traction in the federally run Medicare program, which serves the elderly and certain people with disabilities. By the end of 2015, federal officials had certified well over 400 Medicare ACOs, which were collectively responsible for nearly 8 million enrollees (Baseman, Boccuti, Moon, Griffin, & Dutta, 2016, pp. 20-22; Shortell et al., 2015, pp. 648-650). This development has kindled empirical inquiry into ACOs (e.g., Lewis, Colla, Carluzzo, Kler, & Fisher, 2013; Shortell, McClellan, et al., 2014; Shortell, Wu, et al., 2014). These inquiries have yielded valuable insights into Medicare and commercial ACOs, but they have done little to illuminate the central focus of this study, namely, the collaborative governance strategies employed by state actors to facilitate the development and implementation of Medicaid ACOs. In contrast to Medicare, state Medicaid programs have been slower to spawn ACOs. Medicaid subsidizes health care for over 70 million low-income people at an annual cost to the national and state governments of over US\$500 billion. As is generally the case with third-party federalism, Medicaid features challenges of vertical intergovernmental management involving considerable negotiation and bargaining between national and state officials (Thompson, 2012). In a similar vein, states must also manage and negotiate the terms of their relationship with a vast phalanx of hospitals, physicians, nursing homes, and other mostly private providers to deliver health care to program beneficiaries. As of 2017, federal administrators had approved six state initiatives to develop Medicaid ACOs based on shared savings: Maine, Massachusetts, Minnesota, New Jersey, Rhode Island, and Vermont.²

This study breaks new ground in exploring a P4P health care innovation which has received scant empirical attention, namely, Medicaid ACOs. Focusing on these ACOs in four states, this study advances knowledge of the collaborative governance strategies shaping the adoption and implementation of P4P voluntary networks. Specifically, we examine the potential and limits of these strategies on one key dimension—the degree to which they emphasize control by political principals as distinct from broad administrative flexibility. We consider the relevance of this control-flexibility dimension for state officials as they coped with two pressing implementation challenges: (a) persuading providers to participate in networks that are ostensibly aimed at reducing the income they receive from Medicaid and (b) enticing the ACOs to adopt performance metrics tailored to the relatively unique needs of Medicaid enrollees. We find that administrative flexibility, combined with signals of support from political principals, helped galvanize ACO formation but undermined efforts to deal with the second challenge involving performance metrics. With respect to the second challenge, this research also advances knowledge of the contexts in which perceptions of performance metric overload by administrative agents loom especially large in shaping a P4P system. Finally, our research expands understanding of the different kinds of public–private performance relationships that may exist under third-party federalism. Medicaid’s approach to paying private providers differs appreciably from the conventional contracting model which has received more attention in the third-party literature.

The next section provides the rationale for focusing on the degree to which collaborative governance strategies emphasize administrative flexibility rather than formal control. Subsequent sections deal in order with our methodology, state strategies to induce ACO formation, and state efforts to impose tailored performance metrics on the ACOs. A final section highlights the more general lessons of our study as well as its research limitations.

Collaborative Governance Strategies: Control Versus Administrative Flexibility

Collaborative governance strategies “entail the formal engagement . . . by state actors of non-state policy stakeholders in sustained dialogue” and other actions. These strategies encompass mechanisms or tools (e.g., statutes and administrative rules) that state actors may employ “to create and structure collaborative arrangements” (Siddiki, Carboni, Koski, & Sadiq, 2015, pp. 536-537; see also Emerson & Nabatchi, 2015, p. 187). In exploring the collaborative governance strategies that the four states employed to deal with challenges related to the formation of ACOs and the selection of performance metrics, we primarily

focused on the degree to which the strategies fostered administrative discretion or flexibility. Above all, we examined the extent to which policymakers crafted precise statutes to guide ACO development and further shaped them through formal administrative rulemaking rather than more informal means.

Our interest in administrative flexibility stems from three sources. First, it relates to a central tenet of the new public management—that administrators should possess ample discretion and that accountability should primarily be based on performance rather than obedience to rules (e.g., Behn, 2001). Second, past research on performance management in the states points to the potential relevance of such flexibility. In this regard, Moynihan (2009) has noted that “the willingness of the legislature to give [a] department some autonomy to experiment . . . facilitated significant organizational learning and policy change” (p. 595). Finally, the literature suggests that administrative agencies with greater autonomy relative to political principals often achieve higher levels of policy innovation (e.g., Carpenter, 2001). In this vein, Miller and Whitford (2016, p. 124) note the common occurrence of a “control paradox” whereby greater efforts by political principals to impose direct democratic control over administrative agents undermines program success.

We seek to understand whether greater administrative flexibility facilitated the efforts of state officials to deal with two formidable implementation challenges. The first involved voluntary network inducement—persuading providers to band together to form the ACOs. This was no small problem for state officials. Many providers resented the Medicaid program because its pay rates generally lagged behind those of Medicare and commercial insurers. Moreover, a shared savings ACO is at first blush a revenue-shrinking P4P network. The performance bonus pool for Medicaid ACOs does not come from additional monies the state sets aside to reward high quality providers. Instead, it comes from savings Medicaid providers themselves generate for the state. The ACOs can at best recoup 50% to 60% of this savings as a bonus and only if they score well on quality metrics. In sum, more Medicaid dollars with fewer performance strings attached might well flow to providers if they declined to join the ACO.

A second key challenge for state officials involved the selection of valid performance metrics tailored to the particular needs of Medicaid enrollees. Savings for Medicaid ACOs are assumed to spring primarily from enhancing services to low-income patients with complex, high-cost conditions. These beneficiaries account for a vastly disproportionate share of Medicaid expenditures. In New Jersey, for instance, the top 10% of enrollees absorb 75% of all Medicaid spending on patient health care. Enrollees in this cohort one year tend to be there the next (Cantor et al., 2016). They drive up costs partly

through frequent (and often avoidable) admissions to hospitals and emergency rooms. To a greater degree that Medicare and commercial ACOs, Medicaid enrollees have two defining characteristics that contribute to their health problems (Cantor, Chakravarty, Tong, Yedidia, Lontok, & DeLia, 2014). First, they are disproportionately disadvantaged in terms of the social determinants of health, such as income, education, diet, housing, and transportation. Second, they more readily suffer from mental health and substance abuse disorders. Officials therefore believed that quality metrics for Medicaid ACOs should at least partly reflect their ability and willingness to address these two health problems through aggressive, culturally competent care coordination, and other means.

Our analysis presents mixed findings with reflect to collaborative governance strategies stressing administrative flexibility over democratic control. Such flexibility appears to kindle the development of ACO formation and penetration, but only when accompanied by signals of support from top political principals. As for performance indicators, administrative flexibility appears to have had no salutary effects on the propensity of Medicaid ACOs to adopt quality metrics focused on behavioral health and social factors.

Method

Given the limited number of Medicaid ACOs and the fledgling status of their development, this study relies on an inductive approach that seeks to generate propositions rather than test hypotheses. It follows in the tradition of scholars who have done comparative case analyses of a sample of American states to illuminate the dynamics of performance management (e.g., Moynihan, 2008). Specifically, we target four of the six states that had launched Medicaid shared-savings ACO initiatives—Maine, Minnesota, New Jersey, and Vermont. These states had been engaged in ACO implementation for at least 5 years—enough time to permit us to address our research questions. We excluded Massachusetts and Rhode Island because they had only recently adopted ACO initiatives.

The evidence for this study partly derives from a systematic review of government documents (e.g., laws, administrative regulations, requests for proposals), think tank reports, scholarly articles, and media accounts. We also drew on 33 semi-structured interviews with 41 ACO stakeholders in the four states.³ These interviews, which were conducted from July 2015 through November 2016, averaged about an hour with 14 being done in person and the remainder by phone. The interviewees included top Medicaid administrators in each state as well as representatives from ACO applicants, advocacy groups, nonprofits that provided technical assistance or funding to ACOs,

and Medicaid managed care organizations. With oral permission from the interviewees, we audio recorded and transcribed 31 of the 33 interviews. In two cases, a member of the research team took notes and drafted a summary of the interview immediately after the session.

The interviews probed stakeholder perceptions of key implementation issues and challenges that emerged in assembling and operating the ACOs. We opened the interviews by giving respondents the opportunity to identify the challenges that were foremost in their minds without any specific prompting. We followed with a series of specific questions derived from a review of the program documents and related materials. Two members of the research team content analyzed the interviews and reached consensus on their core themes.

Network Inducement as Implementation Challenge

This section primarily focuses on how state collaborative governance strategies emphasizing administrative flexibility helped induce the formation of Medicaid ACOs. But the backdrop of third-party federalism makes it important to acknowledge the role of the federal agency responsible for monitoring and signing off on the Medicaid ACOs—the Centers for Medicare and Medicaid Services (CMS). In general, the ACO initiatives in the four states were fully in line with CMS priorities to promote the value-based purchasing of health services. Having been directly responsible for implementing the Medicare ACO model, CMS supported its downward diffusion to state Medicaid programs. To the degree that differences between the federal government and the states arose they were less about goals and the core ACO model than about implementation details. These details at times triggered negotiation and bargaining between federal and state officials—a pervasive pattern of implementation interaction in American federalism (e.g., Agranoff, 2004; Ryan, 2011).

Among our four states, these negotiations were more protracted and difficult in the case of New Jersey and Maine. In New Jersey, CMS expressed concerns as to whether the proposal could be reconciled with the Sherman Antitrust Act of 1890, which prohibits collaborations that “unreasonably restrain trade.” State officials went to great lengths in documenting and otherwise persuading CMS and other federal agencies that there was no violation. In turn, Maine administrators had differences with CMS over the proper methodology for estimating ACO cost savings. Maine officials hoped to expedite CMS approval by mimicking the approach Minnesota had successfully used earlier. But this tactic failed. As one Maine official observed,

We worked with Minnesota to see some of the analyses they had to produce pass muster with CMS. We would replicate the same analysis for our own data, and then would be told that that wasn't adequate. (Interview 23: 4)

In essence, the absence of precise CMS guidelines concerning Medicaid ACOs opened the door to inconsistent federal communications over time. On balance, Maine officials found negotiations with CMS to be "an extremely painful process" which was "complicated, tedious, and time intensive" (Interview 23: 4). Eventually, however, CMS endorsed and supported the ACO initiatives in all four states. Structured by the collaborative governance strategies the four states employed, considerable bargaining and negotiation then ensued between state Medicaid officials and health care providers.

New Jersey: The Triumph of Formal Democratic Process

To a much greater degree than the other three states, New Jersey's initiation of Medicaid ACOs met high standards of formal democratic process. The legislature passed a relatively detailed statute to guide the initiative. In interpreting the law, Medicaid officials relied on the formal rule-making process which was transparent and afforded stakeholders ample opportunity for comment. In this process and more generally, Medicaid administrators scrupulously strove to interpret the statute to reflect what they saw as its legislative intent.

Legislative momentum on behalf of Medicaid ACOs sprang from a grassroots initiative in Camden, one of the nation's poorest cities. Under the leadership of Dr. Jeffrey Brenner, the Camden Coalition of Health care Providers had formed in the early 2000s. The coalition and its founder subsequently won acclaim for creatively addressing the needs of Medicaid enrollees with the most acute health problems while driving down costs through reduced hospital visits and other means. Brenner's initiative won national acclaim. An article in the *New Yorker* magazine praised the Camden coalition and claimed that the "net savings" resulting from the initiative were "almost certainly, revolutionary" (Gawande, 2011, p. 10). Dr. Brenner subsequently received a coveted MacArthur Foundation award in recognition of his leadership. Impressed with Brenner's accomplishments, New Jersey lawmakers became interested in extending the Camden model to other areas of the state. A conviction that they had uncovered "best practice" encouraged state legislators to write more detailed legislation that faithfully promoted the Camden approach.

Governor Chris Christie signed the 7½ page law authorizing the Medicaid ACO demonstration in August 2011. The statute provided detailed prescriptions

on several structural matters and a timeline for the application process (New Jersey P.L., 2011). In terms of governance, for instance, the law specified that applicants had to form a “nonprofit corporation” with governing boards representing a spectrum of providers, patients, social service agencies located in the ACO area as well as at least two consumer representatives. Moreover, and of critical importance subsequently, the law imposed provider participation requirements on the ACOs. In this regard, it mandated that applicants have within the areas they designate “support” from all the general hospitals, at least four behavioral health specialists, and no less than 75% of the primary care providers who served Medicaid enrollees.

The law also required New Jersey officials to employ a formal rule-making process to structure the ACOs. This process called for administrators to solicit comments on a proposed rule and provide justifications for accepting or rejecting suggestions that stakeholders made when they issued the final rule. The rule-making process along with the negotiations with federal officials over anti-trust issues (noted earlier) contributed to considerable delay in launching the ACOs. The 2011 founding legislation required Medicaid officials to issue a final rule within 180 days of the law’s effective date⁴ (New Jersey P.L., 2011: C.30.4D-8.15). But officials did not promulgate the final regulation until mid-2,014, about two years behind schedule.

In addition to the rule-making process, Medicaid officials informally responded to questions and issues that various parties raised. But they did not aggressively court stakeholders across the state to persuade them to participate. Within the state, however, two nonprofits—the Nicholson Foundation and the New Jersey Health Care Quality Institute—promoted the initiative thereby generating provider interest in submitting applications. Assembling viable networks to become ACOs was challenging partly because doctors in New Jersey, in contrast to the other three study states, tended to operate in small practices (Cantor et al., 2017). This meant that stakeholders in New Jersey more readily had to build ACOs from scratch rather than simply entice existing networks to sign up. Persuading providers to join the networks was often vexing.

Despite these challenges, state officials received seven ACO applications—from Newark, New Brunswick, Passaic County, and Trenton in central to northern New Jersey and from Camden, Cumberland, and Gloucester in the south. In July 2015, about four years after the authorizing legislation, state Medicaid officials finally certified three of the ACO applicants (Camden, Newark, and Trenton) while rejecting the others. This decision did not rest on an overall assessment of the prospects that these ACOs would succeed. Instead, the pattern sprang from a specific statutory provision that had unintended effects.

As noted above, the 2011 law went to great lengths to specify provider participation requirements among other things mandating that at least 75% of the “qualified” primary care providers in the area participate in the ACO. It further specified that a “qualified” provider be among a subset of physicians devoting at least 25% of his or her professional time to serving Medicaid enrollees, or 10 hr per 7-day week. This provision soon gave rise to what key stakeholders called “the denominator problem.” Meeting the 75% requirement necessitated, of course, that applicants identify the universe of these “qualified” primary care providers in their areas. They would then have to persuade at least three-quarters of them to sign up for the ACO. But drafters of the legislation had failed to realize that no such list of “qualified” providers existed or could easily be compiled.⁵ At first, applicants thought they might be able to derive the denominator from the lists of physicians participating in Medicaid managed care plans in New Jersey. But this proved futile. Calls to providers on the managed care lists found that many were no longer at the posted addresses or accepting Medicaid enrollees.

New Jersey Medicaid administrators became aware of the shortcomings of the managed care provider rosters and attempted to come up with a more accurate tally by having analytic staff examine the Medicaid claims and encounter data reported by providers. This analysis yielded a list that solved the denominator problem for state officials. But then a legal consideration intervened. Medicaid officials believed that they could not share the lists with those working on ACO applications because it would violate the proprietary nature of state contracts with Medicaid managed care organizations. The unwillingness of Medicaid officials to share the lists of “qualified” providers made it hard for applicants to know whether they met the law’s participation standard.

Failure to meet this standard was the key factor leading to the rejection of four of the seven applicants. This rejection significantly reduced Medicaid ACO penetration in the state. As of 2015, an estimated 13% of New Jersey’s Medicaid enrollees were in the three ACOs. Reflecting on this outcome, one New Jersey stakeholder opined, “If you want to have innovation, you want to have people participate and learn, there needs to be a tolerance for diversity and for experimentation. You can’t so strongly prescribe how this is going to be.” It would have been better to have “20 ACOs in 20 communities, each looking a little bit different . . . This variation creates the opportunity for learning” (Interview 2: 12).

Minnesota: Flexibility, Bias Toward Action, and the Big Tent

Unlike the formal democratic model that shaped the formation of New Jersey’s ACOs, Minnesota’s collaborative governance strategy stressed

administrative flexibility. In 2010, Minnesota policymakers approved a brief 2 ½ page statute that delegated vast discretion to state administrators to develop Medicaid ACOs (Minnesota Statute 2010). The law provided only general guidance. For instance, it required ACOs to have a mechanism for consumer advocacy and protection, and to forge partnerships with social service agencies. But at the same time, it endorsed “maximum flexibility to encourage innovation and variation” in ACO characteristics. While certain legislators and Democratic Governor Mark Dayton repeatedly signaled their interest in the ACO initiative, they left it to the bureaucracy to work out the details

Nor did Minnesota officials turn to formal administrative rulemaking to establish the parameters for the ACOs. Instead, they relied on extensive informal consultation with providers, requests for proposals, and contracts to forge the ACO template. To a much greater degree than New Jersey, Minnesota providers had over the decades already organized themselves into integrated care networks. This meant that the primary task for Minnesota officials was to persuade existing networks to tweak their structures and practices to become Medicaid ACOs. Early on, officials used a request for a proposal to kindle discussions with stakeholders. As one Medicaid official noted (Interview 27: 2),

What we did initially was . . . just put out a framework. We actually put out the RFP before we knew some of the design elements and . . . the data analytics.

We were sort of flying the plane and building it . . . Providers were helping us build this along the way, and we didn’t know what some pieces were going to look like.

Having built momentum with providers in 2011 and 2012, administrators did not want to delay in launching the Medicaid ACOs. They believed it was important to start

and that we could fix most anything later . . . We never had the image that the baby had to be born fully functional . . . We knew it was going to have to crawl the first year, and then we would start walking the second. (Interview 27: 6)

Another distinguishing feature of the Minnesota Medicaid ACO initiative was its emphasis on the “big tent”—great flexibility in certifying different types of networks to participate (Interview 27: 9). Motivated to get provider networks “in the door,” Minnesota administrators signed ACO contracts that varied greatly along several dimensions. At the most basic level, Medicaid

officials authorized two kinds of ACOs—virtual and integrated. The former included primary care and specialty providers but not hospitals. In contrast, the integrated network required the participation of general hospitals, primary care providers and community-based organizations. Minnesota officials have also welcomed participation by networks of varying sizes in urban and rural areas some of which offer long-term care. For instance, a nonprofit called Essentia Health, which became a Medicaid ACO in 2013, has about 1500 physicians practicing in Minnesota and three other states.⁶ Its network includes some 17 hospitals, 66 clinics, eight long-term care facilities, and other providers. Toward the other end of the spectrum, Lakewood Health System, which became a Medicaid ACO in 2015, operates a 25-bed critical access hospital and primary care clinics in five rural towns. Medicaid officials also signed ACO contracts with entities that provided specialty rather than primary care.

Minnesota's flexible approach ultimately led to the launching of 21 ACOs—six in 2013, three in 2014, seven in 2015, three in 2016, and two more in 2017. Minnesota's ACOs served over 35% of all program beneficiaries in that state, the highest penetration rate of our four study states. The Dayton administration pledged to increase the number of Medicaid enrollees served by ACOs from 342,000 enrollees in 2015 to a half million by 2018 (Minnesota Department of Human Services, 2015).

Maine: Greater Autonomy and Follow the Leader

To a greater degree than Minnesota, the Medicaid ACO initiative in Maine reflected leadership by program administrators rather than the governor or legislature. In 2010, top officials had contemplated contracting with managed care organizations to serve Medicaid enrollees. In 2011, however, the administration of newly elected Republican Governor Paul LePage decided to stress alternative “value-based” approaches to Medicaid. In response, officials without new legislative authorization launched an ACO initiative by filing an amendment to the state's Medicaid plan with CMS.

Initially, Maine Medicaid officials adopted an approach similar to New Jersey's in seeking to use the administrative rule-making process to solicit stakeholder input and specify the structure of the ACOs. Soon, however, efforts to work with the state Attorney General to issue a rule bogged down. Lacking health care expertise, the Attorney General's staff repeatedly requested that Medicaid officials get CMS sign-offs on specific provisions before promulgating a proposed rule. This complicated negotiations with federal officials and resulted in considerable delay. Realizing that that they were at a “standstill” with the rule-making process, Medicaid officials turned to the

Governor's office and his counsel (Interview 23: 14). With their help, Medicaid administrators reinterpreted the ACO process to be about contracting rather than rulemaking. Through this end run, they gained flexibility to negotiate more informally with providers and ultimately to structure the ACOs through contract language.

More than the three other states, Maine exemplifies the dynamics of horizontal diffusion in the American system of federalism. Maine officials knew that Minnesota "was really ahead of the game in terms of their Medicaid ACO" and strove to borrow "shamelessly from what [that state] had rather than reinvent the wheel" (Interview 23: 3, 5). In promoting ACOs, Maine officials went to great lengths to solicit input from providers and other stakeholders both formally and informally. Among other things, they did a kick-off event talking about value-based purchasing, arranged meetings with provider groups that served large numbers of Medicaid enrollees, and promulgated a formal Request for Information which outlined the proposed ACO structure and invited comments from stakeholders. Like Minnesota, Maine features a provider network legacy marked by substantial consolidation. Relatively few physicians have stand-alone practices and are instead part of formal networks anchored by hospitals or federally supported community health centers. Having engaged in extensive consultation, Maine officials issued a formal request for applications in late 2013.

In response, four networks applied and obtained ACO certification by August 2014. Three of them targeted more circumscribed geographic areas. MaineHealth ACO, which consists of primary care practices, serves the more populous Portland and Lewistown areas on the Atlantic coast. To the north, the Kennebec Regional Health Alliance ACO operates in and around Augusta, the state capital. Still further north, Beacon Health formed a Medicaid ACO in the hospital service area around Bangor. A fourth Medicaid ACO, Community Care Partnership of Maine, encompasses a larger geographic area ranging from Presque Isle on the Canadian border to York County south of Portland. In the aggregate, the ACOs serve about 10% of the state's Medicaid enrollees, the lowest penetration rate achieved in our four states.

Vermont: Reform Legacy and Ample Administrative Flexibility

Like Minnesota, Vermont Medicaid officials worked in a milieu where top elected officials encouraged the creation of Medicaid ACOs but afforded administrators great latitude in shaping them. Democratic Governor Peter Shumlin, who took office in January 2011, envisioned Vermont as a pacesetter for health reform generally. With his support, the legislature approved Act 48 in 2011, which dealt with myriad reform issues (Vermont Legislature,

2011). Of particular note, the law created the Green Mountain Care Board, a quasi-independent entity with multiple functions, including the seeding of Medicaid payment reform. While Act 48 provided no specific guidance on ACOs, Medicaid officials in coordination with the governor's office began to explore their creation in 2012.

Rather than rely on administrative rulemaking, Medicaid officials emphasized outreach and informal negotiations to fuel the formation of ACOs. Early in the process, they held sessions with a broad range of stakeholders (e.g., state agencies, providers, consumer advocates, and insurance companies) often under the auspices of the Green Mountain Care Board, which served as a facilitator (Interview 28: 4). In seeking to win stakeholder support, Vermont officials faced two primary challenges. First, they had to deal with a trust deficit among potential provider participants. As one stakeholder put it, providers tended to see Medicaid as "these guys [who] don't pay us a lot . . . Why would we want to . . . engage in a program like this for them? We're already underpaid." Through a series of meetings, Medicaid officials responded that if the state could foster greater efficiency, "we will be able to pay more for those services that are essential than we do today. Getting waste out of the system is good for everybody" (Interview 28: 4).

Second, state officials had to persuade medical providers, behavioral health specialists, and those providing long-term services and supports to join forces. Like Maine and Minnesota, Vermont featured considerable provider consolidation with hospitals owning physician practices. One major network was the Dartmouth Hitchcock Medical Center, based in New Lebanon, New Hampshire. It included more than 900 primary and specialty physicians many of whom practiced in Vermont. The second was the University of Vermont Medical group headquartered in Burlington, which employed some 475 doctors. While the presence of these large networks eased assembly of the ACOs, it also generated concern among community health centers, behavioral health specialists, and certain advocacy groups who worried that their interests would receive inadequate weight in ACO activities (Interview 29: 4). State officials worked to persuade them that this would not be the case and expressed a willingness to recognize ACOs that did not include either of the major hospital systems.

Vermont officials eventually approved two Medicaid ACOs. OneCare Vermont is the larger of the two with most providers having joined this state-wide ACO. Participants include the two major university medical centers, all other nonfederal acute care hospitals in the state, over 300 primary care providers, and most of the state's specialty care physicians. The second ACO responded to concerns of smaller provider groups who feared domination by the major medical centers. Community Health Accountable Care operates in

8 of Vermont's 14 counties and primarily consists of 9 federally qualified health centers delivering care at over 20 practice sites. Medicaid ACOs in Vermont rank second only to Minnesota in the penetration rate achieved with approximately 35% of the state's Medicaid beneficiaries receiving services from the two ACOs.

Why Participate in a P4P Network Based on Shared Savings?

Noting the role of collaborative governance strategies in inducing the formation of Medicaid ACOs in the four states still leaves open the fundamental question: Why would a provider volunteer for a P4P arrangement predicated on reducing the flow of Medicaid outlays for services to enrollees? Our research method does not permit us to answer this question definitively for each state or more generally. However, interview responses and related evidence suggests that three factors in varying degrees may have prompted providers to participate.

First, *a public service commitment in the form of support for health care reform* was a motivational factor (see Heinrich, 2007; O'Leary, 2015). Some providers grasped the special health problems of Medicaid enrollees and wanted to join an effort to ameliorate them. For instance, one Minnesota stakeholder noted that "we have a very progressive and engaged provider community" in the state with a "high participation rate" in the Medicaid program generally (Interview 27: 18). A Vermont stakeholder attributed the success in forming a state-wide Medicaid ACO to the fact "that the two major medical centers in Vermont . . . truly believe in health care reform" and poured substantial resources into the initiative, even though they had little prospect of reaping a short-term return on their investment (Interview 30: 6).

Second, *resource dependency* and a desire to sustain and build a *reputation for responsiveness* with state officials motivated some providers to participate. While providers complain about Medicaid payment rates, many of them (especially hospitals) heavily depend on revenue from the program. By being at the table to discuss, negotiate and ultimately participate in the ACOs, providers could augment a reputation for being a concerned, responsive, and cooperative partner. These reputations might help head off more sweeping state initiatives to contain Medicaid costs. For instance, key Maine providers thought it advisable to join the ACO because it seemed likely to have a less "drastic impact on their revenues" than Medicaid managed care organizations—an option officials had considered (Interview 22: 11). These interview responses square with O'Leary's (2015, p. 90) observation that individuals or groups at times participate in networks is to "advance their own political interests." They "gain access to . . . officials and decision

processes and cultivate political alliances.” Or, as a prominent health care lobbyist noted, “If you’re not at the table, you’re going to be on the menu” (Brill, 2015, p. 50).

Third, the potential for certain providers to *limit or even eliminate the negative financial effects* of Medicaid ACOs fueled participation. It deserves note that the immediate financial risk to providers of joining an ACO that failed to achieve savings or quality improvements were minimal.⁷ They would continue to receive their customary fees for serving enrollees. Risk to their Medicaid revenues would only occur if the ACO succeeded in generating savings. But under this scenario, not all ACO members were equally at risk. The Medicaid ACO model largely assumes that savings will accrue as primary care doctors, sensitive to the social context of their patients, aggressively coordinate care with behavioral health providers and others to reduce hospital emergency room and inpatient use. The remuneration of primary care providers might therefore increase as a result of ACO participation. In turn, hospitals might compensate for lost revenues. In states, where hospital systems employ primary care doctors, shared savings would still flow to these hospital-anchored networks (Interviews 22:11 and 31:12). Moreover, hospitals with substantial demand for their inpatient services (i.e., less resource dependent on Medicaid) have an economic incentive to replace Medicaid patients in hospital beds with those covered by Medicare and private insurers, which tend to pay higher pay rates for their services. As an administrator from one ACO hospital put it, “The argument I made [to the hospital board] was not that we would have any shared savings off of this, but if we could change the payer mix in our beds and our ER, we would gain from that” (Interview 21: 2).⁸

Overview: Administrative Flexibility and Participation

Table 1 summarizes key characteristics of Medicaid ACO formation and penetration in the four states. It reaffirms that Minnesota and Vermont have gone furthest in assigning Medicaid enrollees to ACOs, substantially outpacing Maine and New Jersey. An array of factors might explain the variation in Medicaid ACO penetration.⁹ Our analysis focused on one of them, the collaborative governance strategies the four states employed. Our research suggests that other things being equal, strategies which bolster administrative flexibility (but not autonomy vis-à-vis political principals) tend to kindle the development of Medicaid ACOs. Less reliance on formal democratic process and controls (e.g., precise statutes, formal administrative rulemaking) eases implementation challenges and fuels ACO penetration. Administrators in Maine, Minnesota, and Vermont possessed much greater latitude to promote

Table 1. Collaborative Governance Strategies for Medicaid ACOs in Four States, 2010-2016.

| Characteristic | Maine | Minnesota | New Jersey | Vermont |
|---|---|---|--|---|
| Precision of authorizing statute | No specific statute; handled administratively through a Medicaid state plan amendment | Two and a half page statute in 2010 that delegated vast discretion to the state bureaucracy to encourage development of different kinds of ACOs | Detailed 7½ page statute passed in 2011; very prescriptive in specifying provider participation, governance, and timeline requirements for the Medicaid ACOs | 2011 statute established a Green Mountain Care Board to encourage and oversee pilot projects that tested new payment models; no specific prescriptions concerning Medicaid ACOs |
| Formal administrative approach to specifying ACO characteristics | Formal request for information; request for applications and contracts | Requests for proposals and contracts | Formal administrative rulemaking with opportunity for public comment on proposed rules | Request for proposals and contracts |
| Elected policymaker involvement | Minimal though Governor LePage generally supportive of efforts to reduce Medicaid costs | Strong, persistent, publicly declared support from Governor Dayton and certain legislators | Legislature drafted and Governor Christie signed bill authorizing the Medicaid ACOs; governor subsequently paid little attention to the ACO initiative | Governor Shumlin and key legislators see Vermont as a pacesetter in health reform; declare support for the Medicaid ACO as part of this broader initiative |
| Number of Medicaid ACOs | 4 | 19 | 3 | 2 |
| Estimated Medicaid enrollees (2015) | 30,000 | 342,000 | 123,000 | 50,000 |
| Estimated ACO enrollment as percentage of all Medicaid enrollees ^a | 11 | 39 | 13 | 35 |

Source. Data are from Lloyd, Houston, and McGinnis (2015).

Note. ACO = accountable care organizations.

^aThe data on total Medicaid enrollment in the four states used to calculate the percent come from Snyder, Robin, Eileen, and Dennis (2014).

ACO development than their counterparts in New Jersey. But latitude alone does not appear to be sufficient. Persistent signals of support from top political principals also help. If New Jersey suggests the perils to ACO penetration of political principals adopting an overly prescriptive approach, Maine suggests that indifference among policymakers may have a similar effect. Potential members of ACOs may assign less priority to cooperating with program administrators if they sense that the initiative is not a top priority of a state's elected leaders.

Performance Metrics as Implementation Challenge

The collaborative governance strategy emphasizing administrative flexibility also shaped the selection of performance metrics. Statutes in all four states, including New Jersey, left the selection of performance metrics substantially in the hands of state Medicaid officials. These officials would play a pivotal role in determining the degree to which quality indicators were tailored to the unique behavioral health and social needs of the Medicaid population. The voluntary nature of stakeholder participation in the ACOs prompts the expectation that the metrics would emerge from negotiation and bargaining between state officials and ACOs participants. However, this expectation was only partly met.

The Medicaid ACO model involves the assessment of two basic performance dimensions—savings and quality. Savings equal the difference between projected Medicaid expenditures for a set of risk-adjusted enrollees attributed to the ACO and the actual spending on them over a given time period. The sheer technical complexity¹⁰ of making savings estimates along with strong CMS oversight of the algorithms used to calculate it meant that this indicator kindled little negotiation between state officials and the ACOs. State Medicaid officials have, with some tweaking, substantially relied on the elaborate methodology that CMS established for Medicare ACOs. In essence, a substantial asymmetry of expertise between state officials and ACO stakeholders led to a more hierarchical imposition of savings metrics.

This asymmetry did not apply to the quality indicators which prompted intense and protracted negotiations. Health care quality can be seen as the extent to which care increases the probability of desired health outcomes and reduces the likelihood of undesirable ones, given the state of medical and related knowledge. Quality in the ACO context includes but goes beyond state-of-the-art medical diagnoses and treatment. It also involves assertive care coordination in and out of medical settings that is culturally competent and community engaged. Ideally, this care coordination integrates services for chronic conditions and behavioral health problems; it also takes into account the social drivers of poor health, such as inadequate housing and

poor nutrition. State officials aspired to have quality metrics that at least in part were tailored to reflect these unique needs of Medicaid enrollees.

Providers, however, strongly resisted such tailoring. The P4P literature suggests that one factor driving this resistance might be a desire by providers to promote metrics that will cast them in a positive light (e.g., Heinrich, 2007, pp. 291-292). In this interpretation, providers resisted behavioral health and social metrics because they thought they would score better on more conventional measures of medical care quality. They worried about being held responsible for the social determinants of health over which they had no control. While at play to some extent, our interviews suggest that this causal interpretation slights a more important factor—the *strong sense among providers that they were subject to performance metric overload that imposed substantial reporting costs on them*. The health care arena has become saturated with payer-driven performance metrics. Commercial insurance companies, Medicare, and Medicaid have increasingly required providers to report their performance on myriad indicators. In doing so, these payers draw on a vast performance metrics infrastructure of government agencies and private nonprofit organizations. The National Quality Forum (2016) has, for instance, evaluated and endorsed over 700 health performance metrics. Drawing on this infrastructure, commercial and government payers naturally want the metrics they require to reflect the unique needs of those they insure.

This dynamic has created a sense among many providers of performance metric overload which has caused their reporting costs to soar. Independent analyses suggest that their concerns are far from baseless. For instance, Casalino et al. (2016) found that physician practices in four common specialties spent more than US\$15 billion annually reporting on quality measures for all payers. Concerns about these reporting costs have driven the Government Accountability Office (GAO; 2016, pp. 1-2) to define “quality measure misalignment” as a problem. Such misalignment exists “when different health care payers . . . require providers to report on different quality measures” or “to report on the same measure but set different specifications for that measure.” The GAO underscored that this misalignment and proliferation of metrics had placed a substantial “administrative burden” on providers at times exposing them to conflicting performance incentives. Hence, provider resistance to tailoring Medicaid ACO metrics substantially reflected a concern to reduce their costs by promoting congruence among the indicators different payers used (Interview 24: 5). Providers also tended to prefer reporting on fewer quality metrics and to have them derived from claims data, the information they submit to insurers to receive payment. They tend to resist metrics derived from other sources, such as medical charts, on grounds that they require too much time and effort to produce.

Despite provider opposition, Medicaid administrators hoped to introduce some quality measures related to behavioral health and social determinants (Interview 31: 9). Officials in Maine, Minnesota, and New Jersey relied on informal processes of conversation and negotiation with the ACOs to determine the metrics. In Minnesota, state officials started with a list of 60 to 70 measures that provoked a provider response characterized by one stakeholder as “Oh my God, if you do that to us, we are not going to participate” (Interview 27: 11). After many meetings with stakeholders, Medicaid officials agreed that the ACOs would only have to report on indicators that state law already mandated for all providers. In Maine, a nonprofit called Maine Quality Counts, facilitated a “deliberate and thoughtful process” involving “many, many meetings” between state officials and the ACOs (Interview 20: 6). In New Jersey, another nonprofit, the New Jersey Health Care Quality Institute, fostered negotiations between state officials and the ACOs which led to agreement on a streamlined, claims-based set of measures in late 2016. In contrast to these three states, Vermont relied on a more formal process to determine quality metrics. Early in the implementation process, state officials launched a quality and performance measures work group, which began by considering some 200 measures. Deliberations and voting proceeded through a series of committees with the Green Mountain Care Board finally signing off on the metrics. This multi-tiered voting process fueled considerable conflict. As one stakeholder observed, “developing performance measures” was one of the “hardest issues” and was the “most heated and debated topic” (Interview 29: 4).

In general, state Medicaid officials bowed to the preferences of providers in seeking to minimize new reporting costs. The four states each selected from 30 to 35 metrics—a number comparable to what the Medicare program used to evaluate its ACOs.¹¹ They tended to use indicators linked to claims rather than more nuanced metrics that might be derived from medical charts. Nor were the metrics appreciably tailored to Medicaid enrollees. The metrics incorporated the “usual suspects” such as patient experience tapped by surveys, preventive measures (e.g., blood pressure monitoring and control), and treatment efficacy (e.g., 30-day readmission rate for those discharged from a hospital; Interview 20: 6). Only a handful of metrics focused on mental health and substance abuse and none on social determinants. More specifically, Vermont had three behavioral health measures, New Jersey, two, and Minnesota, one. Maine also had two measures focused, respectively, on mental health and substance abuse but made them optional rather than mandatory.¹² Stakeholders in the four states generally acknowledged that the quality metrics did not go far in targeting the unique needs of Medicaid enrollees. A Maine stakeholder observed that if ACOs “were really focused

on changing care for Medicaid beneficiaries,” they would be “paying a lot more attention” to “mental health, substance abuse, [and] social health needs” (Interview 20: 13).

Viewed broadly, the collaborative governance strategy rooted in administrative flexibility weakened the ability of state officials to impose more behavioral health and social metrics on providers. This pattern is consistent with the argument that vague statutes at times enable interest groups to dominate or even capture administrators (e.g., Lowi, 1969). Such an interpretation should, however, be tempered by three considerations. First, a trade-off likely existed between provider participation in the ACOs and the adoption of tailored metrics. If political principals had promoted statutory measures or formal administrative rules requiring more tailored indicators, providers would probably have formed fewer ACOs. Second, provider resistance to unique Medicaid metrics had roots in legitimate policy concerns about metric overload—whether the benefits of tailored indicators exceeded the administrative costs and burdens they imposed.

Finally, the metrics adopted were not devoid of merit. The states adopted enough of them—over 30 per ACO—to tap multiple dimensions of quality. Many of the chosen indicators have been vetted by expert agencies and won praise for meeting exacting social science standards.¹³ Moreover, the metrics generally speak to a fundamental objective of the ACOs—the reduction of preventable hospitalizations and emergency room use. No feasible set of metrics can eradicate all uncertainty about the quality of care patients receive. So too, the efficacy of these indicators for P4P also depends on the evaluative standards applied to them (e.g., the amount that must be saved to trigger sharing with the ACO) (Barnow & Heinrich, 2010). Still, the metrics employed by the Medicaid ACOs, if far from tailored, tap important aspects of quality.

Lessons, Limitations, and Future Research

What more general lessons or propositions for public administration emerge from our analysis? Three deserve particular note. *First, this research points to the importance of how collaborative governance strategies which facilitate administrative flexibility shape the formation and efficacy of P4P networks.* Some of our findings support the view found in the literature that flexibility tends to facilitate performance. The two states that had the most success in fostering Medicaid ACO formation and penetration delegated vast discretion to Medicaid administrators. Students of administrative flexibility have identified agency capacity and professionalism as intervening variables contributing to salutary performance results (e.g., Miller & Whitford, 2016). Both tend to be present in state Medicaid agencies, which have long histories

of operating the program. These agencies have over the decades honed their information systems in ways that allow them to track costs and provider payment claims. Given the program's complexity and huge role in drawing down federal funds, governors of both political parties place a premium on appointing and sustaining experienced, capable Medicaid staffs. State Medicaid directors have their own formal association which meets periodically to discuss program issues.

Our findings do not, however, uniformly point to the virtues of administrative flexibility as a catalyst for performance. ACO penetration appears to be a function of the *interaction* between ample administrative discretion and support from political principals. Medicaid ACOs appeared to be low-reward P4P systems of limited appeal to providers. Where the initiative seemed to exclusively derive from Medicaid administrators (Maine), many chose not to participate. Providers had more incentive to participate if they sensed it was a priority of the governor (as in Minnesota and Vermont), as it would buttress their reputation for responsiveness with a key political principal. So too, administrative flexibility to establish performance indicators impeded the adoption of behavioral health and social metrics. The political strength of providers and the fact that statutes and administrative rules did not mandate their participation in ACOs made it relatively easy for them to resist tailored Medicaid metrics.

Second, this study highlights the importance of provider perceptions of metric overload in shaping the administrative politics of performance indicator selection in a P4P system. Efforts to establish P4P systems tend to kindle negotiation, bargaining, and other tactical interchanges between political principals pursuing performance-based accountability and the administrative agents targeted for assessment. Administrative agents naturally prefer indicators they can effectively shape that will cast them in a favorable light. Our interviews, however, strongly suggest that provider concern about the transaction costs associated with performance metric overload was the most potent factor driving their resistance to behavioral health and social indicators. Furthermore, empirical studies suggests that this concern about reporting costs was far from fanciful. Going forward, P4P research should more systematically target both the perceptions administrative agents have of these costs and more objective assessments of them.

The performance management literature provides insight into the role of metric overload in shaping interactions between principals and administrative agents. In their cross-national study of performance budgeting, for instance, Moynihan and Beazley (2016, pp. 2-4) observe that "countries typically produce too many metrics, leading to information overload" with some governments responding by reducing the number of performance indicators

(see also Frederickson & Frederickson, 2006; Radin, 2006). In the case of the Medicaid ACOs, the strategic interaction between principals and agents over metrics takes place in a more fragmented setting than a government's budgetary processes or many contracting contexts. Encouraged and supported by private professional entities (e.g., the National Quality Forum), multiple public (especially Medicare), and commercial payers seek to impose performance metrics on providers thereby fueling overload. Thus, the strategic interaction of providers with Medicaid officials over ACO metrics partially reflected the outcomes of their negotiations with an array of other payers. Above all, they did not want to add to the metrics for which they were already being held accountable. In the interest of holding down transaction costs, providers resist tailoring and become committed to congruence—or one size fits all payers—in the administrative politics of performance metrics.

Third, studies of third-party federalism need to become more nuanced and expansive in considering the type of public-private arrangements shaping performance. Research on third-party federalism has tended to focus on how state or local government grantees contract with existing private organizations to deliver services. For instance, Kettl (1981) focused on the performance and accountability problems city officials in Richmond, Virginia faced as they contracted with private organizations to provide services subsidized by federal grants. In a similar vein, Terman and Feiock (2015) analyzed how local governments used private contractors and subcontractors to implement projects under the federal Energy Efficiency and Conservation Block Grant Program. They identified several contracting factors that led to delays in reaching federal program goals. While not focused explicitly on the dynamics of third-party federalism, other studies have also illuminated P4P contracting by state and local governments implementing federal grants (e.g., Dias & Maynard-Moody, 2007; Heinrich & Choi, 2007).

The Medicaid program in general and its ACOs in particular represent a different type of third-party federalism than the conventional contracting model—one that has yet to be adequately explored by students of performance management.¹⁴ Medicaid embodies a consumer-driven market approach with government authorizing scores of private agents to receive a payment for each service or product; each of the program's beneficiaries then choose a particular provider. Unlike a conventional contracting process, private agents under this approach do not have to be the winning bidder to be paid by Medicaid. In the case of ACOs, Medicaid pays the providers for serving program beneficiaries even if they decline to join. In essence, providers can choose to be paid under an ACO model or a conventional fee-for-service arrangement without the trappings of a robust P4P system. The bargaining position of government officials vis-à-vis private providers therefore tends to

be weaker in the case of ACOs. So too, the ACO model to a greater degree involves the voluntary creation of formal networks rather than reliance on existing private organizations as tends to be the case with the conventional contracting model. Efforts to understand the challenges of performance and accountability under third-party federalism need to factor in these and related variations on the private provider theme. In addition to Medicaid, other programs featuring a consumer-driven market approach anchored in third-party federalism, such as housing vouchers and food stamps, deserve analytic attention.

This study of Medicaid ACOs has, of course, limitations. An array of processes and variables pertinent to these voluntary P4P networks fall beyond the ken of this study. For instance, future research ought to explore the relationship between collaborative governance strategies fostering administrative flexibility and two P4P pitfalls that have garnered much attention in the performance literature—goal displacement (or effort substitution) and gaming (e.g., Grizzle, 2002; Heinrich, 2007; Hood, 2012; Kelman & Friedman, 2009). It deserves emphasis that the standard for assessing ACOs should rest on a comparison not to a perfect system devoid of goal displacement and gaming but to an existing system which also has its share of these imperfections.

So too, future research should probe the links between collaborative governance strategies rooted in administrative flexibility and the efficacy of the Medicaid ACOs. Available evidence does not permit a definitive assessment of whether the Medicaid ACOs in the four states constitute P4P success stories, failures, or something in between. Some research suggests that shared savings ACOs can be a useful component of a value-based portfolio. Nearly 30% of Medicare ACOs qualified for shared savings awards in 2014; mean scores on the great majority of Medicare quality metrics rose (Baseman et al., 2016, pp. 21-22; Shortell et al., 2015). In the case of the Medicaid ACO initiatives, early returns from Minnesota appear promising. One study found that from 2013 through 2015, Medicaid ACOs in that state generated total savings of US\$157 million. Most of the ACOs did well enough on the quality metrics to receive shared savings (Blewett, Spencer, & Huckfeldt, 2017). It is, however, far too early to judge whether the ACOs in Maine, New Jersey, and Vermont will replicate this success.

Conclusion

Third-party federalism is a pervasive phenomenon in America governance. It challenges public administration scholars to illuminate simultaneously the dynamics of vertical intergovernmental management and those defining the

relationship between government grantees and private entities delivering services. The extent to which jurisdictions receiving grants seek to impose various types of P4P regimes on service providers and the collaborative governance strategies they employ deserves additional scholarly attention. The dynamics underlying the conventional contracting model and the consumer-driven market approach should be more thoroughly compared. The health care arena provides a promising venue for such research. Nowhere has the quest to develop P4P under the banner of value-based purchasing been more striking than in this policy sphere. State Medicaid programs have often been at center stage in this quest. This study suggests that the degree to which state collaborative governance strategies foster administrative flexibility markedly shapes the fortunes of P4P initiatives that seek to create voluntary provider networks which simultaneously save money and enhance health care quality.

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Notes

1. For instance, the Medicare Access and CHIP Reauthorization Act of 2015, which received overwhelming bipartisan support, promoted new forms of P4P for health care providers.
2. Other states, such as Colorado and Oregon, also have P4P systems for collaborating groups of providers, but these systems do not feature all the elements of the core accountable care organization (ACO) model, especially the use of shared savings to generate the bonus pools (Lloyd, Houston, & McGinnis, 2015).
3. Several interviews involved multiple individuals from the same stakeholder organization (e.g., an ACO applicant).

4. The law went into effect 60 days after passage in October 2011.
5. Consistent with their legalistic approach to interpreting the statute, Medicaid officials had rejected the request of stakeholders to adopt a more flexible interpretation of the participation requirement in the rule-making process.
6. Neighboring North Dakota and Wisconsin as well as Idaho.
7. See Heinrich and Choi (2007) for a more general assessment of risk sharing in public-private contracting.
8. Revenue loss within the ACO might also be mitigated if enrollees reduced the proportion of their care received from nonACO providers. ACO primary care providers may go out of their way to refer patients to specialists within the ACO network. Medicaid officials would still tabulate the savings generated in serving enrollees, but much of it might come from revenue loss to nonACO providers.
9. Although beyond the ken of this study, potentially relevant factors include state political culture, administrative capacity, and, perhaps especially, norms and networks of trust and reciprocity (i.e., social capital).
10. Various empirical models and methods yield somewhat different estimates (DeLia, 2016).
11. In the case of Maine, this estimate counts each patient survey question as one indicator.
12. The behavioral health metrics typically focused on certain outputs. For instance, Vermont gauged whether providers routinely screened patients for depression and prepared a follow-up plan when they diagnosed it. The state also monitored whether a patient hospitalized for mental illness had a follow-up visit within 7 days.
13. See, for instance, Cleary (2016) on the Consumer Assessment of Health care Providers and Systems survey.
14. Over the last two decades, many state Medicaid programs have moved toward a more conventional contractual model by turning to managed care organizations to serve enrollees. But beneficiaries still have the freedom to drive Medicaid payments by selecting from among competing managed care organizations and among the providers employed by the organization.

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