CHCS Center for Health Care Strategies, Inc.

Policy Brief

The Balancing Act: Integrating Medicaid Accountable Care Organizations into a Managed Care Environment

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Accountable care organizations (ACOs) have the potential to improve health care quality and control rising costs. States can facilitate the implementation of Medicaid ACO models by complementing the existing managed care infrastructure, aligning ACOs across payers, and, clearly delineating ACO and managed care organization responsibilities and performance expectations. This brief addresses key considerations to guide state Medicaid agencies in successfully integrating ACOs within a managed care environment.

Foreword

Among the most rewarding aspects of working with leading-edge Medicaid stakeholders is the opportunity to help shape transformational innovations as they unfold. Over the past two years, with guidance and steady support from The Commonwealth Fund's *Pamela Riley* and *Stuart Guterman*, along with *Kate Nordahl* from the Massachusetts Medicaid Policy Institute, we have convened a mix of early innovating state teams to explore ACO opportunities. Medicaid officials from Massachusetts, Maine, Minnesota, New Jersey, Oregon, Texas, and Vermont as well as select national health plan representatives, academic health policy experts, and provider leaders from the Camden Coalition of Health Care Providers are participating in a collaborative focused on developing accountable care organizations (ACOs) (see list on page 2).

Our exchanges have led to valuable problem solving and peer-to-peer teaching, as well as the development of technical assistance resources to help states and other stakeholders construct ACO platforms that will work under varied delivery system circumstances and constraints. We hope that this brief on creating ACOs in a Medicaid managed care environment will make it easier for more states to determine if and how ACOs can work for them to strengthen the overall health of the population, improve the outcomes of care, and manage the growth in their health care costs.

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

Currently, three different ACO models have emerged within Medicaid: (1) a provider-driven model (Massachusetts, Minnesota, and Vermont); (2) a health plan-driven model (Oregon); and (3) a community-driven model (Colorado, Maine, and New Jersey). The provider-driven model, which aligns closely with Medicare ACO models, is emerging in states with several Medicare and commercial ACOs offering opportunities for multi-payer alignment. In health plan-driven models, the health plan is actively engaged with providers in forming an ACO, delivering data and building the capacity of providers who assume greater accountability for coordinating patient care. Finally, community-driven ACOs emphasize community-wide care delivery infrastructures, such as care teams and standardized data feeds. This enables all providers to develop care delivery approaches that leverage partnerships with social services and community-based organizations.

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States are selecting the model that best meets the underlying delivery system strengths. All three models have been implemented within a mix of Medicaid fee-for-service, managed care, and primary care case management (PCCM) environments. Several states including Massachusetts, Minnesota, New Jersey, Oregon, and Vermont are either designing or implementing Medicaid ACOs within their respective Medicaid managed care systems.

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

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

Background: ACO Implementation in a Managed Care Environment

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

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

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

Given the growing prevalence of Medicaid managed care—more than 74 percent of Medicaid beneficiaries were enrolled in managed care in 2011[1]—states must consider how ACOs will function within a managed care environment and what roles MCOs and ACOs will assume over time. The transition of responsibility is likely to occur gradually and unevenly, as ACOs build their capabilities and MCOs adjust their activities in response. States will need to consider the levers at their disposal, as both purchasers and policymakers, to make this transition smooth, efficient, and consistent across the system.

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

Essential Decisions for Implementing ACOs within Managed Care

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

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

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

1. Weighing Contracting Options

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

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

2. Sharing Savings and Adjusting Capitation Rates

States will need to identify vehicles to share savings with the MCOs. In the short term, this can be achieved via capitation payments. If ACOs achieve

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

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

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

3. *Establishing Performance Metrics, Monitoring, and Oversight*

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

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

Aligning Core ACO Activities across Payers

Within an ACO program, states will want to determine which responsibilities to mandate contractually and which to leave for ACOs and MCOs to negotiate independently. Stimulating creative innovation among MCOs and providers is

important, particularly given that ACO models are relatively new and little evidence exists on what makes models effective. To create the right balance between alignment and innovation, states may wish to identify a core set of elements that all of their MCOs are contractually required to adhere to, while providing both parties the flexibility to enhance the core model in ways they deem advantageous.

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

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

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

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

2. *Standardizing Payment Structures*

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

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

Aligning health information technology (HIT) and data-sharing across participating payers are important to enable ACOs to make data-driven patient and cost management decisions. A lack of a uniform data formats will require ACOs to reformat files across multiple MCOs in order to combine into a single uniform database. Further, ACOs may have to

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reformat this database repeatedly as individual MCOs change or update fields or record-keeping software. Performance reports that are fragmented across MCOs will make it difficult for providers to efficiently manage their attributed patient panels.

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

4. *Establishing Consistent Provider Supports*

Creating uniform provider supports, such as training and coaching programs, technical assistance, learning collaboratives, and other tools and resources, may enable MCOs and ACOs to promote high-performing providers and influence continuous quality improvement.[2] Several states, such as Maine, Massachusetts, Minnesota, Oregon, and Vermont, are working on provider learning collaboratives to help build provider capacity and share lessons broadly.

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

Delineating Complementary ACO and MCO Responsibilities

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

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

contractual changes that result in large shifts between medical and administrative expenses. Since medical expenses now include both medical claims paid *and* any funds spent on quality improvement activities, MCOs have expanded flexibility pertaining to such activities.

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

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

Ultimately, there is no one-size-fits all approach. States will base their decisions on an assessment of MCO strengths and capacity for innovation and ACO readiness to assume certain responsibilities. A state's approach will depend on a variety of factors, including: (a) the proportion of the MCOs' provider networks participating in the ACO program; (b) the extent to which MCOs will continue to support certain functions among non-ACO providers; (c) its provider makeup (large practices vs. small practices); and (d) the state's geography (urban vs. rural). If MCOs and ACOs are given flexibility to develop their own innovative arrangements with one another beyond the core standardized elements identified earlier, market forces may help states to delineate further. For example, an MCO may seek a competitive advantage by working closely with robust ACOs to support tailored reports and build analytic capabilities. Indeed, over time the contractual relationships between MCOs and ACOs may move toward exclusive arrangements, as an MCO invests in certain ACOs. Finally, as these roles crystallize, state Medicaid agencies could consider creating a standardized certification process or using national certification programs, such as those established by the National Committee for Quality Assurance,[4] to promote a clear path toward a defined set of responsibilities.

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

1. Care Coordination, Care Management, and Disease Management

ACOs are designed to give providers financial incentives linked to the effective coordination of patient care via shared savings, shared risk, or global payment arrangements. The model presumes that providers, given their clinical training and direct patient contact, are best positioned to improve patient care in partnership with care teams, social support services, and community-based organizations. Telephonic care and disease management, where MCOs are relatively removed from patient care, is an obvious role that might be better suited to ACOs. ACOs often focus first on high-risk patients, where the opportunity for quality and cost improvement is the greatest and the impact of telephonic care management is likely to be minimal.[5]

To ease this transition, states should consider a phased approach, working with their ACOs and MCOs to enable an efficient reallocation of resources. For example, states may explicitly transition care management responsibilities for high-cost, complex patients to ACOs in an initial phase, while keeping health plan disease management programs in place. Over time, as ACOs demonstrate capacity for broader population management, disease management and prevention programs may also shift to ACOs. Nonetheless, MCOs can still play a critical role in supporting patient care coordination efforts. For example, MCOs can notify ACOs once an attributed

patient has been admitted for an inpatient stay or help establish connections with specialists who are not affiliated with the ACO.

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

2. *Quality Improvement*

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

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

3. *Data-Sharing and Analytics*

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

Consequently, states may wish to encourage or require plans to provide a defined set of HIPAA-compliant data and analytics to ACOs. For example, MCOs can provide recurring claims data feeds and provide in-depth analytic reports to help ACOs identify targeted opportunities for cost reduction. While some MCOs may provide these services to ACOs voluntarily, states should consider the extent to which contractual requirements will facilitate this data-sharing more efficiently.

States must also make decisions regarding how to measure quality, efficiency, and costs, including how often ACOs and MCOs must report data, which entity will report the information, what information will be reported, how the information will be transmitted, and how often performance measurement will be conducted. These are important considerations, as states should distribute these roles equitably to avoid overtaxing ACOs, MCOs, or both.

4. *Utilization and Risk Management*

Utilization management (UM) refers to the evaluation of the medical necessity and efficiency of the use of health care services, procedures, and facilities under the provisions of the applicable health benefits plan.[6] ACOs may be able to assume aspects of UM once they hone their care management and data analytics skills, establish effective partnerships with a network of specialists and hospitals, and assume downside financial risk. For example, California health plans have established a delegated model among medical groups and independent practice associations, which receive partially capitated payments and often have close partnerships with hospitals. Delegating UM to ACOs can help to boost provider satisfaction, since MCO oversight is often perceived as a burden.[7] As ACOs become more sophisticated and bear downside risk, the use of prior authorization may become unnecessary since the ACO will bear the cost of duplicative or expensive procedures. However, if ACOs do not have the building blocks of financial risk management, including data analytics and care management, UM may best reside with MCOs. Massachusetts, for example, has decided to leave UM responsibilities with its plans during its ACO Pilot.

5. *Development and Distribution of Evidence-Based Guidelines*

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

6. *Training and Coaching*

Most states are planning to give ACO providers some level of technical assistance. As states evaluate the technical assistance needs of their ACO providers, they may also evaluate MCO capacity to provide those resources.

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

As noted earlier, to achieve economies of scale and minimize provider burdens, there may be benefits to creating an all-payer platform to deliver provider training. However, MCOs may not choose to invest in resources that will benefit other payers. Therefore, states will need to determine the right balance of

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consistency and incentives for innovation. If MCOs have a clear set of skills in this realm, states may consider letting MCOs apply to requests for applications to support such services.

Conclusion

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

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About the Center for Health Care Strategies

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

Endnotes

[1] "Medicaid Managed Care Enrollees as a Percent of State Medicaid Enrollees." Kaiser Family Foundation State Health Facts. http://kff.org/medicaid/state-indicator/medicaid-managed-care-as-a-of-medicaid/.

[2] R. Mahadevan. "Key Considerations for Supporting Medicaid Accountable Care Organization Providers." Center for Health Care Strategies. June 2013.

[3] Some or all of these issues may not apply for states that adopt health plan-driven models. These models may have a less clearly defined relationship between MCOs and ACOs, especially if ACOs and MCOs act as a single entity, as in Oregon's Coordinated Care Organization (CCO) Model.

[4] "Accountable Care Organization Accreditation." National Committee for Quality Assurance. http://www.ncqa.org/Programs/Accreditation/AccountableCareOrganizationACO.aspx.

[5] C. Michalopoulos, M. Manno, S. Kim, and A. Warren. "Managing Health Care for Medicaid Recipients with Disabilities: Final Report on the Colorado Access Coordinated Care Pilot Program." MDRC, April 2013.

[6] Definition Utilization Review Accreditation Commission (URAC)

[7] P.Ginsburg, J. Christianson, G. Cohen, and A. Liebhaber. "Shifting Ground: Erosion of the Delegated Model in California." California HealthCare Foundation, December 2009.