

Medicaid Accountable Care Organizations: Program Characteristics in Leading-Edge States

As state leaders move beyond their focus on the coverage challenges arising from the Affordable Care Act (ACA), they are paying increasing attention to the payment and delivery system reform opportunities spurred by both the law itself and by changes in the broader health care marketplace. States have been actively pursuing innovative care delivery and payment models to improve the capacity of the health system to deliver high value care and increase provider accountability, particularly for high-need populations facing multiple health and social challenges.

The need to foster integrated care delivery and address social determinants of health has led to the development of accountable care organizations (ACOs) in Medicaid. The common goal of these initiatives is to coordinate a wide array of needed services to improve the quality of care and curb costly and avoidable hospitalizations of Medicaid beneficiaries, particularly those with multiple chronic conditions and behavioral health needs. Given these extensive transformation efforts, states are leveraging existing investments in managed care and primary care to guide the development of their Medicaid ACO programs.

With support from The Commonwealth Fund, the Center for Health Care Strategies (CHCS) has been working with leading-edge states to accelerate ACO program implementation. The following matrix presents key features and requirements for ACO programs in seven of the states participating in the *Medicaid ACO Learning Collaborative*: **Colorado, Maine, Massachusetts, Minnesota, New Jersey, Oregon, and Vermont**. The matrix outlines how each state has configured key ACO program features including: governance; provider eligibility; covered populations; scope of accountable services; required functions; payment models; and quality measures. The details from these seven ACO programs should inform additional states as they consider their own ACO approaches. CHCS will continue to work with these and other emerging state leaders to update the attached matrix and monitor their progress in the months ahead.

The information in this document was gathered through group discussions and from state-specific documents, such as Medicaid ACO provider solicitations (e.g., Requests for Information/Proposals/Applications and State Plan Amendments); see resource links on page two for more information.

IN BRIEF

Accountable care organizations (ACOs) offer a new vehicle for states to improve the quality and cost-effectiveness of care for Medicaid beneficiaries. This resource presents key features and requirements for ACOs in seven states: **Colorado, Maine, Massachusetts, Minnesota, New Jersey, Oregon, and Vermont**. It was developed by the Center for Health Care Strategies (CHCS) with funding from The Commonwealth Fund. The multi-state initiative is supporting several states in designing and implementing Medicaid ACO programs. Visit www.chcs.org for more information.

Reference Material Links

Following are links to resources used to gather information into the ACO Program Design Matrix:

Colorado

- RCCO Contract:
<http://www.colorado.gov/cs/Satellite?blobcol=urldata&blobheader=application%2Fpdf&blobkey=id&blobtable=MungoBlobs&blobwhere=1251860562103&ssbinary=true>

Maine

- RFA: http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/Accountable_Communities_RFA.pdf

Massachusetts

- RFA:
https://www.ebidsourcing.com/displayPublicSolUniversalSummRFRList.do?menu_id=2.3.3.1.5&docId=143813&org.apache.struts.taglib.html.TOKEN=6e26d1336d4fe536c5aac7d118951f18

Minnesota

- RFP:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_177103
- SPA: <http://www.medicaid.gov/State-resource-center/Medicaid-State-Plan-Amendments/Downloads/MN/MN-11-031-Att.pdf>
- Additional resources:
http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_DYNAMIC_CONVERSION&RevisionSelectionMethod=LatestReleased&dDocName=dhs16_161441

New Jersey

- ACO Standards: http://www.njleg.state.nj.us/2010/Bills/PL11/114_.pdf

Oregon

- RFA: https://cco.health.oregon.gov/RFA/Documents/CCO_RFA_without_separate_documents_Final_3-18-12.pdf
- Waiver: <http://www.oregon.gov/oha/OHPB/Documents/cms-waiver.pdf>

Vermont

- ACO Standards: http://gmcbboard.vermont.gov/sites/gmcbboard/files/Medicaid_ACO_Standards_Draft.pdf

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.

Medicaid Accountable Care Program Design Characteristics

State Program Name	Organizational Structure/Governance	Provider Eligibility and Requirements	Covered Populations	Scope of Accountable Services	Required Functions (e.g., reporting, care management, HIE)	Payment Models/Risk	Quality Measures
<p>Colorado Accountable Care Collaborative (ACC)</p>	<ul style="list-style-type: none"> ACC program consists of seven competitively selected Regional Care Collaborative Organizations (RCCOs). RCCOs must have permanently assigned Contract Manager, Financial Manager, and Chief Medical Officer. RCCOs must submit quarterly summary of stakeholder feedback. 	<ul style="list-style-type: none"> Primary Care Medical Providers (PCMPs) must contract with an RCCO. PCMPs must be enrolled as Colorado Medicaid providers and have interest and expertise in serving special populations, including: <ul style="list-style-type: none"> Physically or developmentally disabled; Children and aged; and Members with complex behavioral or physical health needs. Participating PCMP practices must either be certified as providers in the Medicaid and CHP+ Medical Homes for Children Program or be a federally qualified health center, a rural health clinic, clinic or other group practice with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology. 	<p>All enrollees eligible for full Medicaid benefits can enroll in ACC, by selecting a PCMP linked to the RCCO in their region.</p> <p>Enrollment in the ACC Program is voluntary and members can “opt out.” Dual eligibles can opt in.</p> <p>Patients residing in any federal, state, or county institution at the time of enrollment are excluded; any beneficiary who becomes a resident of an institution after their enrollment in the ACC Program may choose to remain in the program or request disenrollment.</p>	<p>Accountable for comprehensive primary care needs through the PCMPs, including preventive care and screenings, prenatal care, and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services for members age 20 and under.</p> <p>Accountable for improved health outcomes in region (based on performance of noted quality measures).</p>	<p>Ensure that care is coordinated with specialists in accordance with state-approved Clinical Referral Protocol. A care coordinator will be assigned to each beneficiary.</p> <p>Support PCMPs with integrated behavioral and primary care and the implementation of ACC program through formal training classes and forums.</p> <p>Apply statewide data and analytics functionality to support transparent, secure data-sharing and enable monitoring and measurement of regional health care costs and outcomes.</p> <p>Statewide Data Analytics Contractor (SDAC) makes claims data available to RCCO and PCMPs through an ACC Program Web Portal.</p>	<ul style="list-style-type: none"> Per Member Per Month (PMPM) payments based on the monthly number of enrollments in the state’s Medicaid Management Information System (MMIS). Quarterly incentive payments made when the RCCO meets or exceeds targets, as calculated based on region-wide performance on four measures (<i>noted in Quality Measures column</i>). 	<p>Four measures and the performance targets selected by RCCO are used as the basis for measuring performance against regional baselines:</p> <ul style="list-style-type: none"> Emergency Room Visits per 1,000 full-time enrollees (FTEs) Hospital Readmissions per 1,000 FTEs Outpatient Service Utilization/ MRI, CT scans, and tests per 1,000 FTEs Well-Child Visits per 1,000 FTEs <p>The RCCO submits a performance improvement plan (PIP) annually that includes health and health care performance improvement goals, at least two targeted performance improvement activities, and objectives, using national standards, the state’s priorities, and the region’s needs.</p> <p>Every quarter, the RCCO submits reports that show performance on the measures included in the performance improvement plan.</p>

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<p style="text-align: center;">Maine Accountable Communities (AC)</p>	<ul style="list-style-type: none"> ▪ Can be comprised of one or multiple provider organizations, of similar or different systems and ownership. ▪ Must designate a legal lead entity to contract with the state to receive and distribute state payments (shared gains or losses); and maintain provider agreements. ▪ Governance structure must include at least two Medicaid members – or their caregivers – served by the ACO. ▪ Must develop partnerships with one or more public health entities, i.e., community organizations, social service agencies, local government. 	<ul style="list-style-type: none"> ▪ Eligible providers must include Medicaid physicians, nurse practitioners, certified nurse midwives, or physician assistants who: <ul style="list-style-type: none"> ○ Have a primary specialty designation of internal medicine, general practice, family practice, pediatrics, geriatric medicine, obstetrics or gynecology; and/or ○ Practice in a rural health center, federally qualified health center, an Indian Health Services center, or school health center. ▪ Required to have a minimum of 1,000 Medicaid members assigned to the ACO. 	<ul style="list-style-type: none"> ▪ All Medicaid beneficiaries, including: <ul style="list-style-type: none"> ○ Those under the Categorically Needy, Medically Needy, and SSI-related coverage groups; ○ Participants in home and community-based and/or HIV waivers; and ○ Dual eligibles with full Medicaid benefits. 	<ul style="list-style-type: none"> ▪ Must deliver primary care services and coordinate care with specialty providers, including behavioral health for non-integrated practices, all hospitals in the proposed service area and long-term services and supports for those ACOs that opt to include these costs under their ACO, <i>regardless of whether these services are directly delivered by the ACO.</i> ▪ Must leverage existing care coordination resources through contractual or informal partnerships with at least one provider of each of the following specialties: <ul style="list-style-type: none"> ○ Chronic conditions, including developmental disabilities; ○ Long-term care; and ○ Behavioral health. 	<ul style="list-style-type: none"> ▪ Integration of physical and behavioral health. ▪ Practice and system transformation. ▪ Inclusion of patients/families in leadership roles and as partners in care and in organizational quality improvement activities. ▪ Participation in accountable community and/or ACO learning collaboratives. 	<ul style="list-style-type: none"> ▪ <i>Model 1:</i> Shared savings contingent on quality performance and patient experience outcomes. Shared savings payments are capped at 10% Total Cost of Care (TCOC). ▪ <i>Model 2:</i> Incorporates shared risk in the second and third year, based on the inverse of the shared savings rate (may not exceed 60 percent.) Payments are capped at 15% TCOC for Years 1-3. ▪ To qualify for shared savings, an ACO average TCOC for the performance year must be below its benchmark TCOC by 2-2.5%, depending on program size. TCOC calculated using risk-adjusted FFS claims data. ▪ All risk/gain payments calculated/disbursed annually via a reconciliation payment. Providers will continue to receive FFS payments in the performance year. 	<p>Quality of care will be measured using 15 core measures and six elective measures across the following four key domains:</p> <ol style="list-style-type: none"> 1) Care Coordination/Patient Safety (4 core, 1 elective, 2 monitoring/evaluation); 2) Patient Experience (1 core); 3) Preventive Health (4 core); and 4) At-Risk Populations: <ul style="list-style-type: none"> ▪ Asthma (1 core, 1 elective) ▪ Diabetes (3 core, 2 elective, 2 monitoring/evaluation) ▪ Chronic Obstructive Pulmonary Disease (COPD) (1 elective) ▪ Coronary artery disease (CAD) (1 elective) ▪ Behavioral Health (2 core, 1 monitoring/evaluation) <p>The core and elective measure sets consist of those measures for which the ACO has accountability for payment purposes. ACOs must select three of the seven elective measures on which to be measured together with the core measure set, for a total of 18 measures tied to shared savings payment per ACO. In addition, five measures have been identified for monitoring and evaluation purposes only.</p>

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Massachusetts Primary Care Payment Reform (PCPR) Initiative	N/A	<ul style="list-style-type: none"> Must have at least 5,000 members on panel to qualify for symmetric shared savings, 3,000 for upside-risk only. Tier 2 and 3 practices must maintain a master's or doctoral-level behavioral health provider who is co-located at each participating practice site, for no fewer than 40 hours per week. 	All Medicaid managed care beneficiaries currently in the PCC Plan and MCO plans (excludes individuals who are dually eligible for Medicare and Medicaid).	<ul style="list-style-type: none"> Provide medically necessary services across the care continuum including physical and behavioral health services and engage patients in shared decision-making, including on palliative and long-term care services and supports. Integrate the provision of behavioral health services and primary care services by implementing behavioral health (BH) elements into three tiers of services: <ul style="list-style-type: none"> <i>Tier 1</i> - Case management/coordination services; no fee-for-service billable services. <i>Tier 2</i> – Tier 1 services plus brief interventions, screening/assessment/triage; fee-for-service billable outpatient BH services by master's and bachelor's-level professionals. <i>Tier 3</i> – Tier 1 services plus psychiatric assessments, medication management, psychotherapy; fee-for-service billable outpatient BH services provided by prescribing clinicians/psychotherapists. 	<ul style="list-style-type: none"> Maintain functional capabilities to coordinate care and financial payments among providers. Implementation of interoperable health information technology for the purposes of care delivery coordination and population management. Electronic medical record system with patient registry functionality, including the capability to: <ul style="list-style-type: none"> Produce at least one report to support evidence-based protocols for chronic disease management; Support documentation of treatment plans; and Identify and assign a primary care provider to each panel enrollee. 	<p>Three payment streams:</p> <ol style="list-style-type: none"> <i>Comprehensive Primary Care Payment</i>: Risk-adjusted, per Panel Enrollee, per month payment for a defined set of primary care services and options for a defined set of BH services. <i>Quality Incentive Payment</i>: Annual incentive (as percentage bonus to base payment) for quality performance. <i>Shared Savings Payment</i>: Primary care providers share in savings on non-primary-care spending, including hospital and specialist services. <p>Each applicant may have the choice of whether to include or exclude long-term services and supports from the shared savings/risk payment calculations.</p>	<ul style="list-style-type: none"> 23 quality measures have been defined in the following areas: <ul style="list-style-type: none"> Adult prevention and screening (5); Behavioral health (4); Pediatric health (8); Adult chronic conditions (2); Access (2); and Care coordination (2).

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<p>Minnesota Integrated Health Partnerships (IHP)</p>	<ul style="list-style-type: none"> ▪ ACOs fall into two categories: <ol style="list-style-type: none"> 1) <i>Virtual</i>: Primary care providers and/or multi-specialty provider groups that are not formally integrated with a hospital or integrated system via aligned financial arrangements and common clinical and information systems. 2) <i>Integrated</i>: Integrated delivery system that provides a broad spectrum of outpatient and inpatient care. ▪ Managed care organizations must participate in the shared savings program with ACOs in their networks, but cannot directly participate as ACOs. ▪ May include an organizing entity and agreement of shared governance with a non-profit or a county or group of counties. 	<ul style="list-style-type: none"> ▪ Provider organizations with a Medicaid population between 1,000-2,000 attributed participants are eligible only for the virtual IHP model, regardless of their level of formal integration. ▪ Must serve at least 2,000 attributed participants to be eligible for the integrated model. ▪ Must be enrolled as Medicaid providers and incorporate into the care delivery model partnerships with community organizations, social service agencies, counties, and demonstrate that they are engaging patients and families as partners. 	<ul style="list-style-type: none"> ▪ Eligible adults and children in Medicaid, who are enrolled under both fee-for-service and managed care programs (who are not dually eligible for Medicaid and Medicare), including: <ul style="list-style-type: none"> ○ Pregnant women, children under 21, adults without children, and those with state-funded medical assistance; and ○ Recipients receiving medical assistance due to blindness or disability. 	<ul style="list-style-type: none"> ▪ Included in the ACO's total cost of care calculation are services provided by primary care entities as well as laboratory, radiology, pharmacy, chiropractic, vision, podiatry, rehabilitation therapies, audiology, outpatient mental health and chemical dependency services (intensive or residential services are excluded), outpatient hospital, ambulatory surgery center services, inpatient hospital, anesthesia, hospice, home health (except personal care assistant services) and private duty nursing services. 	<ul style="list-style-type: none"> ▪ Established processes to monitor and ensure the quality of care provided. ▪ Participation in quality measurement and improvement activities as required by the state. ▪ Demonstrate the capacity to receive data from the state via secure electronic processes ▪ Stratify data to identify opportunities for patient engagement and care model strategies needed to improve outcomes. 	<p><i>Virtual ACOs:</i></p> <ul style="list-style-type: none"> ▪ Shared savings model contingent on quality and patient experience outcomes. Distributes the difference between annual expected and actual realized total cost of care if savings are achieved. ▪ Required to share gains above the 2% minimum performance threshold equally (50/50) with the state for all three years of the demonstration. <p><i>Integrated ACOs:</i></p> <ul style="list-style-type: none"> ▪ Shared risk that builds toward a two-way risk sharing model that distributes difference, <i>whether or not</i> savings are achieved, contingent on quality and patient experience measures. ▪ <i>Year 1</i>: Share gains above the 2% minimum performance threshold equally with the state. ▪ <i>Year 2</i>: Assume some downside risk, at ratio of 2:1 (gain-sharing to loss-sharing thresholds). ▪ <i>Year 3</i>: Assume two-way risk with symmetrical risk sharing thresholds. 	<p>The state has defined 10 quality measures that all ACOs must report on to qualify for shared savings. Performance on the measures has an increasing effect on payment of shared savings. ACOs may propose additional or alternative quality measures where appropriate for their served population.</p> <p><i>Physician Measures</i></p> <ol style="list-style-type: none"> 1. Optimal diabetes care composite 2. Optimal vascular care composite 3. Depression readmission at six months 4. Optimal asthma care 5. Colorectal cancer screening 6. Patient experience <p><i>Hospital Measures</i></p> <ol style="list-style-type: none"> 1. Heart failure 2. Pneumonia 3. Home management plan for care for asthma 4. Patient experience

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<p>New Jersey Medicaid Accountable Care Organization Demonstration Project</p>	<ul style="list-style-type: none"> ▪ Must be formed as a nonprofit corporation pursuant to New Jersey state law. ▪ Must have a governing board that includes a range of provider, social service, and consumer advocacy representatives. 	<ul style="list-style-type: none"> ▪ Must serve at least 5,000 Medicaid patients. ▪ Must apply for state certification and serve a defined geographic “designated area” with the written support of all general hospitals. ▪ Must include 75 percent of Medicaid primary care practitioners (PCPs) and at least four behavioral health providers in the defined geographic area. ▪ MCO participation is optional. 	<ul style="list-style-type: none"> ▪ All Medicaid recipients residing in a designated geographic area for a period of at least three years, with special focus on inpatient and ED “high-utilizer” Medicaid patients (New Jersey’s ACO legislation does not explicitly preclude the inclusion of individuals who are dually eligible for Medicare and Medicaid). 	<ul style="list-style-type: none"> ▪ Accountable for the access to care, quality, health outcomes, and cost of care for Medicaid recipients residing in the designated area for a period of at least three years. 	<ul style="list-style-type: none"> ▪ Required to develop and gain approval of a gain-sharing plan for their ACO by the end of year 1 of the demo and use this methodology for years 2 and 3. ▪ Participating providers must use electronic prescribing and electronic medical records. ▪ In year 1 of the demonstration, the ACOs must report required core and optional quality metrics. 	<ul style="list-style-type: none"> ▪ ACOs and managed care organizations can establish a gain-sharing arrangements (upside and downside) if quality measures are met. The parties are responsible for defining the methodology that will govern their specific agreement, though Rutgers University developed a methodology that participants may use. ▪ Gain-sharing plans must be approved by the New Jersey Department of Human Services (DHS). ▪ No set minimum savings rate (MSR). ▪ Prohibited from negotiating individual reimbursement rates for services with MCOs. 	<ul style="list-style-type: none"> ▪ 24 mandatory quality measures in the following areas: <ul style="list-style-type: none"> ○ Prevention/effectiveness of care (2) ○ Acute care (1) ○ Behavioral health (2) ○ Chronic conditions (2) ○ Resource utilization (2) ○ Preventable hospitalizations (7) ○ CAHPS (8) ▪ ACOs can also select voluntary measures – one item from the prevention category and any five from the chronic conditions category (i.e., cardiovascular, diabetes, respiratory, resource/utilization).

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<p>Oregon Coordinated Care Organizations (CCOs)</p>	<ul style="list-style-type: none"> ▪ Establish community advisory council (CAC) in each of the proposed service areas. ▪ Representation of beneficiaries with severe and persistent mental illness and beneficiaries receiving DHS Medicaid-funded LTC services on governing board and/or CAC. ▪ Encouraged (but not required) to establish a clinical advisory panel to ensure best clinical practices. 	<ul style="list-style-type: none"> ▪ Execute written agreements with Medicaid-certified providers. ▪ Have provider, facility, and supplier contracts in place to demonstrate adequate access and availability of covered services throughout the requested service area. ▪ Maintain accurate process that can be used to validate member enrollment and disenrollment based on written policies, standards, and procedures. ▪ Participate in the state’s learning collaboratives. 	<ul style="list-style-type: none"> ▪ All Medicaid enrollees, including members who are dually eligible for Medicare and Medicaid services. 	<ul style="list-style-type: none"> ▪ Coordinate the delivery of physical health care, mental health and chemical dependency services, oral health care, and covered long-term services. ▪ Development of medically necessary individualized care plans for enrollees. ▪ Involve enrollees in decisions regarding treatment, proper education on treatment options, and coordination of follow-up care. ▪ Address barriers to enrollee compliance with prescribed treatments and regimens. 	<ul style="list-style-type: none"> ▪ Collect, maintain and analyze race, ethnicity, and primary language data for all members on an ongoing basis. ▪ Support quality performance improvement program with sustained improvement in clinical/non-clinical care areas and improved member satisfaction and health outcomes. ▪ Track/document all referrals and prior authorizations to other providers. ▪ Develop efficient and accurate system for capturing, validating and reporting encounter data in a timely fashion. ▪ Promptly facilitate access to clinical information by all providers involved in delivering care plans. 	<ul style="list-style-type: none"> ▪ Operate within a fixed global budget. ▪ Develop and implement alternative payment methodologies based on improving health, health care, and lowering cost. ▪ Manage financial risk while meeting minimum financial requirements: <ul style="list-style-type: none"> ○ Maintain restricted reserves of \$250,000 plus an amount equal to 50 percent of the ACO’s total actual or projected liabilities above \$250,000. ○ Maintain net of at least the greater of: (1) five percent of the ACO’s average annualized total revenue in the prior two quarters; or (2) its authorized control level risk-based capital. ▪ Performance on accountability measures will affect ACOs’ contract status and eligibility for incentives. 	<ul style="list-style-type: none"> ▪ Two types of measures: <ul style="list-style-type: none"> ○ Accountability measures, including both core and transformational measures; and ○ Transparency measures, intended to promote community and consumer engagement (calculated by the state (not ACO) and publicly reported). ▪ Year 1 Accountability Measures: <ul style="list-style-type: none"> ○ Collected by the state and CCOs (one measure): <ul style="list-style-type: none"> ▪ Reduction of disparities - report by race/ethnicity ○ Reported by the state, validated by the ACOs (16 measures). ○ Collected by ACOs or an external quality organization (four measures): <ul style="list-style-type: none"> ▪ Planning for end-of-life care ▪ Screening/follow-up for clinical depression ▪ Timely transmission of transition record ▪ Care plan for beneficiaries with Medicaid-funded long-term care benefits.

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<p style="text-align: center;">Vermont Medicaid ACO Shared Savings Pilot</p>	<p>Governing body members have fiduciary responsibility to the ACO, and board is responsible for oversight and strategic direction via transparent process.</p> <p>At least 75 percent of the ACO’s governing body must be ACO participants, including a representative from:</p> <ul style="list-style-type: none"> ○ BH and substance abuse provider community; and ○ Post-acute care (such as home health or skilled nursing facilities) or long-term care services and supports. <p>The ACO’s governing body must include at least two consumer members, including a Medicaid beneficiary.</p> <p>The ACO must have a consumer advisory board with community membership, including patients, their families, and caregivers.</p>	<ul style="list-style-type: none"> ▪ Must be enrolled as Medicaid providers. ▪ Minimum number of Attributed Lives: 5,000. 	<ul style="list-style-type: none"> ▪ Medicaid beneficiaries including: <ul style="list-style-type: none"> ○ Aged/blind/disabled adults and children; ○ General adult population (including cash assistance recipients and those receiving transitional Medicaid after the receipt of cash assistance); ○ Adults with incomes below 133% of the FPL; and ○ Children under age 21 who are eligible for cash assistance and children up to age 18 who were previously uninsured, living in families up to 300% FPL. ▪ Excluded Medicaid beneficiaries: <ul style="list-style-type: none"> ○ Individuals dually eligible for Medicare and Medicaid; ○ Individuals with third-party liability coverage; and ○ Medicaid-eligible individuals who have commercial insurance or who receive a limited benefit package. 	<p>Expansion included in TCOC will follow an “encourage/incent/require” approach throughout years 1-3 of the program. In year 1, ACOs are responsible for “core-services” including: inpatient/outpatient hospital, professional services, ambulatory surgery center, clinic, FQHC, rural health center, chiropractor, independent laboratory, home health, hospice, prosthetic/orthotics, medical supplies, durable medical equipment, emergency transportation, dialysis facility.</p> <p>In year 2, ACOs can expand TCOC calculation to include “non-core services”:</p> <ul style="list-style-type: none"> ● VT Dept. of Mental Health; ● VT Division of Alcohol/Drug Abuse Programs; ● VT Dept. of Disabilities, Aging and Independent Living; ● VT Dept. for Children and Families; and ● VT Dept. of Education. <p>In year 3, ACOs will be required to include additional state-defined non-core services.</p>	<ul style="list-style-type: none"> ▪ Meaningfully engage beneficiaries and families as partners in care and in quality improvement activities. ▪ Use innovative care models and create community integration/linkages. ▪ Comply with data use standards, which outline specific reports that will be created by the ACO and provided to the agency, and reports that will be created by the agency and provided to the ACO. ▪ Conduct validated “readiness assessment for safety net ACOs” in the first quarter of each performance year. ▪ Submit written plan (at least annually) describing the ACO’s detailed approach to care management. 	<p>ACOs were offered a “two track” option that aligns with the Medicare Shared Savings Program. For potential ACO participants who choose track one: no downside risk in first year with a 50 percent savings rate. Track Two involves two-sided risk equal to one minus final sharing rate applied to first-dollar losses once Minimum Loss Rate (MLR) is met or exceeded; shared losses not to exceed 10%.</p> <p>In the initial years of the program, the focus will be on managing performance risk (i.e. the risk of higher costs from delivering unnecessary services, delivering services inefficiently, or committing errors in diagnosis or treatment), not “insurance risk” (i.e. the risk of whether a patient will develop a health condition).</p> <p>ACOs that choose to expand the TCOC in year 2, will receive an enhanced maximum sharing rate of 60 percent (a 10 percent increase).</p>	<p>29 measures have been defined for Year 1 payment and reporting:</p> <ul style="list-style-type: none"> ▪ Nine claim-based measures will be tied to payments <ul style="list-style-type: none"> ▪ All-Cause Readmission ▪ Adolescent Well-Care Visit ▪ Cholesterol Management for Patients with Cardiovascular Conditions (LDL Screening Only) ▪ Follow-up After Hospitalization for Mental Illness, 7 day ▪ Initiation /Engagement of Alcohol and Drug Dependence Treatment ▪ Avoidance of Antibiotic Treatment for Adults With Acute Bronchitis ▪ Chlamydia Screening in Women ▪ Developmental Screening in First Three Years of Life (Medicaid only) ▪ Depression Screening by 18 years of age (Medicaid only) ▪ 20 additional measures for reporting only: <ul style="list-style-type: none"> ○ Claims-based measures (4) ○ Clinical data-based measures (7) ○ Patient experience measures (9) ▪ ACOs are required to submit these measures annually to the Green Mountain Care Board (GMCB) for monitoring and evaluation purposes. <p>There are a number of identified “pending measures,” which may be added in subsequent years.</p>