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Quality Measurement Approaches of State Medicaid Accountable Care Organization Programs

States interested in using an accountable care organization (ACO) model must think critically about which metrics are best-suited to encourage enhanced access and care coordination and promote provider accountability for these outcomes. There is considerable variety in state Medicaid ACO measurement approaches, related to each state's access, quality, clinical, and cost goals. Common measurement areas include: (1) chronic condition (e.g., asthma, diabetes) processes and outcomes; (2) emergency department use; (3) inpatient admission and readmission; (4) well-child visits; (5) patient experience; and (6) behavioral health. To support collection, states often employ measures that align with those collected for other programs pursuing similar goals, such as behavioral health integration and health homes. States typically seek to mirror the scope and reporting requirements of Meaningful Use, CHIPRA,[a] Adult Core, and Medicare ACO measure sets and also use measures developed and/or endorsed by national performance measurement authorities (e.g., National Committee for Quality Assurance, National Quality Forum, Agency for Healthcare Research and Quality).

Quality measurement is an integral component of the accountable care organization (ACO) model, used by states to promote better access and outcomes for broad populations of Medicaid beneficiaries. This resource presents the quality measures, and related reporting and payment approaches, of ACO programs in six states: **Colorado, Maine, Minnesota, New Jersey, Oregon**, and **Vermont**.

Quality measure requirements for ACOs can range from simple collection and reporting to advanced expectations involving achievement thresholds, benchmark comparisons, and/or rates of improvement over time. Methodologies to calculate performance-based payments can range similarly in complexity. Participation of ACOs in quality measurement is often faciliated by the initial inclusion of claims-based measures and the phasing-in of more demanding elements, such as the collection of non claims-based (e.g., clinical) measures or rigorous performance targets tied to higher financial reward.

States developing ACO quality measurement strategies can borrow from the approaches of six states in the Center for Health Care Strategies' (CHCS) *Medicaid ACO Learning Collaborative*: **Colorado**, **Maine**, **Minnesota**, **New Jersey**, **Oregon**, and **Vermont**. With support from The Commonwealth Fund, CHCS has been working with these states to accelerate Medicaid ACO planning and implementation. This matrix presents the quality measures of each state's Medicaid ACO program and key details, including measure domains, reporting requirements, and contingencies related to payment.

This resource draws from state-specific documents, such as Medicaid ACO solicitations (e.g., requests for information/proposals/applications), state plan amendments, and waivers, as well as research conducted by Rachel Bonheim of the Woodrow Wilson School, Princeton University.

[a] Children's Health Insurance Program Reauthorization Act.

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Colorado – Accountable Care Collaborative

Regional Care Coordination Organizations (RCCOs), the lead organizations in Colorado's Accountable Care Collaborative (ACC) program, are required to collect and report four quality measures, all of which are tied to payment. Quarterly incentive payments are made when the RCCO meets or exceeds the state's quality target, calculated based on region-wide performance on the same measures.

Measure Domain	Core (Tied to Payment)
All	• Emergency room visits per 1,000 full-time enrollees (FTEs) • Hospital readmissions per 1,000 FTEs • Outpatient service utilizations/ MRI, CT scans, and tests per 1,000 FTEs • Well-child visits per 1,000 FTEs

Maine – Accountable Communities

Accountable Communities (AC) in Maine are required to report 16 core quality measures and five elective measures. All core measures and three elective measures (per the AC's choosing) are linked to payment. There are five additional measures for monitoring and evaluation, which are required to be reported but not linked to payment. To qualify for shared savings, an AC must score a rate of 30 percent for at least 70 percent of measures in each domain (excluding patient/caregiver experience). The portion of the savings an AC will receive is determined by its performance compared to state or national Medicaid benchmarks on select measures.

Measure Domain	Core (Tied to Payment)	Elective	Monitoring/Evaluation
Care Coordination/ Patient Safety	• Non-emergent ED use • Pediatric quality composite (PDI #92) • EHR program incentive payment program • Plan all-cause readmission • Prevention quality chronic composite for adults (PQI #92)	• Use of high-risk medication in the elderly	• Cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications • Imaging for lower back pain
Chronic Care/ At-Risk Populations	**Asthma** • Medication management - adults **Behavioral Health** • Follow-up after hospitalization for mental illness • Initiation and engagement of alcohol and other drug dependence treatment **Diabetes** • Glucose control (HbA1c control) - adults • Eye care	**COPD** • Use of spirometry testing in the assessment and diagnosis of COPD **Diabetes** • HbA1c Testing - adults • Nephropathy	**Behavioral Health** • Out of home placement for children and adults **Diabetes** • Glucose control (HbA1c control) - children • HbA1c testing - children
Patient/Caregiver Experience	• Clinician and group CAHPS		
Preventive Health	• Adolescent (12-21 years) well-care visits • Developmental screening - first three years of life • Well-child visits (0-15 months) • Well-child visits (3-6 years) • Well-chidl visits (7-11 years)	• Breast cancer screening	

Minnesota – Integrated Health Partnerships

Minnesota's Integrated Health Partnerships (IHP) are required to report 36 measures. These measures score as 10 composite measures, comprised of eight clinical measures and two patient experience measures. Composites comprise bundles of measures to indicate more clinically-meaningful outcomes for domains such as diabetes, asthma, or vascular care. The clinical and patient-experience measures include both clinic- and hospital-level metrics.

Each IHP's portion of shared savings is tied to its performance on the 10 core measures. The clinical measures are assigned 75 percent of quality performance weight and the patient experience measures as assigned 25 percent. Distribution of shared savings is scaled over the course of an IHP's involvement in the program:

- **First year**: IHP receives a maximum of 25 percent of shared savings for reporting the core measures.
- **Second year**: IHP receives a portion of shared savings relative to its performance on core measures.
- **Third year**: IHP can receive up to a maximum of 50 percent of shared savings, based on performance on the core measures.

In the second and third performance years, the measures are assessed for achievement and improvement, respectively. Points are awarded on a sliding scale based on pre-defined thresholds and relative improvement compared to baseline. The remainder of available shared savings (e.g., beyond 50 percent in third year) is not contingent on quality measure performance.

Measure Domain	Core (Tied to Payment)
Clinical	• Pneumonia: initial antibiotic selection (hospital) **Asthma** • Optimal asthma care composite: child/adolescent • Optimal asthma care composite: adult • Home management plan for care for asthma (hospital) **Behavioral Health** • Depression remission at six months **Cardiovascular** • Optimal vascular care composite (LDL control, blood pressure control, tobacco cessation, aspirin use) • Heart failure: left ventricular failure (LVF) assessment (hospital) **Diabetes** • Optimal diabetes care composite (HbA1c control, LDL control, blood pressure control, tobacco cessation, aspirin use)
Patient Experience	• Clinician and Group CAHPS • Hospital CAHPS

Oregon – Coordinated Care Organizations

Oregon has designated 33 core quality measures for its Coordinated Care Organizations (CCOs), 17 of which are linked to a CCO's quality pool payment, and 16 of which are used for state monitoring. The state has established funds in a quality incentive pool, which comprise two percent of aggregated payments from all CCOs. An individual CCO may receive a maximum payment of two percent of its actual payments, contingent on quality performance. There are two phases by which the quality incentive pool funds are distributed.

- **First phase**: Each CCO's portion of the maximum quality pool payment is relative to the number of measures for which it demonstrates an improvement over its own baseline or reaches a benchmark defined by the state. For 13 of the measures, performance is rated on a pass/ fail basis. For three clinical measures (diabetes blood sugar control, hypertension control, and depression screening measures), performance is rated based on measurement and reporting activities, not on performance. The Patient Centered Primary Care Home (PCPCH) enrollment measure is rated on a sliding scale. If a CCO meets the targets on at least 75 percent of measures (one of which must be electronic health record adoption), and reaches a milestone score on PCPCH enrollment, it will receive 100 percent of quality pool funds available to it.
- **Second phase**: If there are leftover funds in the quality incentive pool, these are distributed to CCOs that meet performance benchmarks on "challenge" measurements that focus on care integration and patient outcomes. These metrics are HbA1c poor control, screening for clinical depression and follow up, PCPCH enrollment, and alcohol or other substance misuse.

Measure Domain	Quality Pool (Tied to Payment)	Monitoring
At-Risk Populations	**Children** • Follow-up care for children prescribed ADHD medication • Mental and physical health assessment within 60 days for children in DHS custody **Pregnant Women** • Timeliness of prenatal care • Elective delivery	**Children** • Appropriate testing for children with pharyngitis **Pregnant Women** • Postpartum care rate
Care Coordination/ Patient Safety	• Outpatient and ED utilization • Patient Centered Primary Care Home enrollment • EHR adoption	• Plan all-cause readmissions
Chronic Care	**Behavioral Health** • Alcohol or other substance misuse • Follow-up after hospitalization for mental illness **Diabetes** • HbA1c poor control **Hypertension** • Controlling high blood pressure	**Asthma** • Adult asthma admission rate **Cardiovascular** • COPD admission • Congestive heart failure admission rate **Diabetes** • HbA1c testing • LDL-C screening • Short-term complication admission rate
Patient/Caregiver Experience	• CAHPS adult and child composites	• Child and adolescent access to primary care practitioners • Provider access questions from the Physician Workforce Survey
Preventive Health	• Screening for clinical depression and follow-up • Colorectal cancer screening • Developmental screening in the first 36 months of life • Adolescent well-care visits	• Well-child visits in the first 15 months of life • Childhood immunization status • Immunization for adolescents • Medical assistance with smoking and tobacco use cessation • Chlamydia screening in women ages 16-24 • Cervical cancer screening

New Jersey – Medicaid ACO Demonstration Project

New Jersey requires ACOs to measure and report a "core" set of 21 quality measures across six domains: (1) Acute Care; (2) Behavioral Health; (3) Chronic Conditions; (4) Patient Experience; (5) Prevention and Effectiveness of Care; and (6) Resource and Utilization. Some of these metrics are only required to be collected in year 2 of the demonstration. New Jersey also requires ACOs to report six "voluntary" quality measures. While the reporting of six measures is mandatory, the ACOs voluntarily select these measures, including one measure from a list of 14 Prevention/Effectiveness of Care measures and five measures from a list of 25 chronic conditions provided by the state. In addition to the core and voluntary measures, the state requires ACOs to report six "demonstration" quality measures. Each ACO's performance on the core and voluntary measures is tied to the state's calculation of its gain-sharing payment, while the demonstration measures are not tied to payment.

Measure Domain	Core (Tied to Payment)	Voluntary (Tied to Payment)	Demonstration
Acute Care	• Respiratory Syncytial Virus in neonates <35 weeks	N/A	• Follow-up after hospitalization for mental illness • Medication reconciliation (year 2) • Mental health utilization • Transportation • Referrals/connections to social supports (housing, food) • Identification of alcohol & other drug services
Behavioral Health	• Initiation and engagement of alcohol and other drug dependence treatment • Anti-depressant medication management	N/A	
Chronic Conditions	• Annual monitoring for patients on persistent medications (year 2) • Annual HIV/AIDS medical visit	**Cardiovascular Disease** • Cholesterol management for patients with cardiovascular conditions • Controlling high blood pressure • Complete lipid panel and LDL control • Use of aspirin or another antithrombic • Beta blocker therapy for left ventricular systolic dysfunction • Drug therapy for lowering LDL cholesterol • ACE or ARB therapy for patients with CAD or LVSD **Diabetes** • HbA1c testing • HbA1c poor control >9 • HbA1c control <8 • LDL screening • LDL control <100 • Neuropathy monitoring • Blood pressure control <140/80 • Eye exam **Respiratory** • Use of appropriate medications for people with asthma • Medication management for people with asthma • Use of spirometry testing in assessment and diagnosis of COPD • Pharmacotherapy of COPD exacerbation **Resource/Utilization** • 30 day readmission rate following AMI • 30 day readmission rate following HF • 30 day readmission rate following PNE • COPD admission rate • CHF admission rate • Adult asthma admission rate	

Measure Domain	Core (Tied to Payment)	Voluntary (Tied to Payment)	Demonstration
Patient Experience	• Getting timely care, appointments and, information • How well your doctor communicates • Patients' rating of doctor • Access to specialists • Health promotion and education • Shared decision making • Health status/functional status	N/A	
Preventon and Effectiveness of Care	• Screening for clinical depression and follow-up plan • Annual dental visit	• Childhood immunization status • Adolescent immunization • Well-child visits first 15 months • Well-child visits 3, 4, 5 , & 6 • Adolescent well-care • Weight assessment and counseling for children and adolescents • Frequency of ongoing prenatal care • Medical assistance with smoking and tobacco use cessation • Cervical cancer screening • Colorectal cancer screening • Tobacco screening and cessation • Breast cancer screening • Chlamydia screening in women 21-24 • Prenatal and postpartum care	
Resource and Utilization	• Emergency department visits • Inpatient readmission within 30 days • Preventable hospitalizations • Provider visit within 7 days of hospital discharge • Return to ED within 7 days of hospital discharge	N/A	

Vermont – Medicaid ACO Shared Savings Program

The state has identified 28 "core" quality measures for reporting in year one of its ACO demonstration, eight of which are linked to payment. There are an additional 23 "monitoring and evaluation" measures, which are required for reporting, but not tied to payment. Distribution of shared savings is contingent on an ACO meeting a quality threshold ('gate") of 35 percent of eligible points on the eight measures linked to payment. Once this is achieved, 75 percent of the shared savings is guaranteed. The scale of payment is based on a scoring methodology ("ladder"), by which the ACO can earn up to 100% of savings if at least 60 percent of eligible points on the eight measures are acquired. Vermont may add an additional 23 "pending" measures to the core quality measure set, pending approval from the Green Mountain Care Board.

Measure Domain	Core (Tied to Payment)	Core (Reporting Only)	Monitoring/Evaluation
Claims	• 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 and engagement of alcohol and other drug dependence • Treatment: a) initiation; b) engagement • Avoidance of antibiotic treatment for adults with acute bronchitis • Chlamydia screening in women • Developmental screening in the first three years of life (Medicaid only)	• Ambulatory care-sensitive conditions • Admissions: COPD • Mammography/Breast cancer screening • Rate of hospitalization for ambulatory care-sensitive conditions: PQI composite • Appropriate testing for children with pharyngitis	• Appropriate medications for people with asthma • Comprehensive diabetes care: eye exams for diabetics • Comprehensive diabetes care: medical attention for nephropathy • Use of spirometry testing in the assessment and diagnosis of COPD • Follow-up care for children prescribed ADHD medication • Anti-depressant medication management

Clinical	• Childhood immunization status (combo 10)
	• Pediatric weight assessment and counseling
	• Diabetes composite (D5) (all or nothing scoring):
	  • Hemoglobin A1c control (<8 percent)
	  • Diabetes composite (D5) (all or nothing scoring): low
	  • Density lipoprotein (<100)
	  • Blood pressure <140/90
	  • Tobacco non-use
		• Diabetes composite (D5) (all or nothing scoring): aspirin use
		• Diabetes mellitus: HbA1C poor control (>9 percent)
		• Colorectal cancer screening
		• Depression screening and follow-up
		• Adult weight (BMI) screening and follow-up
			N/A

Patient Experience/ Survey	N/A	• Access to care composite • Communication composite • Shared decision-making composite • Self-management support composite • Comprehensiveness composite • Office staff composite • Information composite • Coordination of care composite • Specialist composite	• Family evaluation of hospice care survey
Non-ACO Source	N/A	N/A	• School completion rate • Unemployment

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