

Adapting the Medicare Shared Savings Program to Medicaid Accountable Care Organizations

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States are increasingly looking to use a shared savings approach, similar to the Medicare Shared Savings Program (MSSP), to integrate care for Medicaid beneficiaries and link payment with higher quality care.¹ A multi-payer approach can increase provider participation in value-based purchasing initiatives that are focused on improving quality and controlling costs by paying for outcomes rather than services. Both Minnesota and New Jersey based their Medicaid accountable care organization (ACO) payment methodologies on the MSSP model, adapting the methodology to suit their Medicaid populations and programs, since Medicaid beneficiaries have much different needs than the Medicare population. Additionally, since Medicaid programs are administered at the state level, they vary greatly in terms of population needs, the penetration of managed care, patient attribution techniques, and existing initiatives and innovations that may not be perfectly compatible with the MSSP model. The experiences of these states can serve as examples for other states, and even commercial payers, on adapting the MSSP for specific beneficiary populations.

This technical assistance brief explores how Minnesota and New Jersey modified the MSSP methodology to better support Medicaid goals and improve integration of care for beneficiaries. It describes how these states have modified the MSSP approach to: (1) better incentivize providers to treat medically and socially complex, high-cost patients; (2) align with existing programs; and (3) integrate ACOs into managed care programs. The brief also suggests how other states can use MSSP to build their own Medicaid shared savings arrangement. See Table 1 for a comparison of the MSSP model with the approach undertaken in the two profiled states.

Medicare Shared Savings Methodology Overview

Developed as a result of the ACO provisions of the Affordable Care Act, the MSSP final rule was introduced in October 2011, and is currently used by Medicare ACOs nationwide. The MSSP is designed to reduce costs, improve quality of care, and enhance patient experience. The

IN BRIEF

Many state Medicaid agencies have used the Medicare Shared Savings Program (MSSP) model as a basis for new accountable care organization (ACO) programs that seek to better align provider incentives to improve care for low-income populations. Medicaid agencies have modified the MSSP methodology to account for differences in the populations served and the structure of their ACO programs, including adjustments for managed care delivery systems.

This brief explores the shared savings approaches of Minnesota and New Jersey, which both used the MSSP as a foundation for their Medicaid ACO shared savings programs. The innovations in these states are particularly relevant for states creating multi-payer alignment through initiatives such as the Center for Medicare and Medicaid Innovations (CMMI) State Innovation Model (SIM) initiative.

program does not alter Medicare reimbursement methodology, but simply places a shared savings incentive atop the existing Medicare structure. The intent is to offer providers a financial incentive to curb the overutilization of services and reward improved care coordination, by giving them a share of the savings they generate.

Design

The MSSP is used by Medicare ACOs that are approved for the MSSP demonstration programs authorized by the Centers for Medicare & Medicaid Services (CMS). These ACOs can serve participants in Medicare Parts A and B, which operate under a fee for service (FFS) arrangement. Beneficiaries enrolled in Medicare Advantage plans are not eligible. Beneficiaries are retrospectively assigned to ACOs based on their utilization of primary care services at the end of the performance period. If a beneficiary is not able to be attributed to a participating primary care physician (PCP), he or she may be attributed to a participating specialist with a plurality of visits.

Measuring Savings

In the MSSP model, shared savings and losses are measured by comparing actual expenditures to a benchmark of the average expenditures of Medicare Part A and Part B beneficiaries attributed to the ACO in the three years prior to the ACO's existence. The benchmark is adjusted for national Medicare expenditure growth trends and patient risk and trended forward to account for projected future growth using actuarial methods developed by CMS. Within the list of assigned beneficiaries, both in the benchmark period and savings calculation years, individuals whose health expenditures are above the 99th percentile of the national Medicare spending average are removed, so as not to skew the savings measurements. The MSSP model applies the CMS-Hierarchical Condition Categories risk adjustment model (CMS-HCC), and caps excessive losses at five percent of benchmark in year one, 7.5 percent in year two, and 10 percent in year three.

Distributing Savings

There are two tracks that Medicare ACOs must select from to participate: (1) a one-sided model, in which the ACO is paid if the percent of savings achieved is greater than two to 3.9 percent (depending on the number of patients attributed to the ACO) of its trended benchmark (the Minimum Savings Rate (MSR)); and (2) a risk-based, two-sided model, where the ACO can share in any savings if savings exceed a two percent MSR, but must also share in losses if the ACO's actual expenditures exceed the benchmark by more than two percentage points. In the two-sided model, the ACO is allowed to capture a greater percentage of shared savings, since it bears downside risk. Both tracks distribute "first dollar" savings, in which ACOs share in all savings achieved if those savings exceed the MSR (e.g., if an ACO has a two percent MSR and achieves 2.3 percent savings, savings are calculated based on a figure of 2.3 percent, not the 0.3 percent above the MSR).

The amount of savings distributed is also dependent on quality. Medicare ACOs enrolled in MSSP-eligible programs must meet specific quality goals based on a series of 33 performance measures on a yearly basis in order to receive shared savings distributions. In year one, they must simply report the required data, but quality is increasingly tied to performance in year two, and by years three and four, ACO performance in 32 of the 33 measures determines the payment level. ACOs receive a distribution if they meet a minimum quality level, but receive a greater amount if they outperform certain percentages of other Medicare providers during that period.

Minnesota Health Care Delivery Systems Demonstration

Minnesota's Health Care Delivery Systems (HCDS) Demonstration is a comprehensive effort that creates ACO-like provider entities (which may be composed of hospitals, health systems, and/or provider groups) to serve the state's Medicaid population. This program builds off a 2010 legislative mandate that the Minnesota Department of Human Services develop and implement innovative health care delivery systems and payment models, including ACOs. Minnesota's program was approved by CMS in July 2012 through a state plan amendment (SPA).

HCDS builds on an existing patient-centered medical home (PCMH) initiative and aims to improve care coordination and move away from paying for volume to paying for value in health care services. It also seeks to align with other payers to provide consistency in how providers are paid so they can deliver consistent and quality care to all patients and effectuate changes needed in the health care system. Under the three-year demonstration, interested providers can bid to form an ACO and participate in shared savings (and shared risk) arrangements with Medicaid. While provider participation is optional, the participation of managed care organizations

is mandatory. The program covers non-dual eligible adults and children in fee for service (FFS) and managed care. Nine organizations applied and six were selected to participate in the first iteration of the program beginning January 1, 2013.

HCDS includes a shared savings component that is similar to the MSSP model. The HCDS has two tracks for shared savings, though ACOs are assigned a track based on the structure of the organization. Non-integrated providers and organizations have a 50/50 upside risk-only model, while fully-integrated systems participate in the integrated option, in which shared losses are gradually incorporated over the demonstration period.

New Jersey Medicaid ACO Demonstration Project

The New Jersey ACO Demonstration Project will test a community-wide ACO model, largely inspired by Dr. Jeffrey Brenner's program targeting "super-utilizers" in Camden, NJ. The Camden Coalition of Health Care Providers identifies members of the Camden community who are super-utilizers of inpatient hospital services and deploys a care management team to help the patient manage their existing conditions and establish a relationship with a primary care provider (PCP).² The approach uses "hot spotting" techniques to analyze pockets of high hospital utilization within a community, a sign that health care resources are not deployed efficiently. Unlike the MSSP and the Minnesota program, this ACO model seeks to serve patients within a clearly geographically defined community and to engage a preponderance of providers across that community.

State legislation passed in 2011 established a demonstration for New Jersey Medicaid ACOs, enabling the creation of community-wide ACOs and the development of shared savings arrangements. Under the initiative, the ACOs must apply for state certification and serve a defined geographic "designated

area" with the written support of all general hospitals, 75 percent of Medicaid PCPs, and at least four behavioral health providers in this area. Applicants must be non-profit organizations serving at least 5,000 Medicaid patients. Certified ACOs are able to establish a gain-sharing arrangement with the Medicaid program and Medicaid managed care organizations (MCOs), but it is up to the parties to define the methodology that will govern their specific agreement. Thus, the participation of the health plans is voluntary in New Jersey. The state partnered with the Rutgers Center for State Health Policy (CSHP) to develop an upside-only gain-sharing arrangement, largely based on the MSSP, to give the ACOs guidance in developing their shared savings methodology. New Jersey is operating this initiative under its existing managed care authority, and is also developing a method to enroll the state's small FFS general assistance population.

Minnesota and New Jersey Adaptations of MSSP

Both Minnesota and New Jersey used components of the MSSP shared savings program as a model for their own demonstration programs, but made significant adjustments to better serve their Medicaid population and achieve program goals. The states sought to modify the MSSP approach in order to: (1) give providers an incentive to treat the most vulnerable, high-cost patients; (2) align with existing programs; and (3) integrate their managed care programs.

Meeting the Requirements of High-Need, High-Cost Beneficiaries

The most vulnerable patients served by Medicaid are often the most expensive to serve due to their high rate of chronic conditions and comorbidities such as substance abuse or mental health issues, and the larger socioeconomic challenges in their lives. From a provider perspective, these patients can be incredibly challenging to engage through traditional care management approaches, and often fall

through cracks in the system. Providers need significant financial incentives, not only to cover the investments needed for a high-touch care model, but also to make it worthwhile to take on difficult cases. However, the MSSP methodology does not necessarily have the right incentives in place for Medicaid ACOs to attend to such high-need patients. Consequently, states are modifying the methodology to expand the incentives available to providers for focusing on these patients, who may represent the greatest opportunities for statewide cost savings and quality improvement.

Truncating Claims of High-Cost Patients

The shared savings methodology excludes individuals whose costs fall above the 99th percentile of national Medicare spending and truncates a patient's total claims at approximately \$100,000. The benefit of this approach is that there is less potential for extremely high-cost patients to skew the variation of shared savings on a year-to-year basis. However, since this risk-adjustment tactic may create a perverse incentive for providers to focus less on Medicaid's highest-need beneficiaries, New Jersey and Minnesota decided to modify this aspect of the MSSP.

Minnesota created a tiered annual claims cap based on the size of an ACO's beneficiary population, which expands the incentives for targeting high-cost patients while incentivizing smaller provider organizations to participate. The annual per member per year total cost of care cap is structured as follows:

- For ACOs with 1,000 to 2,000 enrollees, the cap is \$50,000;
- For ACOs with 2,000 to 5,000 enrollees, the cap is \$200,000; and
- For ACOs with more than 5,000 enrollees, the ACO may choose to set the cap at either \$200,000 or \$500,000.

Minnesota not only increased the ceiling for ACOs with more than 2,000 enrollees

above the MSSP level, but also tiered the ceiling by ACO size, thereby enabling smaller ACOs to participate and ensuring confidence in the payment model. For small ACOs (with 1,000 to 2,000 enrollees), the lower cap reduces the fluctuations in shared savings that may occur for high-cost patients, which is more pronounced with a smaller group of enrollees. Additionally, providers working with larger ACOs with more than 2,000 enrollees have a greater financial incentive to provide care for these high-cost individuals than they would under the MSSP, since they would share in a larger amount of the savings achieved. Providers still receive full credit for diagnoses on claims that exceed the cap in risk adjustment for the purposes of calculating their cost target.

New Jersey had a simpler solution to incentivize ACOs to provide care management for high-cost populations: it decided not to truncate claims at all. Since the New Jersey demonstration is structured to target inpatient and ED super-utilizers, who are by definition the program's highest-cost beneficiaries, truncation of costs would not provide any financial incentive to help these beneficiaries. Unlike the Minnesota model, New Jersey requires that ACOs serve at least 5,000 Medicaid beneficiaries.

Use of a Minimum Savings Rate

Using an MSR is another aspect of the MSSP that some states will emulate to ensure that the savings achieved by ACOs are real. The MSSP uses a MSR for both its one- and two-sided models to ensure that savings or losses are a result of improved care coordination or quality, and not a random fluctuation. After analyzing its data to determine which MSR would meet appropriate confidence thresholds, Minnesota decided to use a two percent MSR for all ACOs regardless of size or model used. Minnesota includes first-dollar savings if the threshold is met, on both its one-sided model for virtual HCDS and two-sided integrated HCDS, since its models were similar to the MSSP.

However, New Jersey decided not to incorporate an MSR into its one-sided gain-sharing arrangement because it worried that it would discourage ACOs from participating in the demonstration. Particularly in early years, when ACOs are beginning to establish their population identification and care management processes, Medicaid ACOs are more likely to achieve smaller, but real savings.³ Additionally, the New Jersey threshold requirement of 5,000 Medicaid patients lowers the likelihood that the savings achieved were the result of random chance and not true improvements.

Alignment with Existing Programs

Since Medicaid structures and initiatives tend to vary dramatically from state to state, each state must determine how to adjust the MSSP's provisions to work in concert with these existing programs. By aligning key aspects of the ACO program with other delivery reform initiatives, states can make it easier for providers to participate and improve the impact of such programs. Both Minnesota and New Jersey found ways to adapt the MSSP to work with their existing programs and goals by altering their patient attribution methodologies.

Patient Attribution

The MSSP uses a two-step method of retrospective attribution for patients. Patients are first assigned to a PCP if they have a plurality of visits with that PCP over the past 12 months. If a patient does not have a plurality of visits with a PCP, they may be assigned to a specialist if he or she has a plurality of visits with a particular specialist during the same 12-month period.

In addition to having active Medicare ACOs, Minnesota also has a strong and widespread Medicaid PCMH program in place, in which patients are assigned a medical home. In order to preserve and strengthen the relationships between patients and their medical home, Minnesota decided to modify the MSSP patient attribution process to better align with existing patient attribution methods. Under

this approach, if a patient is already enrolled in a medical home, he or she stays with that medical home and is attributed to the integrated HCDS that is linked to that medical home. If the patient is not served by a medical home, he or she is then attributed to a PCP, or specialist, in a process similar to the MSSP model.⁴ However, unlike the MSSP, Minnesota is considering an additional step if a patient cannot be attributed to a specialist, in which the patient could then be assigned to an ED if a patient received a plurality of visits at the ED.

New Jersey also needed to modify the MSSP attribution logic in order to align with the community-based model designed to serve patients in a designated area. In New Jersey's demonstration, Medicaid patients will be attributed to the ACO based upon whether they reside in the designated area that the ACO is certified to serve. This geographic approach also has the benefit of including patients that do not have a relationship with a PCP or specialist, as is the case with many high-cost patients, because it incentivizes ACOs to create such a relationship.

Integrating Managed Care Organizations

Roughly 75 percent of Medicaid beneficiaries across the nation are in some form of managed care.⁵ While Medicare Advantage enrollees are not eligible for Medicare ACOs, excluding managed care beneficiaries would greatly limit the model's utility for Medicaid, reducing the likelihood that providers would be willing to participate. While states with low managed care penetration may elect not to include these beneficiaries, 97 percent of New Jersey's and 75 percent of Minnesota's Medicaid populations are enrolled in managed care,^{6,7} which prompted both states to include MCOs in their ACO arrangements.

Minnesota and New Jersey used different methods to include MCOs in their ACO demonstrations. New Jersey made its MCO

participation voluntary, and allows MCOs and ACOs to negotiate their shared savings methodology with one another. In order to ensure a fair process, all ACO gain-sharing plans must be approved by the New Jersey Department of Human Services (DHS), and ACOs are prohibited from negotiating individual reimbursement rates for services with MCOs. Gain-sharing agreements will also be made public and subject to a public comment process. Additionally, CSHP will calculate the attributable savings for all MCOs, regardless of their participation with an ACO or shared savings arrangement. This information could be used to make adjustments to capitation payments for non-participating MCOs in the future.

Minnesota went a step further and made MCO participation in the HCDS program mandatory. The state law prohibited the MCOs from participating directly in an HCDS or forming an HCDS. It did, however, incorporate requirements into each MCO's contract with Minnesota Medicaid specifying that the MCO must to pay its "share" of savings (or losses) achieved at the HCDS level back to the ACO. This "share" is calculated by the Minnesota DHS.

It is important to note that the MCOs participating in the Minnesota and New Jersey Medicaid shared savings arrangements will also retain a portion of the savings in a de facto manner. If actual expenditures fall below those anticipated, the fully capitated MCOs will experience a lower medical expense ratio and achieve higher profit margins for those patients attributed to the ACO, even once a portion of the savings are distributed to the ACO. Thus, MCOs have a built-in incentive to participate in Medicaid shared savings arrangements.

Conclusion

As the experiences of Minnesota and New Jersey demonstrate, the MSSP model can be used as a platform to build a Medicaid shared savings arrangement that incentivizes improved quality and cost efficiencies through ACOs or ACO-like entities. Moreover, the MSSP approach can be tailored to address a state's Medicaid population as a whole, or a specific portion of the population. For example, New Jersey chose to modify the MSSP criteria for highest-cost beneficiaries, minimum savings rate, and downside risk because it wanted to encourage its ACOs to target the super-utilizer population. Similarly, Minnesota decided to assign beneficiaries through its existing medical home program, rather than a PCP, since its initiative seeks to link individuals to a primary care home. While state Medicaid agencies may need to modify MSSP features to better suit the needs of the Medicaid population, the core elements of the MSSP will likely remain intact.

These two state examples demonstrate that it is possible for a state to adapt the MSSP approach to meet the needs of its Medicaid population. Therefore, other states looking to improve quality and reduce costs for Medicaid populations through multi-payer payment models should consider using the MSSP as a basis for developing their own shared savings arrangements.

Table 1: Comparison of MSSP with Minnesota and New Jersey’s Modified Approaches

PROGRAM FEATURES	MEDICARE SHARED SAVINGS ACO PROGRAM (MSSP)	MINNESOTA HEALTH CARE DELIVERY SYSTEMS (HCDS) DEMONSTRATION	NEW JERSEY MEDICAID ACO DEMONSTRATION (PROPOSED)
Background	<ul style="list-style-type: none"> ▪ Allows eligible providers, hospitals and suppliers to form ACOs. Those that meet quality and performance standards are eligible for shared savings under two tracks: <ol style="list-style-type: none"> 1. One-sided model with gain-sharing only; or 2. Two-sided model with shared gains or losses. 	<ul style="list-style-type: none"> ▪ Allows providers to form ACO-like HCDS entities to serve non-dually eligible adults and children in FFS and managed care programs over a three-year demonstration. Two options: <ol style="list-style-type: none"> 1. <i>Virtual</i>: Non-integrated providers and provider organizations engage in one-way upside shared savings; or 2. <i>Integrated</i>: Delivery systems that provide both inpatient and ambulatory care will share savings/losses . 	<ul style="list-style-type: none"> ▪ Allows community-based ACOs to form in geographically defined “Designated Areas.” ACOs are free to propose their own method of shared savings, but NJ Medicaid worked with Rutgers Center for State Health Policy to provide a model gain-sharing arrangement. The model is upside risk only and is largely based on MSSP.
Timeframe	<ul style="list-style-type: none"> ▪ CMS final rule for ACOs released October 2011. Approved ACOs began performance period in April 2012, July 2012, or January 2013. 	<ul style="list-style-type: none"> ▪ Six signed demonstration contracts effective January 1, 2013. Next RFP released early 2013 for participation in 2014. 	<ul style="list-style-type: none"> ▪ Anticipated release of ACO regulations for public comment in spring 2013.
Eligible Entities	<ul style="list-style-type: none"> ▪ ACO professionals in group practice arrangements; networks of individual practices; partnerships or joint venture arrangements between hospitals and ACO professionals; hospitals employing ACO professionals; and others. 	<ul style="list-style-type: none"> ▪ Providers responding to the Request for Proposals (RFP) must provide the full scope of primary and demonstrate how their model will impact the total cost of care and coordinate with other providers and community organizations. ▪ Health plans are excluded from responding directly to RFP, but are required to participate in the payment methodology by administering their proportion of shared savings/shared losses to ACOs determined by the state. 	<ul style="list-style-type: none"> ▪ ACOs are composed of all general hospitals, at least 75 percent of PCPs, and at least four behavioral health providers in the Designated Area. ▪ Specialists and other personnel may be a part of shared savings if the ACO’s shared savings arrangement allows it.
Covered Beneficiary Populations	<ul style="list-style-type: none"> ▪ Individuals enrolled in the Medicare FFS program under Parts A and B. 	<ul style="list-style-type: none"> ▪ All Medicaid FFS and managed care beneficiaries attributed to providers in an HCDS, except those who are dual eligible for Medicare and Medicaid, Third party liability (TPL) claimants, the aged, blind and disabled (ABD) population, and other selected limited benefit sets. 	<ul style="list-style-type: none"> ▪ All Medicaid FFS and managed care beneficiaries in a Designated Area. ▪ Includes General Assistance populations, but excludes dual eligible beneficiaries and individuals in nursing homes.
Participation of Managed Care Enrollees	<ul style="list-style-type: none"> ▪ Medicare Advantage enrollees are not eligible for attribution. 	<ul style="list-style-type: none"> ▪ MCO participation is mandatory. While MCOs are prohibited from participating in the program as an HCDS, each MCO is directed via its DHS contract to pay its “share” of savings or losses achieved at the HCDS level back to the organizations. 	<ul style="list-style-type: none"> ▪ MCO participation is voluntary. ACOs negotiate their own gain-sharing distribution agreements with MCOs.

PROGRAM FEATURES	MEDICARE SHARED SAVINGS ACO PROGRAM (MSSP)	MINNESOTA HEALTH CARE DELIVERY SYSTEMS (HCDS) DEMONSTRATION	NEW JERSEY MEDICAID ACO DEMONSTRATION (PROPOSED)
Attribution	<ul style="list-style-type: none"> ▪ Step-wise process based on: ▪ Past primary care services received; or ▪ Upon specialty services received. 	<ul style="list-style-type: none"> ▪ Step-wise process based on : <ol style="list-style-type: none"> 1. Enrollment in a health care home; 2. Attribution to a PCP; 3. Attribution to a specialty provider; or 4. Attribution through a plurality of ED visits. (Step 4 is currently undergoing review and will not be used in year 1) ▪ 12-month attribution period, minimum threshold for enrollment is six months of continuous or nine months of non-continuous enrollment. 	<ul style="list-style-type: none"> ▪ Beneficiaries are assigned based upon residing in an ACO's "Designated area".
Minimum Beneficiary Requirement	<ul style="list-style-type: none"> ▪ Serve at least 5,000 attributed beneficiaries 	<ul style="list-style-type: none"> ▪ Serve at least 1,000 beneficiaries 	<ul style="list-style-type: none"> ▪ Serve a "designated area" with at least 5,000 beneficiaries
Upside Sharing and Downside Risk	<ul style="list-style-type: none"> ▪ One-sided model: Share in first dollar savings once savings meet or exceed MSR (2-3.9%% of benchmark depending on the number of patients attributed to the ACO). No downside risk. ▪ Two-sided model: Share in first dollar savings once savings meet or exceed MSR (2% of benchmark), and shared losses when applicable. ▪ Advance Payment Model available for certain small and rural practices, which can receive additional start-up resources. Advance payments are recovered from future savings. 	<ul style="list-style-type: none"> ▪ <i>Virtual</i>: HCDS share in first dollar savings once savings meet or exceed MSR (2% of benchmark). No downside risk. Savings are split equally between HCDS and the state. ▪ <i>Integrated</i>: Share in first dollar savings once savings meet or exceed MSR (2% of benchmark) and shared losses when applicable. Upside risk only (50/50 split) in year 1. In year 2, shared losses are incorporated. In year 2, there is flexibility in the downside risk, but the upside cannot be more than twice downside. In year 3, the risk is symmetrical. In years 2 and 3, HCDS is flexible on the amount of risk and shared savings between the organization and the state.¹ 	<ul style="list-style-type: none"> ▪ ACOs qualify for shared savings if shared savings exist. There is no downside risk and no MSR.

¹ Minnesota Department of Human Services. Request for Proposals for A Qualified Grantee(s) to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Under Alternative Payment Arrangements Through the Health Care Delivery Systems (HCDS) Demonstration. September 14, 2011. Available from: http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs16_162632.pdf.

PROGRAM FEATURES	MEDICARE SHARED SAVINGS ACO PROGRAM (MSSP)	MINNESOTA HEALTH CARE DELIVERY SYSTEMS (HCDS) DEMONSTRATION	NEW JERSEY MEDICAID ACO DEMONSTRATION (PROPOSED)
Baseline Spending Calculation	<ul style="list-style-type: none"> Initial baseline based on Medicare A and B FFS expenditures of beneficiaries who would have been assigned to ACO in 3 years prior to start of ACO. 	<ul style="list-style-type: none"> Baseline per member per month (PMPM) total cost of care (TCOC) calculated for assigned population from FFS claims and managed care encounter data from the base year. TCOC is based on range of services HCDS can reasonably be expected to impact (inpatient, ambulatory, and mental health services; excludes most long-term supports and services, dental, supplies, transportation). 	<ul style="list-style-type: none"> A retrospective PMPM will be calculated based on Medicaid claims/encounters provided to the ACO's "designated area" during the most recent 3 years before the first year of the demonstration.
Trend Rate Calculations	<ul style="list-style-type: none"> Trending of baseline based on projected national growth in per capita Medicare spending. 	<ul style="list-style-type: none"> Trending of baseline based on the trend for the aggregate MHCP for managed care with appropriate adjustments for services not included in the base TCOC and incorporating actual HCDS program trend as appropriate and methodologically sound. 	<ul style="list-style-type: none"> Trending of baseline based on statewide growth rate in per capita Medicaid spending, adjusted by eligibility category.
Risk Adjustment Mechanisms	<ul style="list-style-type: none"> Historical benchmark expenditures and each performance year costs adjusted based on CMS-HCC risk adjustment model. Loss limits: Five percent of benchmark (year 1), 7.5% (year 2), 10% (year 3). 	<ul style="list-style-type: none"> Adjusted Clinical Groups (ACG) risk scores (with custom weights to reflect difference in populations in the HCDS payment model) applied to adjust for the risk composition of changing attributed population over time. 	<ul style="list-style-type: none"> Spending amounts will be risk adjusted using the Chronic illness and Disability Payment System (CDPS), which currently forms the basis for setting payment rates to NJ Medicaid managed care plans, when applicable.
Truncation of High-Cost Claims	<ul style="list-style-type: none"> Spending for patients whose costs fall above the 99th percentile of national Medicare spending are truncated. 	<ul style="list-style-type: none"> Per member per year established claims cap/catastrophic risk protection for small, medium, and large populations to mitigate risk. For 1,000 to 2,000 enrollees, cap is \$50,000; for 2,000 to 5,000 enrollees, cap is \$200,000; for over 5,000 enrollees, the ACO chooses a cap of either \$200,000 or \$500,000. 	<ul style="list-style-type: none"> No truncation of high-cost claims/patients.
Savings/Loss Calculations	<ul style="list-style-type: none"> Comparison of actual spend to trended benchmark; paid retrospectively. 	<ul style="list-style-type: none"> Comparison of actual spend to base year cost target adjusted for trend and changes in health risk of attributed population; paid retrospectively. Total shared savings/losses calculated by the state for each HCDS and paid through multiple MCO contracts and FFS allocated based on membership and experience. 	<ul style="list-style-type: none"> Comparison of actual spend to trended benchmark; paid retrospectively.

PROGRAM FEATURES	MEDICARE SHARED SAVINGS ACO PROGRAM (MSSP)	MINNESOTA HEALTH CARE DELIVERY SYSTEMS (HCDS) DEMONSTRATION	NEW JERSEY MEDICAID ACO DEMONSTRATION (PROPOSED)
Covered Services	<ul style="list-style-type: none"> Medicare continues to pay individual health care providers and suppliers for specific items and services as it currently does. 	<ul style="list-style-type: none"> ACOs must deliver full array of primary care services (preventative care and care for “a full range of acute and chronic conditions”) and directly deliver or demonstrate ability to coordinate with specialty providers and hospitals, with the exception of most long term supports and services (LTSS). ACOs must demonstrate how they will partner with community organizations/ social service agencies. Medicaid recipients will continue to receive all services covered under the benefit. 	<ul style="list-style-type: none"> ACOs will deliver the same array of covered services currently offered through Medicaid FFS and managed care contracts, with the exception of LTSS.
Performance Measures	<ul style="list-style-type: none"> ACOs must report on a set of 33 performance measures each year. Year 1: pay for reporting; Year 2: mix of pay for reporting and pay for performance; Year 3 and 4: 32 measures pay for performance, 1 measure pay for report. 	<ul style="list-style-type: none"> Year 1: Measure for reporting data in accordance with requirements will have a 25 percent effect on the shared savings payments. Year 2: Quality and patient experience measure performance will have a 25 percent effect on the shared savings payments. Year 3: The quality and patient experience measure performance will have a 50 percent effect. 	<ul style="list-style-type: none"> NJ will offer a set of required and suggested measures which ACOs will report on an annual basis. ACOs must demonstrate that they are not rationing care through specific quality metrics.
Collection of Performance Data	<ul style="list-style-type: none"> The program encourages the use of electronic health records (EHR) for data collection, in part, by double weighting quality measures related to qualifying for Meaningful Use EHR incentive payments. 	<ul style="list-style-type: none"> All HCDS core quality measures submitted via an electronic direct data submission portal to Minnesota Community Measurement – the state’s quality measurement vendor. The HCDS does not have any required health information technology (HIT) components as conditions of participation. 	<ul style="list-style-type: none"> All performance data will be submitted to DHS on an annual basis. Specific methods of data collection are currently in development. Legislation provides that the demonstration must “ensure the use of E-Prescriptions and EHRs.”
Pathway	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> SPA for FFS portion of the HCDS attributed populations. Existing managed care authority for MCO enrollees. 	<ul style="list-style-type: none"> Existing managed care authority for MCO enrollees. Currently developing method to enroll FFS portion of the population.

About Advancing Medicaid Accountable Care Organizations: A Learning Collaborative

With support from The Commonwealth Fund, and additional funding from the Massachusetts Medicaid Policy Institute, a program of the Blue Cross Blue Shield of Massachusetts Foundation, the Center for Health Care Strategies (CHCS) developed *Advancing Medicaid Accountable Care Organizations: A Learning Collaborative* to help states collaborate with multiple delivery system stakeholders and advance ACO models to drive improvements in quality, delivery, and payment reform. CHCS is working with Medicaid agencies from Maine, Massachusetts, Minnesota, New Jersey, Oregon, Texas, and Vermont to accelerate ACO program design and implementation.

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 D. Bachrach, W. Bernstein, and A. Karl. *High-Performance Health Care for Vulnerable Populations: A Policy Framework for Promoting Accountable Care in Medicaid*, The Commonwealth Fund, November 2012.

² A. Gawande. "The Hot Spotters." *The New Yorker*. January 24, 2011.

³ D. DeLia and J. Cantor. *Recommended Approach for Calculating Savings in the NJ Medicaid ACO Demonstration Project*. Rutgers Center for State Health Policy, July 2012.

⁴ Minnesota included a set of codes that expands upon those used by MSSP for attribution to a PCP or specialist.

⁵ <http://www.statehealthfacts.kff.org/comparemaptable.jsp?ind=217&cat=4>

⁶ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/new-jersey.html>

⁷ <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/minnesota.html>