

Program Design Considerations for Medicaid Accountable Care Organizations

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IN BRIEF

Medicaid accountable care organizations (ACOs) are becoming increasingly prevalent throughout the United States. Eight states have successfully launched such programs with the goal of improving health outcomes and reducing health care costs.¹ States are looking to this model to shift more accountability to providers through strategic monitoring of quality measures tied to alternative payment models (APMs), such as shared savings arrangements. This brief distills key lessons from the early experiences of state Medicaid ACO programs and offers considerations for additional states designing ACO approaches.

Accountable care organizations (ACOs) are designed to shift responsibility for patient outcomes and health care costs to health care providers, instead of payers such as managed care organizations (MCOs) and Medicare and Medicaid agencies. Through refined payment incentives, quality measurement and monitoring, analysis of patient and population health data, and an increased emphasis on care coordination, ACOs have the potential to improve health care quality while reducing costs.

Over the past four years, eight states – Colorado, Illinois, Maine, Minnesota, New Jersey, Oregon, Utah, and Vermont – have launched Medicaid ACO or ACO-like programs.² These programs serve more than 2.5 million beneficiaries and have saved roughly \$167.9 million to date.³ Of these eight states, four of the more mature programs have reported promising cost and utilization results:

- Colorado achieved \$77 million in net savings over four years;⁴
- Minnesota saved \$76.3 million over two years;⁵
- Oregon decreased emergency department (ED) visits by 23 percent and held costs under the programs' required two percent growth rate since 2011;⁶ and
- Vermont saved \$14.6 million in the program's first year.⁷

Most ACOs in these four states have met or exceeded quality performance standards.⁸ These initial outcomes are encouraging, and 10 more states have begun to develop ACO models.⁹ Unlike Medicare ACO models such as the Medicare Shared Savings Program (MSSP) and the Pioneer ACO model, there are no uniform national standards for Medicaid ACO programs. While the Centers for Medicare & Medicaid Services (CMS) has issued federal guidance pertaining to shared savings arrangements¹⁰ and integrated care models,^{11,12} states have flexibility in designing

Medicaid ACO models. As a result, state ACO programs vary significantly, driven by the specifics of each state’s health care market and political environment.

Since 2012, the Center for Health Care Strategies’ (CHCS) *Medicaid ACO Learning Collaborative*, which is supported by The Commonwealth Fund, has helped 13 states design, launch, and improve their Medicaid ACO models through peer-to-peer collaboration and technical support.¹³ Through these efforts, CHCS has learned a great deal about Medicaid ACO models, including important decisions that must be made in designing a program. This paper distills these lessons and discusses key considerations for additional states interested in building ACO programs.

Designing a Medicaid ACO Program

While states’ programmatic goals, structures, and scope will vary, many common elements must be considered when developing a Medicaid ACO program. Three basic steps define the process: (1) evaluate the current environment; (2) define program goals and framework; and (3) develop a structural model.

Exhibit 1: Steps to Design a Medicaid ACO Program



Evaluate the Current Environment

Assessing the existing health care environment helps states weigh the feasibility of potential program elements and narrow potential options. It also helps determine how prescriptive to make the program’s regulations. States typically assess four main factors:

1. **Provider readiness.** Providers’ ability to perform ACO financial and care management activities is a key consideration for determining provider participation in the program as well as effectiveness of potential approaches. In addition to existing knowledge of the provider environment, many states have used provider readiness assessments or requests for information (RFIs) to examine the capacity of providers to accept financial risk; electronic health record (EHR) penetration; data analysis, exchange, and reporting capacity; network adequacy; and other factors.
2. **Market dynamics.** A state’s Medicaid ACO program will be driven by market dynamics. An environment with few dominant provider organizations or hospital systems may call for a different model than one with several smaller providers and evenly distributed market power. Additionally, if the state currently contracts with providers via Medicaid MCOs, the market power of MCOs relative to providers will likely be an important factor.

3. **Existing programs.** States need to examine how Medicaid ACO programs will interact with existing care delivery models and health reform efforts, such as patient centered medical homes (as Colorado, Minnesota, and Oregon have done), health homes (as in Maine), and other programs. If there is a significant presence of Medicare or commercial ACOs in the state, a state may want to align with those programs as well, though significant adjustments may be required to address the needs of Medicaid enrollees relative to Medicare and commercial populations (Maine, Minnesota, New Jersey, and Vermont used the MSSP as a basis for their programs).¹⁴ Designing a program that builds on successful existing programs and/or existing resources can benefit both a state and its providers by reducing administrative burden and costs.
4. **Political factors.** Political factors may include budget deficits, trends in Medicaid spending, grassroots efforts, and lobbying, among others. The impetus for an ACO program may come from the state legislature, the governor's office, Medicaid agency, public interest, or a combination of these factors. Where the program is initiated will likely play a part in which policy or regulatory levers, such as legislation, executive/Medicaid department action, or contracting, can be used for implementing the program.

Define Program Goals and Framework

The state should have a clear vision of its Medicaid ACO program objectives and its health care market. Goals should be clear and measurable, address specific issues that the state is seeking to improve, and directly relate to program-wide cost targets and quality improvement opportunities. For example, Oregon's Coordinated Care Organizations (CCOs) must collectively reduce the state's per capita Medicaid spending by two percent during the three-year demonstration period, while improving quality and access to care.¹⁵

Before diving into the details of the ACO model, many states first develop a general framework. In doing so, it is helpful to consider: (1) the scope of the model; (2) the level of program prescriptiveness/flexibility; and (3) if there are any structural elements that must be included in the model. The scope of the model depends largely on the program's goals. Six states (Illinois, Maine, Minnesota, New Jersey, Utah, and Vermont) launched their Medicaid ACO programs as voluntary pilot demonstrations. These states gave interested providers the opportunity to enter into ACO arrangements, while not requiring all providers to participate. Two states, Colorado and Oregon, implemented statewide models that cover the vast majority of their Medicaid enrollees because broad reach was a key goal of their programs. However, Colorado did use "focus communities" to pilot the program in the first year before going statewide.

States may seek to be more or less prescriptive in their structural model, particularly around care delivery requirements. Some states, such as New Jersey and Utah, specifically wanted to give their ACOs flexibility to design their own models for improving care delivery. Other states have taken a more nuanced approach, being flexible on certain program elements, but firm on others. For example, Vermont allowed its ACOs flexibility on whether to include pharmacy and non-emergency transportation services, but clearly defined care management requirements. States may want to retain the ability to modify the program during a demonstration period based on

results to date or allow more ACOs of varying size, experience, or sophistication to participate in the program. Both Maine and Vermont allowed their ACOs to select a risk-based or non-risk-based payment track, while Minnesota assigned a risk track to ACOs based on the ACO’s structure and size. Finally, probability that providers and MCOs (if applicable) will embrace the program and help achieve its goals will be critical. If the state believes it will not be able to achieve the voluntary commitment from its stakeholders, it may require provider participation.

A state may also include a few essential elements of its structural model in their Medicaid ACO framework. For example, if a state’s goal is to improve outcomes associated with behavioral health conditions, it could include related services in its total cost of care calculation (TCOC), the total spending on services from which shared savings or capitation rates are based. Determining these key elements early in the process can help focus program design discussions, ease model development decisions, and identify policy and regulatory levers to aid program implementation.

Develop a Structural Model

States must address eight key questions in designing a Medicaid ACO program. These questions and state examples are listed in Exhibit 2 and discussed below. While this is not an exhaustive list of options, they help clarify how states have approached structural elements of their programs:

Exhibit 2: Key Design Questions and State Approaches to Creating a Medicaid ACO

Question	Examples of State Approaches
1. Who will lead the ACOs?	<ul style="list-style-type: none"> ▪ Provider-led organizations (IL, ME, MN, NJ, VT) ▪ Payer-led organizations (OR¹⁶, UT) ▪ Regional Care Collaborative Organizations (CO)
2. Whom will ACOs serve?	<ul style="list-style-type: none"> ▪ Medicaid enrollees (IL, MN, UT, VT) ▪ Medicaid and Medicare-Medicaid enrollees (CO, ME, NJ, OR)
3. How will patients be attributed?	<ul style="list-style-type: none"> ▪ Prospectively based on geography (CO, NJ, OR) ▪ Prospectively based on patient selection (UT) ▪ Retrospectively based on utilization (IL, ME, MN, VT)
4. What services will the ACOs provide?	<ul style="list-style-type: none"> ▪ Care coordination and practice support (CO) ▪ Physical health services (UT) ▪ Physical health services plus additional services (IL, ME, MN, NJ, OR, VT)
5. How will the payment model be structured?	<ul style="list-style-type: none"> ▪ Pay-for-performance (CO) ▪ Shared savings (NJ) ▪ Shared savings/risk (IL, ME, MN, VT) ▪ Capitation/global payments (OR, UT)
6. How will quality be measured?	<ul style="list-style-type: none"> ▪ Few metrics (<20), all tied to payment (CO,¹⁷ ME) ▪ Many metrics (>20), some tied to payment (IL, OR, VT) ▪ Many metrics (>20), all tied to payment (MN,¹⁸ NJ) ▪ Many metrics (>20), none tied to payment (UT)
7. How will data be collected and analyzed?	<ul style="list-style-type: none"> ▪ State and contractor collect and analyze data (CO, IL, ME, MN, NJ, OR, UT, VT)
8. How will MCOs be involved?	<ul style="list-style-type: none"> ▪ Leading ACOs (OR, UT) ▪ Required to share savings with ACOs (MN) ▪ Given option to enter into contracts with ACOs (IL, NJ) ▪ No role (CO, ME, VT)

Who will lead the ACOs?

A core decision in developing an ACO model is determining the entity that is financially responsible for on-the-ground care management and how that entity is governed. States that prioritize shifting accountability directly to providers may prefer a provider-led model, while those that prioritize risk management experience may want to have MCOs run ACOs. Most Medicaid ACO models are provider-led (Illinois, Maine, Minnesota, New Jersey, and Vermont), but these models have a variety of structures. For example, New Jersey requires its ACOs to be state-registered nonprofit organizations with strict governance requirements, while Minnesota and Vermont have broader governance definitions designed to attract a range of provider organizations. Oregon's CCOs are payers, but providers and community-based organizations are required to be part of the CCO's Boards of Directors. Colorado created Regional Care Collaborative Organizations (RCCOs), which help providers by offering care coordination support, supporting practice transformation efforts, and helping them navigate the Medicaid system. In addition to the ACO's primary lead organization, many states also include requirements on community and enrollee involvement, such as seats on the Board of Directors or formation of a Community Advisory Council.¹⁹

Whom will ACOs serve?

In addition to the broad Medicaid population, Medicaid ACOs may also serve Medicare-Medicaid enrollees or a specific subset of Medicaid enrollees. The majority of Medicaid ACO programs have elected to exclude Medicare-Medicaid enrollees due to: the difficulty of achieving a return on investment since Medicare expenditures are not included; administrative complexities; the diverse needs of the population; and/or the presence of existing state programs to serve this population.²⁰ Only Colorado, Maine, and Oregon use Medicaid ACOs to serve Medicare-Medicaid enrollees. Colorado's program did not initially include Medicare-Medicaid enrollees, but these individuals were included once Colorado received approval for their Financial Alignment Demonstration.²¹

What services will the ACOs provide?

While all states except Colorado provide physical health services through their Medicaid ACO programs,²² many have also included other services such as behavioral health care, long-term services and supports (LTSS), oral health services, pharmacy services, and non-emergency transportation services. Broadening the scope of services to better serve enrollees can be a powerful tool for ACOs. For example, ACOs can encourage more meaningful collaboration between physical health and non-physical health providers. ACOs can be made accountable for these services by requiring ACO providers to offer these services, including them in the TCOC calculations or by including quality metrics for these conditions.

Important factors for states in considering whether to include non-medical services are: (1) existing relationships across medical and non-medical providers; (2) provider capacity to offer additional services; and (3) how the ACO may interact with existing programs that support integration. The state may also consider if these services are necessary to achieve program goals.

Exhibit 3 is a matrix of services included in payment calculations for active Medicaid ACOs. Six states have launched ACOs that include options beyond traditional physical health services.

Exhibit 3: Services Included in Medicaid ACO Payment Calculations

State	Services Included in Payment Calculation
Colorado	Care coordination and practice support
Illinois	Physical health, behavioral health
Maine	Physical health, behavioral health (<i>optional</i> : LTSS and oral health)
Minnesota	Physical health, behavioral health, pharmacy (<i>optional</i> : LTSS, oral health, non-emergency medical transport)
New Jersey ²³	Physical health (<i>optional</i> : behavioral health, LTSS, oral health, pharmacy)
Oregon	Physical health, behavioral health, oral health
Utah	Physical health
Vermont	Physical health (<i>optional</i> : pharmacy, non-emergency medical transport)

How will the payment model be structured?

Many Medicaid ACO programs include financial risk for providers in their payment models to encourage greater accountability for their patient population. In doing so, states must assess whether their providers are ready to accept risk. This can be determined by examining key factors such as organizational size, services provided, data capacity, and experience with risk-based models. Phasing in risk gradually or offering upside-only models, as Maine, Minnesota, and Vermont have done, may be a palatable approach that acknowledges varying provider capacity. States may also opt to help providers with the upfront infrastructure investment required to begin an ACO program. Finally, the state will need to determine the amount of savings the ACO will receive and the amount the state would retain. This decision may be influenced by the need to demonstrate immediate savings due to budgetary issues or political factors.

The most prevalent payment model among active Medicaid ACO programs is shared savings arrangements. ACOs in five states (Illinois, Maine, Minnesota, New Jersey, and Vermont) are responsible for the TCOC for their attributed patients and receive a percentage of shared savings if cost savings are achieved and quality standards are met. Three of these state ACO models (Maine, Minnesota, and Vermont) also include downside risk, where providers are also accountable for exceeding cost benchmarks. Maine and Vermont offer the option for ACOs to select from an upside-only model or a model with downside risk that phases in shared risk over three years in exchange for greater potential savings. Minnesota assigns participating ACOs to an upside-only or upside/downside model based on the ACO's attributed population and provider makeup. Illinois' shared savings program goes a step further, transitioning payment to a capitated model over 36 months. States developing a shared savings payment must carefully determine methodological factors such as risk adjustment methods, a minimum savings rate, benchmarking criteria, and whether or not to remove high-cost patients from shared savings calculations.²⁴

The two states with payer-led models, Oregon and Utah, have full-risk, capitated per member per month payments in place from day one. In capitated models, payments are naturally limited since ACOs are paid a flat fee, but states must determine how often this fee is rebalanced and how the population is risk-adjusted to ensure an effective model.²⁵

How will patients be attributed?

Patients are assigned to ACOs through retrospective or prospective attribution. The attribution model typically follows the payment model, though there are exceptions. Patients are attributed to ACOs retrospectively under shared savings or shared savings/risk arrangements, while prospective models are for capitated arrangements or global payments.

In retrospective attribution models, a patient is assigned to an ACO or provider (typically a primary care provider) based on actual utilization. This approach allows states to evaluate the ACO on the patients who received the majority of their care from ACO providers. However, this approach makes it difficult for ACOs to proactively identify patients and coordinate care. This could create perverse incentives, such as ACOs selectively treating low-cost patients who will save them money in a capitated payment model or focusing only on serving high-cost patients in a shared savings model. However, this model might be more palatable for providers who may be concerned about being held responsible for the costs and quality of care for patients who they may have served and who are assigned prospectively.

In prospective attribution models, patients can be assigned geographically (as in Oregon),²⁶ through patient selection (as in Utah), and could also be handled through algorithmic prospective assignment, where patients are assigned based on past utilization patterns, proximity to primary care providers, or other criteria. Under prospective attribution, ACO providers know at the outset for whom they are responsible. This arrangement may also encourage ACOs to invest in activities that support public health and the community. Given the prospective assignment process recently established by the Next Generation ACO model,²⁷ there may be more Medicaid programs looking into a prospective attribution option.

How will quality be measured?

ACO quality measurement approaches vary greatly. States typically assess the following in constructing their quality measurement plan:

1. How many quality metrics to include;
2. What the mix of process, outcome, and patient experience metrics will be;
3. Which conditions to target;
4. Whether or not to tie some or all metrics to payment;
5. Whether quality performance is measured against attainment of a benchmark, improvement over time, or relative to other ACO performance; and
6. How to align metrics with other state programs and Medicare and commercial ACO models.

States have as few as three and up to as many as 33 metrics for ACOs, and some tie every metric to payment while others link only a subset.²⁸ It is just as important for states to create a set of

outcome, process, and patient experience metrics to accurately measure performance and the achievement of program goals. Ideally, states seek to identify a set of evidence-based quality metrics that accurately evaluates an ACO's performance, but that does not overburden providers with undue data reporting. Finding this balance is imperative and often requires an iterative process. For example, Minnesota has reduced the number of quality metrics, while Vermont has added measures. Maine, Minnesota, New Jersey, and Vermont give ACOs flexibility on the selection of some quality metrics.

States must also determine how to tie payment to quality. All states with active Medicaid ACO programs allow "pay-for-reporting" arrangements in the first year, and then evaluate ACOs on quality performance beginning in the second year. Some models also gradually increase either the percentage of payment tied to quality or the number of metrics tied to payment after the second year. States must also determine what triggers a payment. Exhibit 4 below shows the range of payment approaches.

Exhibit 4: Approaches for Quality Activation of Payment²⁹

Method	Description	States Using Method
Gate (Benchmark)	ACO performance must meet or exceed a performance benchmark for ACO to receive payment.	Colorado, ³⁰ Illinois, Minnesota, New Jersey
Two Gate	ACO performance must meet or exceed a baseline performance benchmark to receive payment. ACOs performing over an improvement target receive an enhanced payment.	Oregon
Gate and Ladder	ACO performance must meet or exceed a baseline performance benchmark to receive payment. If ACOs exceed the baseline, they receive a bonus payment tied to the percentage that they exceeded the benchmark.	Colorado, ³¹ Maine, Vermont

How will data be collected and analyzed?

Data sharing and analysis – key components of care coordination and program evaluation – form the backbone of a successful Medicaid ACO program. Each ACO program must track quality and cost performance, and therefore will need to collect this data and analyze the data. Some states have also elected to provide reports and analysis at the patient and population level to help with care management activities. All states with Medicaid ACO programs have taken different approaches to working with a contractor to provide some of these functions. Colorado and New Jersey outsource much of their data collection and evaluation to a contractor, which requires less staff capacity and could be less expensive. Other states, such as Maine, Minnesota, Oregon, Utah, and Vermont, stay more actively involved in collection and evaluation and hire a contractor for limited and specific roles. For example, Oregon and Vermont hired an outside contractor to validate financial and quality performance findings. Minnesota uses a contractor to collect and validate quality data from physicians and medical groups. Maine uses its contractor to provide analytic support to its Accountable Communities. Utah offers its ACOs the option to collect data on their own or use a state contractor, but performs its own analysis.³²

How will MCOs be involved?

States with Medicaid managed care have taken varied approaches to involve MCOs in Medicaid ACOs, but a key factor is the state's satisfaction with the quality and cost outcomes that MCOs provide. If a state is satisfied with MCO results, the state may opt for a payer-led model, or incentivize providers and payers to collaborate to improve costs and quality. For example, New Jersey does not require its MCOs to participate in its model, and instead MCOs and ACOs are free to form their own contractual arrangements, including payment methodologies.^{33,34} Minnesota does not allow MCOs to participate in its Integrated Health Partnerships program, but requires MCOs to share savings with ACOs if their patients are attributed to an ACO that has achieved savings. If MCOs are not performing to expectations, states may choose a provider-led model independent from managed care.³⁵ In its recent proposed rule for managed care regulations, CMS explicitly granted states the regulatory authority to require Medicaid MCOs to participate in statewide payment reform initiatives.³⁶ If this provision is included in the final rule, it could help facilitate state efforts to implement Medicaid ACOs in a managed care environment.

In a managed care environment, a state must also consider the role ACOs will play relative to MCOs. While MCOs traditionally have performed care management responsibilities, ACOs will likely take on that role in a state where both ACOs and MCOs exist. Other activities, including quality improvement, data sharing and analytics, establishing evidence-based guidelines, and utilization management, may also be delineated to ensure that ACOs and MCOs are not duplicating efforts.³⁷ As ACOs gain more experience, they may be expected to take on more of these responsibilities. However, states may also opt to give general guidance and allow ACOs and MCOs to figure out mutually beneficial arrangements on a case-by-case basis.

A Final Consideration

Medicaid ACOs are now a significant presence in state Medicaid programs, with additional states seeking to launch Medicaid ACO programs in the coming years. As these states begin to design Medicaid ACO models, they should be mindful of their state's health care environment, clearly define program objectives, and design program parameters to achieve these goals. In designing Medicaid ACO approaches, it is helpful to recognize that models will evolve over time. For example, Colorado and Minnesota, two of the earliest Medicaid ACO programs, are now seeking to update their programs to "Version 2.0" in 2017. Similarly, states that have shared savings payment models may consider transitioning into full risk capitation or global payments in the future to address the inevitably limited benefits of shared savings programs. Given the evolution of ACO programs, states designing Medicaid ACOs should not limit future possibilities by rigidly defining certain aspects of ACOs. By building in flexibility for evolving ACO models, states can realize greater success in the future through their Medicaid ACO programs.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit policy center dedicated to improving the health of low-income Americans. It 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 Accountable Care Organizations: State Update*. Center for Health Care Strategies, August 2015. Available at: <http://www.chcs.org/resource/medicaid-accountable-care-organizations-state-update/>.
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- ¹⁶ Oregon’s model also allows patients to choose a CCO if their geographic area is served by more than one CCO.
- ¹⁷ Colorado tracks metrics on RCCO performance in addition to measures collected for its Accountable Care Collaborative (ACC) program. For more information, see ACC 2015 Annual Report: <https://www.colorado.gov/pacific/sites/default/files/Supporting%20a%20Culture%20of%20Coverage%20Accountable%20Care%20Collaborative%202014-15%20Annual%20Report.pdf>.
- ¹⁸ Minnesota’s 32 quality metrics are grouped into and scored as nine aggregate metrics.
- ¹⁹ “Comparing State Medicaid Accountable Care Organization Governance Models.” Center for Health Care Strategies, July 2015. Available at: <http://www.chcs.org/resource/comparing-state-medicaid-accountable-care-organization-governance-models/>.
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- ²² Colorado’s RCCOs do not provide nor are accountable for direct services to patients, but rather support providers with a combination of care coordination and practice support. These services are paid for by a per member per month fee and an opportunity to receive bonuses if providers in the RCCO’s geographic area meet or exceed quality standards.
- ²³ New Jersey’s program assumes a broad total cost of care, but ACOs and MCOs negotiate their own agreements.

11 BRIEF | Program Design Considerations for Medicaid Accountable Care Organizations

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- ²⁶ Oregon’s model also allows patients to choose a CCO if their geographic area is served by more than one CCO.
- ²⁷ For information on the ACO Next Generation Model, visit <https://innovation.cms.gov/initiatives/Next-Generation-ACO-Model>.
- ²⁸ J. Lloyd, et al., op. cit.
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- ³⁰ Colorado uses “gate” incentives for certain metrics and “gate and ladder” incentives for others.
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- ³² J. Lloyd, et al., op. cit.
- ³³ Ibid.
- ³⁴ A recommended gainsharing methodology produced by the Rutgers Center for State Health Policy can be found here: <http://www.cshp.rutgers.edu/Downloads/9290.pdf>
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