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Quality Measurement Approaches of State Medicaid Accountable Care Organization Programs

IN BRIEF

Quality measurement is an integral component of the accountable care organization (ACO) model, which is used by states to promote better access and outcomes for broad populations of Medicaid beneficiaries. Drawing from state-specific documents — such as Medicaid ACO solicitations, state plan amendments, and waivers — this resource presents the quality measures, and related reporting and payment approaches, of Medicaid ACO programs in eight states: **Maine, Massachusetts, Minnesota, New Jersey, Oregon**, **Rhode Island, Utah,** and **Vermont**. Each of these states have participated in the Center for Health Care Strategies' *Medicaid ACO Learning Collaborative*, made possible by The Commonwealth Fund.

Many states are pursuing Medicaid accountable care organizations (ACOs) as a way to improve care coordination and delivery by holding providers financially accountable for the health of their patient populations. Quality metrics are used to track whether Medicaid ACOs improve patient outcomes and to help ensure that providers are not withholding health services in order to retain savings. States interested in using an 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 management (e.g., asthma, diabetes); (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. Historically, state Medicaid ACO measurement strategies have typically mirrored the scope and reporting requirements of the Centers for Medicare & Medicaid Services (CMS) Health Care Quality Measures for Children[1] and Adults;[2] CMS' health information technology requirements, such as "meaningful use" of electronic health records;[3] and quality measure sets for Medicare ACO programs. States also tended to use measures developed and/or endorsed by national authorities (e.g., National Committee for Quality Assurance, National Quality Forum, Agency for Healthcare Research and Quality). More recently, there is an interest in aligning quality measurement strategies with CMS' Core Quality Measures[4] — a set of quality measures, including ACO measures, that are designed to align quality measurement across commercial and government payers — and CMS' Quality Payment Program (QPP), which launched in January 2017. Although QPP is focused on Medicare provider reimbursement, a number of states are interested in aligning their Medicaid quality measurement approaches with this program. States are also beginning to test "non-traditional" quality measures that are not developed or endorsed by a national measurement authority, such as measures for care integration, care coordination, social determinants of health, and long-term services and supports.

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. ACO quality measurement often begins with the collection and reporting of non-claims-based (e.g., clinical) measures, and phases in more rigorous performance targets tied to higher financial reward over time. Key questions to address when developing an ACO quality measurement strategy include:

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1. ***What is the process used to choose quality measures?*** What criteria will the state use to identify and select the quality measure set? Some factors for consideration include whether measures are nationally recognized or endorsed; whether they align with CMS and/or state requirements, programs, or measure sets; and level of burden required to collect and report data. See CHCS' brief, *Medicaid Accountable Care Organization Measurement Tool for States* for additional guidance.[5]

2. ***How many measures to select?*** How many measures does the state want to use for its quality measurement approach? Does the state want to a high number of quality measures (e.g., >20) that enable it to evaluate an ACO's quality performance across various patient populations, health conditions, and quality domains, or does it want to use fewer measures (e.g., <20) that puts less burden on providers and potentially helps them focus their quality improvement efforts. The Medicare Payment Advisory Commission (MedPAC) noted that quality measurement approaches used for Medicare ACOs — which have been adopted by select Medicaid ACO programs — have been overly complex, expensive, and too reliant on process measures. MedPAC recommends moving quality measurement in the direction of a small set of population-based outcome measures, such as potentially avoidable admissions.[6]

3. ***Should the ACO assess performance or reporting (or both)?*** How will the state use the selected measures to evaluate ACOs? Will it reward ACOs for collecting and reporting selected clinical quality measures (i.e., pay-for-reporting) or will it reward ACOs based on their actual performance on these measures (i.e., pay-for-performance)? Alternatively, will it implement a "phased" approach, whereby ACOs are rewarded for quality reporting in earlier years of ACO program participation, and become increasingly accountable for actual performance in later years?

4. ***How to assess performance (via achievement, or improvement, or both)?*** If rewarding ACOs based on performance, how exactly will the state assess performance? Will it be based on an ACO's achievement of a pre-defined benchmark, such as national Medicaid benchmarks, and/or measure an ACO's improvement over its own historical performance?

5. ***How to weight quality measures and domains?*** Are all measures treated equally or do some count more than others? Will the state assign varying weights to different measures and/or domains to align with the state's access, quality, clinical, and cost goals?

6. ***How to tie payment to quality performance?*** How many and which of the measures will be tied to payment? Will the state use a "quality gate" approach, whereby an ACO must achieve a minimum threshold of performance in order to be eligible for payouts? For ACOs with shared savings or shared savings/shared risk payment arrangements, what percentage of an ACO's possible savings and/or losses will be contingent upon quality performance? For ACOs with capitated payment arrangements, will the state use a quality withhold approach? If so, what percentage of payments will ACOs be able to recoup based on quality performance?

7. ***How to monitor and revise quality measurement over time***. How will the state monitor and revise the ACO quality measurement strategy over time? Will measures by reviewed annually to determine whether any need to be added, removed, and/or revised?[7]

States developing ACO quality measurement strategies can borrow from the approaches of eight states that have participated in or are currently participating in the Center for Health Care Strategies' (CHCS) *Medicaid ACO Learning Collaborative*: **Maine**, **Massachusetts**, **Minnesota**, **New Jersey**, **Oregon**, **Rhode Island**, **Utah**, and **Vermont**. With support from The Commonwealth Fund, CHCS has worked with these states to accelerate Medicaid ACO planning and implementation. The chart on the following pages presents the quality measures of each state's Medicaid ACO program and key details, including measure domains and weights, reporting requirements, and contingencies related to payment.

Overview of Select Medicaid ACO Quality Programs

State	Program Name	Number of Measures	Measures Weighted	Pay-for-Reporting (P4R) and/or Pay-for-Performance (P4P) Strategy	How Quality Performance is Assessed	How Payment is Tied to Quality Performance
Maine	Accountable Communities Initiative	22 quality measures, including 14 core measures, three elective measures, and five monitoring measures	Yes	P4R: Year 1 P4P: Years 2 and 3	Assesses for achievement	■ 17 of 22 measures tied to payment ■ **Shared savings**: 100% of savings payout contingent upon quality score ■ **Shared losses**: Not contingent upon quality score
Massachusetts	Accountable Care Organizations	39 quality measures	Yes	P4R: Year 1 P4P: Certain measures transition from P4R to P4P over Years 2 through 5	Assesses for both achievement and improvement	■ All measures tied to payment ■ **Shared savings**: 100% of savings payout contingent upon quality score ■ **Shared losses:** 20% of losses contingent upon quality score
Minnesota	Integrated Health Partnerships	22 quality measures scored as four domains	Yes	P4R: Year 1 P4P: Years 2 and 3	Assesses for both achievement and improvement	■ All measures tied to payment ■ **Shared savings**: 25-50% of savings payout contingent upon quality score ■ **Shared losses**: Not contingent upon quality score
New Jersey	Medicaid Accountable Care Organization Pilot	33 quality measures, 21 mandatory measures, six voluntary measures	No	P4R: Year 1 P4P: Years 2 and 3	Assesses for improvement	■ 27 of 33 measures potentially tied to payment ■ Specifics of payment arrangements and impact of quality negotiated by parties in accordance with state guidelines
Oregon	Coordinated Care Organizations	17 incentive measures	No	P4P	Assesses for both achievement and improvement	All measures tied to payment via funding from a "quality pool," composed of a set percent of aggregated payments to all CCOs
Rhode Island	Accountable Entities (AE) Pilot	Between 7 and 35 quality measures, jointly defined by the AE and contracting managed care organization (MCO), and approved by the state[8]	No	P4P	Negotiated by the parties in accordance with state guidelines; reviewed and approved by the state	Negotiated by the parties in accordance with state guidelines; reviewed and approved by the state
Utah	Accountable Care Organizations	25 quality measures, not tied to payment	No	n/a	n/a	Quality measures not tied to payment
Vermont	Vermont Medicaid Next Generation Accountable Care Organization	12 quality measures	No	P4P[9]	Assesses for both achievement and improvement	Quality withhold (increases from 0.5% to 3% over 3 years) tied to performance on 10 out of 12 measures

TIP FOR READERS

When a quality measure used in a state's Medicaid ACO program is endorsed by a national body, such as the National Quality Forum (NQF), a reference number is indicated in parentheses next to the measure. This reference number was included in cases where the information was readily available in state-specific documents or provided by state officials who reviewed this technical assistance tool. The reference number enables users of this technical assistance tool to search online for additional information about the quality measure, including more detailed measure specifications such as exclusion and inclusion rules for the numerator and denominator.

Maine: Accountable Communities *(Program Launch: 2014)*

Maine based its quality scoring methodology for its Accountable Communities (AC) on the initial Medicare Shared Savings Program (MSSP) methodology.[10] ACs in Maine are evaluated on 17 quality measures, including 14 core measures and three of seven possible elective measures. All 14 core measures and three elective measures (per the AC's choosing) are linked to payment. There are five additional monitoring measures, which are required to be reported by ACs but are not linked to payment. [11] ACs earn quality points on a sliding scale based on their level of performance, with higher levels of performance corresponding to a higher number of quality points. To qualify for shared savings, an AC must meet the minimum attainment level (either 30 percent or the 30th percentile, depending on what performance data are available) on at least one measure in each quality domain. Each AC receives an overall quality score based on actual level of performance on each measure.[12] The final portion of shared savings an AC will receive is based on its quality performance score.[13]

Measure Domain	Domain Weights	Quality Measures (Evaluated on All Core Measures and Three Selected Elective Measures)	
		Core quality measures	Elective measures
At-Risk Populations	30%	■ Comprehensive Diabetes Care: HbA1c control (adults) (NQF#0575, HEDIS-CDC) ■ Comprehensive Diabetes Care: Eye exam (NQF#0055, HEDIS-CDC-D/SQC) ■ Asthma: medication management (HEDIS ASM)	■ Follow-up after hospitalization for mental illness (NQF#0576, HEDIS FUH) ■ Initiation and engagement of alcohol and other drug dependence treatment (NQF#0004, HEDIS IET) ■ Comprehensive Diabetes Care: HbA1c testing (NQF#0057, part of HEDIS-CDC) ■ Comprehensive Diabetes Care: Nephropathy monitoring (NQF#0062, HEDIS-CDC) ■ Use of spirometry testing in the assessment and diagnosis of chronic pulmonary disease (HEDIS SPR)
Care Coordination/ Patient Safety	30%	■ Prevention Quality Indicator – composite of chronic conditions per 100,000 population, ages 18 and older (PQI#92) ■ Pediatric Prevention Quality Indicator – composite of chronic conditions per 100,000 population, ages 6 through 17 (PDI#92) ■ Non-emergent emergency department use ■ Percent of primary care providers who successfully qualify for a health information technology electronic health record (EHR) program incentive payment (CMS ACO MSSP#11) ■ Hospital-wide, all-cause readmission (NQF#1789)	■ Use of high-risk medications in the elderly (HEDIS DAE)
Patient Experience	10%	■ Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey (CG-CAHPS), 12-month survey with patient-centered medical home (PCMH) items	
Preventive Health	30%	■ Adolescent well-care visits, age 12 to 21 (HEDIS AWC) ■ Development screening, first three years of life (NQF#1448) ■ Well-child visits ages 0 to 15 months (HEDIS W15) ■ Well-child visits ages 3 to 6 (HEDIS W34) ■ Well-child visits ages 7 to 11 (HEDIS CAP)	■ Breast cancer screening measure (NQF#0031)[14]

Source: Maine State Plan Title XIX of the Social Security Act, Integrated Care Model. Available at: http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/AC/Reimbursement_Section4_9%20AC_SPA%205%2012%20.pdf. Attachment 4.19-B, Section D (Quality Measures) and Section E (Savings and Loss-Sharing Calculation Methodology). See also MaineCare's Accountable Communities Initiative (Slide 19). Available at: http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/AC/2015%20AC%20Pres%20for%20VBP%20Site.pdf.

Massachusetts: Accountable Care Organizations *(Pilot Launch: 2016; Program Launch: 2017)*

Effective December 18, 2017, Massachusetts will implement three Medicaid ACO models: (1) Accountable Care Partnership Plan — a managed care organization (MCO) with a closely partnered ACO provider or a single, integrated entity that includes both an ACO provider and an MCO; (2) Primary Care ACO — an ACO provider organization that contracts directly with MassHealth, which remains the insurer; and (3) MCO-Administered ACO — an ACO provider organization that contracts directly with MassHealth-contracted MCOs. MassHealth's ACOs are anticipated to be evaluated on 39 quality measures across seven domains.[15] Of the 39 measures, 19 are expected to be clinical quality measures that will need to be reported by the ACOs.[16]

Massachusetts implemented a "phased" approach to assess ACO quality performance. Measurement begins as pay-for-reporting (P4R) in the first contract year (i.e., ACOs will be required to report all clinical quality measures satisfactorily to achieve a full quality score), and then certain measures transition to pay-for-performance (P4P) over the next four contract years (i.e., ACOs' scores will be based on their performance on identified measures). ACOs may receive "achievement points" and "improvement points" for all measures except those in the "Avoidable Utilization" domain.[17]

The entire amount of the ACO's shared savings is contingent upon the quality score, which is a number between 0 and 1.[18] To determine the ACO's shared savings, the potential shared savings amount is multiplied by the ACO's quality score. If an ACO has shared losses, only 20 percent of the losses are contingent upon the quality score.[19]

Measure Domain	Domain Weights	Proposed Quality Measures
Prevention & Wellness	Year 1: 20% Years 2-5: 10%	■ Well-child visits in first 15 months of life (NQF#1392) ■ Well-child visits ages 3-6 (NQF#1516) ■ Adolescent well-care visit ■ Weight assessment/nutrition counseling and physical activity for children/ adolescents (NQF#0024) ■ Prenatal care (NQF#1517) ■ Postpartum care (NQF#1517) ■ Oral evaluation, dental services (NQF#2517) ■ Tobacco use: screening and cessation intervention (NQF# 0028) ■ Adult BMI assessment ■ Immunization for adolescents (NQF#1407)
Chronic Disease Management	Year 1: 20% Years 2-5: 15%	■ Controlling high blood pressure (NQF#0018) ■ COPD or asthma admission rate in older adults ■ Asthma medication ratio (NQF#1800) ■ HbA1c poor control (NQF#0059) ■ Diabetes short-term complications admission rate (NQF#0272)
Behavioral Health/ Substance Use	Year 1: 25% Years 2-5: 15%	■ Developmental screening for behavioral health needs: under age 21 ■ Screening for clinical depression and documentation of follow-up plan: age 12+ (NQF#0418) ■ Depression remission at 12 months (NQF#0710) ■ Initiation and engagement of AOD treatment (Initiation) (NQF#0004) ■ Initiation and engagement of AOD treatment (Engagement) (NQF#0004) ■ Follow-up after hospitalization for mental Illness (NQF#0576) ■ Follow-up care for children prescribed ADHD medication – Initiation Phase (NQF#0108) ■ Follow-up care for children prescribed ADHD medication – Continuation Phase (NQF#0108) ■ Opioid addiction counseling
Long-Term Services and Supports (LTSS)	Year 1: 10% Years 2-5: 5%	■ Assessment for LTSS
Avoidable Utilization	Year 1: 0% Years 2-5: 20%	■ Potentially preventable admissions (3M) ■ All-cause readmission (NQF#1789) ■ Potentially preventable emergency department (ED) visits (3M)
Progress Toward Integration Across Physical Health, Behavioral Health, LTSS, and Health-Related Social Services	Year 1: 25% Years 2-5: 20%	■ Care plan collaboration across PC, BH, LTSS and SS providers ■ Utilization of Behavioral Health Community Partner (CP) care coordination services[20] ■ Utilization of LTSS Community Partners ■ Social service screening ■ Utilization of flexible services ■ Utilization of outpatient behavioral health services ■ Hospital admissions for SMI/SED/SUD population ■ ED utilization for SMI/SED/SUD population ■ ED care coordination of ED boarding population ■ All-cause readmission among LTSS CP eligible
Member Care Experience	Year 1: 0% Years 2-5: 15%	■ Primary care setting ■ Behavioral health care setting ■ LTSS care setting *[Note: Massachusetts has not yet finalized the survey instrument to evaluate enrollee experience in its ACO programs, but indicated that it intends to use a nationally validated survey, such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Clinician and Group Survey.]*

Source: Massachusetts bid solicitation for procurement of ACOs. Available at: https://www.commbuys.com/bso/external/bidDetail.sdo?docId=BD-17-1039-EHS01-EHS01-00000009207. For the list of Accountable Care Partnership Plan anticipated quality measures, see: RFR Attachment A_Appendix Q revised 012517. For the Primary Care ACO quality scoring approach, see RFR Attachment B – ACO Model B Model Contract.docx (Section 4.3.C). For the list of Primary Care ACO anticipated quality measures, see RFR Attachment B_Appendix B revised 012517. For the MCO-Administered ACO quality scoring approach, see RFR Attachment C – ACO Model C Model Contract.docx (Section 2.7.C). For the list of MCO-Administered ACO anticipated quality measures, see RFR Attachment C_Appendix B revised 012517.

Minnesota: Integrated Health Partnerships *(Program Launch: 2013)*

Minnesota offers two ACOs, known as Integrated Health Partnerships (IHPs): (1) Virtual IHPs, which include 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, as well as provider organizations with attributed populations from 1,000 - 1,999 patients; and (2) Integrated IHPs, which include integrated delivery systems with at least 2,000 attributed patients that provide a broad spectrum of outpatient and inpatient care as a common financial and organizational entity. Both ACOs are evaluated on 22 clinic- and hospital-level quality metrics. IHPs have flexibility to propose alternative measures and methods.

Each IHP's portion of shared savings is tied to its reporting and performance on these 22 measures.[21] The clinical measures are assigned 75 percent of quality performance weight and the patient experience measures are assigned 25 percent (the specific weights for hospital- and clinic-level metrics vary for integrated and virtual IHPs as indicated in the table below). The impact of the quality measures on shared savings payouts is scaled up over the course of an IHP's involvement in the program:

- **First year**: 25 percent of shared savings amounts will be impacted by the IHP's ***reporting*** of the core measures.
- **Second year**: 25 percent of shared savings amounts will be impacted by the IHP's ***performance*** on core measures.
- **Third year**: 50 percent of shared savings amounts will be impacted by the IHP's ***performance*** on the core measures.

In the second and third performance years, IHPs are assessed for their performance on each measure. More specifically, IHPs are assessed on both achievement and improvement, and awarded a score for each measure that is the greater of the achievement or improvement score.[22] 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	Domain Weights	Quality Measures	
Physician Clinical Measures	Integrated: 45% Virtual: 60%	**Optimal Diabetes Care Composite** ■ HbA1c control ■ Statin use unless allowed contraindications or exceptions are present ■ Blood pressure control ■ Tobacco cessation ■ Aspirin use for selected patients **Optimal Vascular Care Composite** ■ Statin use unless allowed contraindications ■ Blood pressure control ■ Tobacco cessation ■ Aspirin use **Behavioral Health** ■ Depression remission at six months	**Optimal Asthma Control Composite: Child/Adolescent** ■ Well-controlled ■ Not at risk of exacerbation **Asthma Care: Child/Adolescent** ■ Asthma education and self-management **Optimal Asthma Control Composite: Adults** ■ Well-controlled ■ Not at risk of exacerbation **Asthma Care: Adults** ■ Asthma education and self-management
Patient Experience Clinic Measures	Integrated: 15% Virtual: 20%	**Consumer Assessment of Healthcare Providers and Systems Clinician & Group Survey** ■ Timely appointments, care and information ■ How well providers communicate with patients	■ Helpful, respectful, and courteous office staff ■ Patient rating of provider as 9 or 10 ■ Measuring care coordination
Hospital Clinical Measures	Integrated: 30% Virtual: 15%	**AHRQ Patient Safety for Selected Indicators composite (PSI 90)** ■ Pressure ulcer rate (PSI 03) ■ Iatrogenic pneumothorax rate (PSI 06) ■ Central venous catheter- related blood stream infections rate (PSI 07) ■ Postoperative hip fracture rate (PSI 08) ■ Postoperative hemorrhage or hematoma rate (PSI 09)	■ Postoperative physiologic and metabolic derangement rate (PSI 10) ■ Postoperative respiratory failure rate (PSI 11) ■ Postoperative pulmonary embolism or deep vein thrombosis rate (PSI 12) ■ Postoperative sepsis rate (PSI 13) ■ Postoperative wound dehiscence rate (PSI 14) ■ Accidental puncture or laceration rate (PSI 15)
Hospital Patient Experience Measures	Integrated: 10% Virtual: 5%	**Consumer Assessment of Healthcare Providers and Systems Hospital Survey** ■ Communication with nurses ■ Communication with doctor ■ Responsiveness of hospital staff ■ Pain management ■ Communication about medications	■ Cleanliness of hospital environment ■ Quietness of hospital environment ■ Discharge information ■ Overall hospital rating ■ Recommend the hospital as 9 or 10 ■ Care transitions

Source: Minnesota Department of Human Services, Integrated Health Partnerships Contract [2017 RFP Version]. Available at: http://www.dhs.state.mn.us/main/groups/business_partners/documents/pub/dhs-286917.pdf. See Attachment B-2 for quality measure information.

New Jersey: Medicaid ACO Demonstration Project *(Program Launch: 2015)*

New Jersey requires ACOs to measure and report a "core" set of 21 quality measures across five domains: (1) Behavioral Health; (2) Chronic Conditions; (3) Patient Experience; (4) Prevention and Effectiveness of Care; and (5) Resource and Utilization.[23] 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 condition-related measures provided by the state. The New Jersey Medicaid ACO Demonstration Project requires quality to be improved in order for gain-sharing payments to be made. The impact of quality measures on shared savings payouts is scaled up over the course of the three-year demonstration program, as follows:

- **First year**: Reporting only, performance is not measured.
- **Second year**: Relative performance improvement must be shown for at least two quality measures.
- **Third year**: Relative performance improvement must be shown for at least five quality measures, and absolute improvement must be shown for at least two quality measures.

A report conducted by the Rutgers Center for State Health Policy, *Year 1 of the New Jersey ACO Demonstration Project: Assessment of Operations and Care Management Strategies*,[24] found that ACOs are developing targeted strategies to engage providers and improve targeted subsets of quality measures. The ACO representatives interviewed for this report generally agreed that emphasizing too many measures at one time is distracting, and that a narrower focus is required to make a meaningful impact on quality.

Measure Domain	Core Measures
Behavioral Health	■ Initiation and engagement of alcohol and other drug dependence treatment ■ Anti-depressant medication management
Chronic Conditions	■ Annual monitoring for patients on persistent medications (year 2) ■ Annual HIV/AIDS medical visit
Patient Experience (CAHPS/Satisfaction)	■ 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
Prevention and Effectiveness of Care	■ Screening for clinical depression and follow-up plan ■ Annual dental visit ■ Well-child visits first 15 months
Resource and Utilization	■ Emergency department visits ■ Inpatient readmission within 30 days ■ Preventable hospitalizations ■ Provider visit within 7 days of hospital discharge ■ Return to emergency department within 7 days of hospital discharge ■ All hospitalizations ■ Percent of PCPs who successfully qualify for EHR incentive payment

Voluntary Measures (Must Select Six Voluntary Measures)

Prevention/Effectiveness of Care
(Must select one measure from list below)

- Childhood immunization status
- Adolescent immunization
- Well-child visits first 15 months
- Well-child visits ages 3 to 6 years
- 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 ages 21-24
- Prenatal and postpartum care

Chronic Conditions
(Must select five measures from list below)
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 acute myocardial infarction
- 30-day readmission rate following heart failure
- 30-day readmission rate following pneumonia
- COPD admission rate
- CHF admission rate
- Adult asthma admission rate
- Respiratory Syncytial Virus in neonates <35 weeks

Source: New Jersey Medicaid ACO Demonstration Project Quality metrics. Available at: http://www.nj.gov/humanservices/dmahs/info/NJ_Medicaid_ACO_Demonstration_Project_Quality_Metrics_4-18-16.pdf.

Oregon: Coordinated Care Organizations *(Program Launch: 2013)*

In 2017, Oregon will evaluate its Coordinated Care Organizations (CCOs) on 17 incentive measures. The state has established funds in a "quality incentive pool" that will be used to reward CCOs for the quality of care provided to Medicaid members. CCOs' performance on the 17 incentive measures will determine the amount of their quality pool payment.[25] In order to be awarded funds from the quality pool, CCOs will be measured against a specified benchmark for each of the 17 CCO incentive measures. CCOs that do not meet the benchmark for a given measure will be assessed on improvement against their own baseline target ("improvement target"). There are two phases for the distribution of quality incentive pool funds:

- **First phase**: Each CCO's portion of the maximum quality pool payment is based on the number of measures on which it achieves either an absolute benchmark or demonstrates improvement over its own performance in the previous performance year. The benchmarks are the same for all CCOs — regardless of geographic region and patient mix — and CCO performance on these measures is treated on a pass/fail basis. The Patient Centered Primary Care Home (PCPCH) enrollment measure is rated on a sliding scale. If a CCO meets either achievement or improvement targets on at least 75 percent of measures, 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 that have not been allocated to CCOs, these funds are then distributed to CCOs that meet either achievement or improvement targets on "challenge" measures. The 2017 challenge measures are depression screening and follow up; developmental screenings in the first 36 months of life; and effective contraceptive use.

Oregon has a Metrics and Scoring Committee that reviews data and relevant literature; determines which measures will be included in the CCO incentive program; and establishes the performance benchmarks and targets to be used in the incentive program. This committee has tracked the CCO quality measures used since 2013,[26] the first year of the program. As part of its approved 1115 Medicaid Demonstration waiver renewal,[27] Oregon also plans to develop capitation rates with a profit margin range that varies by CCO, as opposed to a fixed percentage of premium for each CCO. The capitation rates for CCOs identified as high performing (i.e., those showing quality improvement and cost reduction in the previous years) will have a higher percentage of profit margin built into their capitation rates than lower performing CCOs. This aspect of the capitation rate development is separate from the quality incentive pool.

Measure Domain	Quality Measures *[Challenge measures annotated with an asterisks (*)]*
Chronic Condition Management	■ Controlling high blood pressure (NQF#0018) ■ Follow-up after hospitalization for mental illness (NQF#0576) ■ HbA1c poor control (NQF#0059)
Patient/Caregiver Experience	**Access to Care, Composite - Consumer Assessment of Healthcare Providers and Systems (CAHPS) - Health Plan Survey 5.0H** ■ Got care right away for illness / injury / condition as soon as you/child needed ■ Got an appointment for routine care as soon as you/child needed **Satisfaction with Care, Composite - Consumer Assessment of Healthcare Providers and Systems (CAHPS) - Health Plan Survey 5.0H** ■ Health plan's customer service gave needed information or help ■ Treated with courtesy and respect by health plan's customer service staff
Population Health	■ Ambulatory care: emergency department utilization (HEDIS AMB) ■ Cigarette smoking prevalence ■ Patient Centered Primary Care Home enrollment
Preventive Health	■ Adolescent well-care visits (HEDIS AWC) ■ Childhood immunization status (NQF#0038) ■ Colorectal cancer screening (CMS#130) ■ Dental sealants on permanent molars for children ■ Depression screening and follow-up plan (NQF#0418)* ■ Developmental screening in the first three years of life (NQF#1448)* ■ Effective contraceptive use (among women at risk for unintended pregnancy)* ■ Mental, physical, and dental health assessment within 60 days for children in DHS custody (foster care) ■ Prenatal and postpartum care (NQF#1517)

Source: 2017 CCO Incentive Measure Benchmarks. Available at: http://www.oregon.gov/oha/analytics/CCOData/2017%20CCO%20Incentive%20Measure%20Benchmarks.pdf.

Rhode Island: Accountable Entities *(Pilot Launch: 2016)*

Rhode Island's Accountable Entity (AE) pilot program began in January 2016. Under this program, pilot AEs deemed eligible by the state entered into contractual arrangements with Medicaid managed care organizations (MCOs) to manage a population of Medicaid members under a total cost of care arrangement. Pilot AEs are evaluated on a set quality measures jointly defined by the MCO and the AE and approved by the state, in accordance with state specifications. The table below outlines the quality measures used by MCOs to assess performance of their contracted AEs for 2016 and 2017.

While the specific terms of savings and risk transfer between the MCO and the AE are at the discretion of contracting parties, Rhode Island did stipulate that any savings observed must be in light of defined quality metrics to help ensure that any cost savings realized are due to improved care and outcomes rather than denial of services. More specifically, Rhode Island initially recommended that MCOs apply a "quality score factor" to any potential shared savings to determine the final amount of payout for distribution to AEs. For example, a quality score of 75 percent applied to a potential shared savings pool of $100 would result in a maximum pool of $75. However, each MCO ultimately took a different approach to determine the methodology behind how quality performance would impact AE savings payouts in methodologies that were reviewed and approved by the state.

Rhode Island will be launching its full AE program in January 2018, and the state is considering revisions to its quality process based in part on stakeholder feedback[28] on its AE Program Roadmap.[29] Stakeholder feedback included recommendations that the state minimize the number of required quality measures used for the AE program and to align them with those developed under its State Innovation Model (SIM) Test Grant.[30] The final product under the SIM grant was a "menu" of 64 measures,[31] with a core set of 11 measures specifically for use with ACOs.

Health Plan	Quality Measures	
Neighborhood Health Plan of Rhode Island Contracts with four AEs: Blackstone Valley Community Health Care, Coastal Medical, Inc., East Bay Community Health Center, and Providence Community Health Centers	**HEDIS Pediatric Measures** ■ Immunizations for adolescents (NQF#1407, HEDIS IMA) ■ Lead screening for children ■ Chlamydia screening, ages 16-20 (NQF#0033, HEDIS-CHL/SQC) ■ Appropriate testing for children with pharyngitis (NQF#0002, NEDIS-CWP/SQC) ■ Appropriate treatment for children with upper respiratory infection (NQF# 0069, HEDIS URI) ■ Medication management for people with asthma, ages 5 – 11 (HEDIS MMA) ■ Medication management for people with asthma, ages 12 – 18 (HEDIS MMA) ■ Follow-up care for children prescribed ADHD medication – Initiation Phase (NQF#0108) ■ Follow-up care for children prescribed ADHD medication – Continuation Phase (NQF#0108) ■ Children and adolescents' access to primary care, ages 12 – 24 months ■ Children and adolescents' access to primary care, ages 25 months – 6 years ■ Children and adolescents' access to primary care, ages 7 –11 years ■ Children and adolescents' access to primary care, ages 12 –19 years ■ Well-child visits in the first 15 months of life, 6+ visits (NQF#1392, HEDIS W15/EPSDT) ■ Well child visits ages 3 to 6 years (HEDIS W34) ■ Adolescent well child visits (HEDIS AWC)	**HEDIS Adult Measures** ■ Adherence to antipsychotic medications for schizophrenia (HEDIS SAA) ■ Adults' access to preventive/ambulatory health services, ages 20-44 years ■ Adults' access to preventive/ambulatory health services, ages 25-60 years ■ Adults' access to preventive/ambulatory health services, ages 65+ ■ Antidepressant medication management: acute phase ■ Antidepressant medication management: continuation phase ■ Avoidance of antibiotic treatment in adults with acute bronchitis ■ Breast cancer screening (NQF#0031, HEDIS-BCS) ■ Cervical cancer screening (NQF#0032, HEDIS-CCS/SQC) ■ Chlamydia screening in women, ages 21 – 24 years (NQF#0033, HEDIS-CHL/SQC) ■ Comprehensive Diabetes Care: HbA1c testing (NQF#0057, HEDIS-CDC-D/SQC) ■ Comprehensive Diabetes Care: Eye exam (NQF#0055, HEDIS-CDC-D/SQC) ■ Comprehensive Diabetes Care: Nephropathy monitoring (NQF#0062, HEDIS-CDC-D/SQC) ■ Diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication ■ Medication management for people with asthma, ages 19 – 50 (HEDIS MMA) ■ Medication management for people with asthma, ages 51 – 64 (HEDIS MMA) ■ Monitoring of persistent medications ACE inhibitors or ARBs ■ Monitoring of persistent medications: diuretics ■ Use of imaging studies for low back pain (NQF#0052, HEDIS LBP/SQC)
United HealthCare Contracts with two AEs: Integra Community Care Network (an AE focused on behavioral health) and Prospect Health Services Rhode Island, Inc.	**Measures for Integra Community Care Network** ***(AE focused on behavioral health)*** ■ Adults' access to preventive services ■ Diabetes eye exam ■ Breast cancer screening ■ Asthma medication ratio ■ Chlamydia screening in women ■ Adherence to antipsychotic medications for individuals with schizophrenia ■ Follow-up after hospitalization for mental illness: 7 days	**Measures for Prospect Health Services Rhode Island, Inc.** ■ Adults' access to preventive services ■ Diabetes eye exam ■ Diabetes nephropathy ■ Asthma medication ratio ■ Antidepressant medication management: continuation phase ■ Follow-up after hospitalization for mental illness: 30 days ■ Chlamydia screening in women

Source: Information provided to CHCS by Rhode Island on the quality measures used by each health plan for the AE pilot program.

Utah: Accountable Care Organizations *(Program Launch: 2014)*

In Utah, the State Quality Committee initially recommended a set of 25 quality measures for the state's Accountable Care Organizations (ACOs) to track and trend using performance benchmarks and scoring methodologies. Currently, the state has contracts with four Medicaid ACOs providing physical health services — all of which meet the CMS definition of an MCO. All of Utah's managed care contracts are full risk, capitated contracts and therefore assume the risk for all health care costs for their members.[32] The measures selected for the ACO contracts focus on preventive, chronic, and acute care for adults and children as well as maternity care — and are not tied directly to capitated rates. However, the ACOs are required to report the information below and are given flexibility to pursue innovative payment mechanisms with their network providers that encourage improved quality of care.

Measure Domain	Quality Measures (Reporting Only)
Maternity Care	■ Access to care, maternity - Consumer Assessment of Healthcare Providers and Systems (CAHPS) - Health Plan Survey ■ Caesarean rate for nulliparous singleton vortex (NQF#0471) ■ Prenatal and postpartum care rate (NQF#0139, HEDIS FPC/SQC) ■ Percentage of live birth weighing less than 2,500 grams (NQF#1392) ■ Satisfaction with care, maternity - CAHPS Health Plan Survey
Newborn/Infant Care	■ Childhood immunization status: Combo 3 (NQF#0038, HEDIS-CIS/SQC) ■ Well-child visits in the first 15 months of life (NQF#1392, HEDIS W15/EPSDT)
Pediatric Care	■ Appropriate testing for children with pharyngitis (NQF#0002, NEDIS-CWP/SQC) ■ Appropriate treatment for children with upper respiratory infection (NQF#0069, HEDIS-URI/SQC) ■ Access to care, child - CAHPS Health Plan Survey ■ Immunizations for adolescents (NQF#1407, HEDIS IMA) ■ Hospital-wide, all-cause readmission (NQF#1789) ■ Satisfaction with care, child - CAHPS Health Plan Survey ■ Well-child visits, ages 3-6 (HEDIS W34) ■ Use of appropriate medications for asthma (NQF#0036, HEDIS-ASM/SQC)
Adult Care	■ Access to care, adult - CAHPS Health Plan Survey ■ Breast cancer screening (NQF#0031, HEDIS-BCS) ■ Cervical cancer screening (NQF#0032, HEDIS-CCS/SQC) ■ Chlamydia screening in women (NQF#0033, HEDIS-CHL/SQC) ■ Comprehensive Diabetes Care: Eye exam (NQF#0055, HEDIS-CDC-D/SQC) ■ Comprehensive Diabetes Care: HbA1c Testing (NQF#0057, HEDIS-CDC-D/SQC) ■ Controlling high blood pressure (NQF#0018, HEDIS-CBP) ■ Hospital-wide, all-cause readmission (NQF#1789) ■ Satisfaction with care, adult - CAHPS Health Plan Survey ■ Use of imaging studies for low back pain (NQF#0052, HEDIS LBP/SQC)

Source: ACO Model Contract, Section 11.2.6. Quality Measures. Available at: https://sites.google.com/a/utah.gov/cqm/aco-model-contract/ACO_ModelContractFinalJul_14.docx?attredirects=0&d=1

Vermont: Vermont Medicaid Next Generation ACO model *(Program Launch: 2017)*

In January 2017, the Department of Vermont Health Access (DVHA) launched the Vermont Medicaid Next Generation (VMNG ACO) Model pilot program. The VMNG is a new program in which an ACO (or ACOs) receives a prospective payment, and assumes accountability for the costs and quality of care for prospectively attributed Medicaid members. Building off of the previous Vermont Medicaid ACO Shared Savings Program, which launched in 2014, the VMNG ACO reduced the number of quality measures from 28 to 12 — with 10 out of the 12 linked to payment (just over a third were previously tied to payment). Vermont has introduced an upside-and-downside risk capitated payment arrangement for the VMNG, with a quality withhold that grows over time from 0.5 percent of capitation in 2017 to three percent of capitation in 2019.[33] The amount of the quality withhold that ACOs receive is based on their performance attainment relative to national (or multi-state) benchmarks and/or improvement over prior performance. [34] ACOs must distribute some or all of the quality incentive pool funds they receive to their provider networks using a methodology of their choosing, subject to DVHA approval; any monies not distributed will be reinvested in quality improvement initiatives at the ACO level. DVHA may adjust performance measures and targets in future contract years.

Measure Domain	Measure Use	Quality Measures	**Benchmarks** *[ACOs will be granted full credit in 2017 for reporting on measures with an asterisks (*), due to lack of available national or multi-state benchmark for that year.]*
Avoidable Utilization	**Payment**	All cause unplanned admissions for patients with multiple chronic conditions (CMS ACO #38)*	N/A — national or multi-state benchmark not available for 2017
Behavioral Health/ Substance Use	**Payment**	Engagement of alcohol and other drug dependence treatment (NQF#0004)	National Medicaid Benchmark for 2017
	Reporting	Follow-up after hospitalization for mental illness (7 day rate) (NQF#0576, HEDIS FUH)	National Medicaid Benchmark for 2017
	Payment	Initiation of alcohol and other drug dependence treatment (NQF#0004)	National Medicaid Benchmark for 2017
	Payment	30 day follow-up after discharge from the ED for mental health (NQF#2605)*	N/A — national or multi-state benchmark not available for 2017
	Payment	30 day follow-up after discharge from the ED for alcohol and other drug dependence (NQF#2605)*	N/A — national or multi-state benchmark not available for 2017
Chronic Disease Management	**Payment**	Diabetes: HbA1c poor control (>9%) (NQF#0059)	National Medicaid Benchmark for 2017
	Payment	Hypertension: controlling high blood pressure (NQF#0018)	National Medicaid Benchmark for 2017
Prevention and Wellness	**Payment**	Adolescent well care visits (HEDIS AWC)	National Medicaid Benchmark for 2017
	Payment	Developmental screening in the first three years of life (NQF#1448)	Multi-state Medicaid benchmark for 2017
	Payment	Depression screening and follow-up plan (NQF#0418)	National Medicaid Benchmark for 2017
	Reporting	Timeliness of Prenatal Care (HEDIS PPC)	National Medicaid Benchmark for 2017

Source: Attachment B, DVHA/Accountable Care Organization Contract #32318, pp. 85-91. Available at: http://dvha.vermont.gov/administration/contracts.

ABOUT THE CENTER FOR HEALTH CARE STRATEGIES

The Center for Health Care Strategies (CHCS) is a nonprofit health policy resource center dedicated to advancing health care access, quality, and cost-effectiveness in publicly financed care. 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.

ADDITIONAL RESOURCES

State-based Medicaid ACOs are becoming increasingly prevalent, with more states pursuing this model as a way to improve health outcomes and control costs. CHCS' *Medicaid Accountable Care Organization Resource Center*, made possible through The Commonwealth Fund, houses practical resources to help states design, implement, and refine ACO programs. Visit www.chcs.org/aco-resource-center.

ENDNOTES

[1]Initial Core Set of Children's Health Care Quality Measures, available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/child-core-set/index.html.

[2]Adult Health Care Quality Measures, available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html.

[3]The Health Information Technology for Economic and Clinical Health (HITECH) Act authorized the Medicare and Medicaid Electronic Health Records (EHR) Incentive Programs. To qualify for these incentive payments and subsequently avoid penalties, eligible providers must demonstrate the use of certified EHR technology in a meaningful manner and meet other requirements, including submitting information to CMS on measures of their clinical quality.

[4]CMS' Core Quality Measures, available at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityMeasures/Core-Measures.html.

[5] *Medicaid Accountable Care Organization Measurement Tool for States*, Center for Health Care Strategies, April 2013. Available at: http://www.chcs.org/resource/medicaid-accountable-care-organization-quality-measurement-strategy-tool/.

[6] Medicare Payment Advisory Commission (MedPAC) Comment Letter to CMS on Accountable Care Organizations, June 16, 2014, available at: http://www.medpac.gov/docs/default-source/comment-letters/comment-letter-to-cms-on-accountable-care-organizations-june-16-2014-.pdf?sfvrsn=0.

[7]A state may want to remove measures for a variety of reasons, including the identification of new or improved measures; data measurement challenges; weak correlation with health outcomes; no longer clinically relevant due to new advances in medical treatment; or measures being "topped-out" (i.e., allow little room for improvement because most providers already perform highly). For example, a state may want to remove a measure that assessed providers' adoption of electronic health records once such systems have been widely adopted.

[8]The specific number of measures used in Rhode Island varies by AE and the contracting MCO.

[9]For the first contract year (2017) Vermont has 10 payment measures and two reporting measures. Payment measures are measures for which ACO performance will impact the way the quality incentive pool funds may be distributed. Reporting measures are those that the ACO is required to and receives "points" for reporting; however, ACO performance on the two reporting measures will not impact the distribution of quality incentive pool funds in 2017.

[10]Medicare Shared Savings Program Guide to Quality Performance Scoring Methods for Accountable Care Organizations, available at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2012-11-ACO-quality-scoring-supplement.pdf.

[11]The five monitoring measures are: (1) diabetes glucose control in children; diabetes HbA1c testing in children; out-of-home placement days in behavioral health residential treatment center for children and adults; cardiovascular health screening for people with schizophrenia or bipolar disorder who are prescribed antipsychotic medications; and imaging for low back pain.

[12]A quality score is calculated for each AC by summing the total points earned for each quality measure in each domain and dividing by the total points available for that domain to produce a percentage score for each domain. The domain percentages are then multiplied by the domains weights to obtain an overall quality score.

[13]Maine implemented both a one-sided model (sharing savings, but not losses, for the entire term of the first agreement) and a two-sided model (sharing both savings and losses in Years 2 and 3 of the agreement), allowing ACs to opt for one or the other model.

[14]NQF #0031 is no longer endorsed.

[15]The anticipated quality measures were specified in appendices to the Model Contracts included as attachments to the Requests for Responses (RFR), originally released in September 2016 by MassHealth to solicit responses from ACOs and amended in November and December 2016 and in January 2017.

[16]MassHealth anticipates ongoing evaluation of this methodology, including, but not limited to, the list of quality measures, during the contract term.

[17]For the Avoidable Utilization measures — potentially preventable admissions and hospital all-cause readmissions measures — the ACO will be measured against a reduction target that is set based on the ACO's baseline performance relative to other ACOs.

[18]A quality score is calculated for each ACO by summing all achievement points and improvement points in a given domain; dividing by the maximum number of available points in each domain; and then weighting the resulting domain scores by the domain weights outlined the table below.

[19]The information in this section refers to the use of the quality score to modify shared savings and losses for Primary Care ACOs and MCO-Administered ACOs. The quality score approach for Accountable Care Partnership Plans is not yet finalized, but is anticipated to apply analogously to gain and loss on capitated payments.

[20]MassHealth will procure Community Partners — entities experienced with Behavioral Health (BH) and Long Term Services and Supports (LTSS) — to support ACOs in providing coordinated care to members with complex BH and LTSS needs.

[21]Integrated IHPs are at risk for shared losses; however, the amount of shared losses are not contingent upon quality performance.

[22]The total points earned by IHPs in each measure category are the summed and divided by the total points available for that category to produce a category score of the percentage of points earned versus points available. This score is then converted into an overall quality score that it weighted for clinical versus patient experience measures as defined in the table above.

[23]Some of these metrics are only required to be collected in year 2 of the demonstration.

[24]Year 1 of the New Jersey ACO Demonstration Project: Assessment of Operations and Care Management Strategies, available at: http://www.cshp.rutgers.edu/Downloads/11150.pdf.

[25]The quality incentive pool is comprised of a pre-defined percent of aggregated payments made to all CCOs. In 2016, the quality pool amount was 4.25 percent of aggregate CCO payments made to all CCOs for calendar year 2016 services.

[26]Coordinated Care Organizations Incentive Measures since 2013, available at: http://www.oregon.gov/oha/analytics/CCOData/CCO%20Incentive%20Measures%20and%20changes%20since%202013.pdf.

[27]CMS Letter to Oregon Health Authority on Approval of Oregon's Section 1115 Waiver Extension, January 12, 2017, available at: http://www.oregon.gov/oha/hpa/Medicaid-1115-Waiver/Documents/Waiver%202017.pdf.

[28]Accountable Entities Public Comments, available at: http://www.eohhs.ri.gov/Initiatives/AccountableEntities/PublicComments.aspx.

[29]Accountable Entities Resource Documents, available at: http://www.eohhs.ri.gov/Initiatives/AccountableEntities/ResourceDocuments.aspx.

[30]As part of its SIM grant, Rhode Island developed a SIM steering committee comprised of payers, providers, measurement experts, consumer advocates and other community patterns to develop an aligned measure set for use across all payers in the state. See http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/State%20Innovation%20Model/RISIMOperationalPlanVersion1April282016.pdf.

[31]SIM Aligned ACO Measure Set for 2017, available at: http://www.eohhs.ri.gov/Portals/0/Uploads/Documents/SIM/BailitFinalMeasureSetsCompiled.pdf.

[32]Utah Department of Health, Managed Care Quality Strategy, avaialable at: https://medicaid.utah.gov/Documents/pdfs/ManagedCareQualityStrategy.pdf. See pages 3 and 13.

[33]Under Vermont's quality withhold arrangement, a state health plan, or organization such as an ACO retains or "withholds" a portion of payments that are contractually due to their provider network. The withheld amounts are placed in one or more risk pool funds, and whether or not the provider network will receive all or a portion of the money will depend on the extent to which the provider network achieves specific, predetermined quality targets. Any money not distributed to the ACO's network providers will be reinvested at the ACO level for quality improvement initiatives.

[34]The ACO may earn up to two points per measure for attainment relative to national (or multistate) benchmarks. Beginning in the second year (2018), the Contractor may earn points for improvement over the prior year's performance.