



## Fact Sheet

### Accountable Care Organizations in Medicaid<sup>1</sup>

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#### **Background**

Accountable Care Organizations (ACOs) are entities that agree to provide coordinated care to enrollees and are eligible for incentive payments if they improve health and reduce costs. ACOs have been used in Medicare for several years but, until recently, much less so in Medicaid. That is beginning to change. At least 17 states have authorized or are considering implementing Medicaid ACOs. Nearly all of the current ACO models will be serving at least some Medicaid beneficiaries with disabilities.

In this fact sheet, we describe Medicaid ACOs and provide a brief history of the evolution of ACOs. We also highlight how some states are using ACOs and the similarities and differences between ACOs in different states, particularly those affecting people with disabilities. Finally, we provide tips for advocates when their states consider or operate Medicaid ACOs.

#### **Background**

According to the federal Centers for Medicare and Medicaid Services (CMS), the purpose of the ACO is to improve the quality of care while saving money. Most Medicaid ACOs are not governed by specific federal statutory or regulatory

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requirements and therefore vary in design and function. Common features, however, are the emphasis on care coordination and the requirement to meet certain quality measures combined with a reimbursement system allowing for shared savings for participating providers. ACOs usually consist of a group of providers that contract with the state to provide care for a set group of enrollees. They are responsible for providing a comprehensive set of services; in many cases, this includes behavioral health and long-term services and supports. Many use a medical or health home model. They may be reimbursed on a capitated or fee for service basis. Significantly, ACOs are eligible to receive bonus-like payments if they achieve a certain level of savings and meet specified quality measures. Some are subject to risk, meaning that they will be exposed to financial losses if they do not meet savings or quality targets. In some cases, managed care organizations (MCOs) or primary care case managers (PCCMs) contract to act as ACOs. This may leave Medicaid beneficiaries and advocates confused about who has responsibility for their care.

Adding to the confusion, states may use different names for their ACOs. In Oregon, they are called Coordinated Care Organizations (CCOs). In Illinois, they are Accountable Care Entities (ACEs) and in Colorado, Accountable Care Collaboratives (ACCs). Alabama has recently submitted a proposal for an 1115 demonstration to operate Regional Care Organizations (RCOs). For clarity, in this fact sheet, we refer to these organizations generically as ACOs.

## Sample Definitions:

### Illinois:

**Accountable Care Entity (ACE):** An organization comprised of and governed by its participating providers, with a legally responsible lead entity, that is accountable for the quality, cost, and overall care of its Enrollees and meets the requirements specified in this Solicitation. The ACE demonstrates an integrated delivery system, shares clinical information in a timely manner, and designs and implements a model of care and financial management structure that promotes provider accountability, quality improvement, and improved health outcomes.

State of Illinois, Solicitation for Accountable Care Entities (2014-24-002) at 3.

### Maine:

**Accountable Community (AC):** Provider(s) under a Lead Entity that contracts with the Department to share in a percentage of any savings achieved for an assigned member population, commensurate with performance on specified quality metrics. Providers also have the option to agree to share in any downside risk in years two and three of the initiative in exchange for sharing in a greater percentage of any shared savings.

Maine Dep't of Health and Human Servs., Request for Applications, MaineCare Accountable Communities Initiative at 5 (2013).

### Oregon:

**Coordinated Care Organizations** are community-based comprehensive managed care organizations which operate under a risk contract with the state. For purposes of CMS regulations, CCOs are managed care organizations and will meet the requirements of 42 CFR Part 438 unless a requirement has been specifically identified in the waiver authorities for this demonstration.

CMS Amended Waiver List and Expenditure Authority: Oregon Health Plan at 26 (No. 21-W-00013/10 and 11-W-00160/10) (April 8, 2014)

## History: Medicare ACOs

ACOs have been serving Medicare beneficiaries since the mid 2000s. CMS defines Medicare ACOs as “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the Medicare patients they serve.”<sup>2</sup> There are three basic types of ACOs in Medicare: Pioneer ACOs, Advance Payment Models, and Shared Savings Models. Pioneer ACOs are provider groups that already had some experience coordinating care. As their

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<sup>2</sup> CMS, Accountable Care Organizations, <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/aco>.

names indicate, Advance Payment ACOs receive advance payments to coordinate care.<sup>3</sup> Shared Savings models were created by the Affordable Care Act, and are structured to receive part of any savings obtained by the method of care delivery.<sup>4</sup>

## Medicaid ACOs

The ACA also authorized Pediatric Accountable Care Organization Demonstration Projects through which pediatric providers would join to form ACOs. These ACOs are subject to the same legal requirements as Medicare Shared Savings ACOs.<sup>5</sup> The Demonstration, which was supposed to run from 2012 to 2016, has not been funded.

CMS has, however, encouraged states to establish Medicaid ACOs as part of its efforts to encourage states to create integrated care models (ICMs).<sup>6</sup> ICMs provide coordinated care and are intended to improve health outcomes and beneficiary experience while reducing expenditures. ICMs include ACOs and medical or health homes.<sup>7</sup> States have authorized ICMs, including Medicaid ACOs, using authority from CMS such as Section 1115 Demonstrations, Section 1115A innovation waivers, or state plan options that allow states to provide health homes for enrollees with chronic conditions or establish primary care case management systems.<sup>8</sup>

CMS has issued guidance to states on how they can develop shared savings initiatives in Medicaid, including Medicaid ACOs. While Medicare ACOs may be models in some respects, CMS states that Medicaid and Medicare enrollees have different needs, thus states are not obligated to comply with requirements governing Medicare shared savings arrangements.<sup>9</sup> Significantly, the guidance states that the agency “is not interested, at this time, in partnering with states on

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<sup>3</sup> 42 U.S.C. § 1395jjj, added by Pub. L. No. 111-148, § 3022 (Mar. 23, 2010); see also 42 C.F.R. part 425 (governing Medicare Shared Savings program and defined ACOs).

<sup>4</sup> 42 U.S.C. § 1395jjj; 42 C.F.R. part 425 (governing Medicare Shared Savings program and defined ACOs).

<sup>5</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2406, codified at 42 U.S.C. § 1396a note.

<sup>6</sup> For general information about integrated care models, see CMS, Integrated Care Resource Center, <http://www.integratedcareresourcecenter.com/> (last visited June 26, 2014).

<sup>7</sup> CMS, *Dear State Medicaid Director*, (July 10, 2012) (SMDL#12-001).

<sup>8</sup> CMS, *Dear State Medicaid Director* at 1, (July 10, 2012) (SMDL #12-002). Primary Care Case Management can be provided to all Medicaid enrollees through a state plan amendment. *Id.* at 3; see 42 U.S.C. § 1396d(t)(1); 42 C.F.R. § 440.168. To limit enrollees to providers with PCCM contracts, states must use the authority of 42 U.S.C. § 1396d(a)(25) and 42 C.F.R. § 438.6. *Id.* at Attachment 1.

<sup>9</sup> *Id.* at 2.

shared savings proposals that are based only on cost savings and that do not improve quality and health outcomes or that limit access to eligible beneficiaries.”<sup>10</sup>

According to the National Association of State Health Policy, 18 states have some form of Medicaid ACOs planned, in development, or operating: Alabama, Arkansas, California, Colorado, Illinois, Iowa, New Jersey, Louisiana, Maine, Massachusetts, Minnesota, New York, North Carolina, Oregon, Texas, Utah, Vermont, and Washington.<sup>11</sup> Although the structure and organizations of these Medicaid ACOs vary, they have several features in common. All are responsible for ensuring delivery of a comprehensive package of services to a defined set of enrollees. They are also eligible for shared savings if they meet specified cost and quality goals. Below we provide some examples of similarities and differences between ACO models in various states.<sup>12</sup>

## Structure

ACOs are commonly defined as affiliations of individual or group health care providers, but they can also include - or be- managed care organizations. For example, Maine’s ACs are comprised of provider organizations that are governed by a lead legal entity.<sup>13</sup> Vermont’s system is similar. Notably, according to draft standards, 75% of the Vermont ACO governing body must be selected by ACO participants and be representative of the types of practitioners practicing in the ACO. At least one member must be a Medicaid beneficiary.<sup>14</sup>

In contrast, Oregon’s CCOs are essentially MCOs and are therefore required to comply with the federal regulations governing those entities.<sup>15</sup> This means that, among other things, they must cover a comprehensive package of services and are

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<sup>10</sup> CMS, *Dear State Medicaid Director* at 1, (Aug. 30, 2013) (SMDL #13-0005).

<sup>11</sup> National Academy for State Health Policy, *Accountable Care Activity Map* (Interactive), <http://nashp.org/state-accountable-care-activity-map> (last visited June 23, 2014). Although NASHP identifies North Carolina as a state that is considering ACOs, recent legislation

<sup>12</sup> We reviewed a variety of sources for this fact sheet, including laws, statutes, applications for 1115 demonstrations, and requests for proposals or applications. In some cases, states are at the early stages of implementing ACOs, so this information may change before the ACOs actually begin operating.

<sup>13</sup> Maine Dep’t of Health and Human Servs., *Request for Applications, MaineCare Accountable Communities Initiative* at 9-10, [http://www.maine.gov/dhhs/oms/pdfs\\_doc/vbp/Accountable\\_Communities\\_RFA.pdf](http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/Accountable_Communities_RFA.pdf).

<sup>14</sup> Vermont Medicaid ACO Shared Savings Program (SSP) Pilot Compilation of Pilot Standards at 2 (August 20, 2013 Draft), [http://gmcboard.vermont.gov/sites/gmcboard/files/Medicaid\\_ACO\\_Standards\\_Draft.pdf](http://gmcboard.vermont.gov/sites/gmcboard/files/Medicaid_ACO_Standards_Draft.pdf).

<sup>15</sup> CMS Amended Waiver List and Expenditure Authority: Oregon Health Plan at 26 (No. 21-W-00013/10 and 11-W-00160/10) (April 8, 2014) (available from NHeLP).

compensated on a per capita risk basis, which means that they receive a set payment for each person enrolled and if the services provided exceed that amount, they incur a loss.<sup>16</sup> In 2011, Louisiana originally authorized two types of ACOs: Coordinated Care Networks – Shared Savings (CCN-S) and Prepaid Coordinated Care Networks (CCN-P). The shared savings CCN were organized as Primary Care Case Management (PCCM) entities and are subject to the Medicaid requirements governing PCCMs.<sup>17</sup> CCN-P models were required to meet the federal definition of Medicaid MCOs.<sup>18</sup> Colorado’s Accountable Care Collaboratives operate as Primary Care Case Management entities.<sup>19</sup>

ACOs have many features in common with – and sometimes actually are - health homes. Health homes coordinate and integrate primary care, behavioral health, and long term care services and treat individuals holistically.<sup>20</sup> The ACA created a new state plan option for states to provide health homes for people with chronic conditions. Health home services include care management, referral, and patient and family support.<sup>21</sup> In many cases, states explicitly require ACOs to act as health homes. For example, in Illinois, ACEs must meet the ACA statutory health home definition.<sup>22</sup> Maine’s Accountable Communities must “align with and build on the principles of Maine’s multi-payer Patient-Centered Medical Home (PCMH) Pilot and MaineCare Health Homes Initiatives.”<sup>23</sup> Alabama also proposes to use health homes as part of the RCO service delivery structure.<sup>24</sup>

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<sup>16</sup> 42 C.F.R. § 438.10.

<sup>17</sup> Louisiana Dep’t of Health & Hospitals, CCN-Shared Savings Requests for Proposals (RFP # 305PUR-DHHRFP-CCN-S-MVA) at 5 (Apr. 11, 2011).

<sup>18</sup> Louisiana Dep’t of Health & Hospitals, Request for Proposals: Prepaid Coordinated Care Networks (RFP # 305PUR-DHHRFP-CCN-P-MVA) at 12, (Apr. 11, 2011).

<sup>19</sup> Colorado, Dep’t of Health Care Pol. And Financing Contract, App’x A at 2, <http://tinyurl.com/orx6qx9> (last visited June 30, 2014).

<sup>20</sup> CMS, “Health Homes,” <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Supports/Integrating-Care/Health-Homes/Health-Homes.html> (last visited July 1, 2014).

<sup>21</sup> 42 U.S.C. § 1396w-4.

<sup>22</sup> State of Illinois, Solicitation for Accountable Care Entities (2014-24-002) at 12, [http://www2.illinois.gov/hfs/SiteCollectionDocuments/HFS%20ACESolicitation\\_080113.pdf](http://www2.illinois.gov/hfs/SiteCollectionDocuments/HFS%20ACESolicitation_080113.pdf).

<sup>23</sup> MaineCare Services, “Accountable Communities Initiative,” <http://www.maine.gov/dhhs/oms/vbp/accountable.html> (last visited June 30, 2014).

<sup>24</sup> Alabama Medicaid Agency, Section 1115 Demonstration Proposal: Alabama Medicaid Transformation at 36, (May 30, 2014), [http://medicaid.alabama.gov/documents/2.0\\_Newsroom/2.7\\_Topics\\_Issues/2.7.3\\_RCOs/2.7.3.3\\_1115\\_Waiver/2.7.3.3\\_1115\\_Waiver\\_Draft\\_Application\\_2-28-14.pdf](http://medicaid.alabama.gov/documents/2.0_Newsroom/2.7_Topics_Issues/2.7.3_RCOs/2.7.3.3_1115_Waiver/2.7.3.3_1115_Waiver_Draft_Application_2-28-14.pdf).

## **Service package and enrollees**

Generally, the majority of Medicaid beneficiaries are eligible to enroll in ACOs – in some states, they are required to do so. In Maine, for example, the plan is that all Medicaid beneficiaries will eventually be served through these entities.<sup>25</sup> In Minnesota, most beneficiaries are served through ACOs, with the exception of dual eligibles and some other special types of disability-linked categories.<sup>26</sup> Illinois is an exception – its ACEs will be required to enroll only pregnant women, caretaker relatives, and children who don't qualify based on and may eventually the Medicaid expansion population. Adults and children who qualify based on disability are excluded.<sup>27</sup>

ACOs usually provide a comprehensive service package, but the extent of services covered varies. For example, Alabama has proposed to provide all state plan services through RCOs, while long term care services, hospice, and home and community-based waiver services will be provided separately through a fee-for-service system.<sup>28</sup> In Maine, entities will be responsible for delivering only primary care services, but also will be responsible for coordinating and integrating behavioral health and long term services and supports.<sup>29</sup>

## **Shared savings and risk**

One feature that all existing and proposed Medicaid ACOs share is the potential for the ACO and other providers to share in savings resulting from care delivery. These financial performance incentives are intended to reward ACOs for reducing the cost of care as well as meeting certain quality standards.

The methodologies for determining eligibility for and the amount of shared savings differ, but share some basic characteristics. Generally, a total cost of care (TCOC) benchmark is established to which expenditures will be compared. The establishment of the TCOC is a complex process usually involving risk adjustment.

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<sup>25</sup> Maine Dep't of Health and Human Servs., Request for Applications, MaineCare Accountable Communities Initiative at 15.

<sup>26</sup> Minnesota Dep't of Human Servs. Health Care Admin., Request for Proposals to Provide Health Care Services to Medical Assistance and MinnesotaCare Enrollees Through the Integrated Health Partnerships (IHP) Demonstration at 5 (Feb. 11, 2014), <http://tinyurl.com/ovcabyp>.

<sup>27</sup> Illinois, Solicitation for ACEs at 7.

<sup>28</sup> Alabama Medicaid Agency, Section 1115 Demonstration Proposal at 8.

<sup>29</sup> Maine Dep't of Health and Human Servs., Request for Applications at 12.

If costs of serving the population are less than the benchmark – or a certain percentage of it – the ACO will be awarded some share of the savings. Some – but not all - ACO models also put the lead entity at risk for failing to keep costs below a certain level. Even in systems that require ACOs to take financial risk, most do not do so for at least the first year of their operation.

These shared savings methodologies are fairly complex. Readers who would like more detailed examples see the box below:

### Shared Savings Calculation Examples<sup>30</sup>

Maine Accountable Communities (ACs): The state agency sets a risk-adjusted total cost of care (TCOC) for all ACs. There are two AC models – Model I, which is eligible for shared savings only and Model II, which is both eligible for shared savings and subject to risk. Model I is eligible to share in up to 50% of the amount saved. The total savings shared, however, cannot exceed 10% of the total cost of care. In the second model, in which the entity is subject to risk, it may receive 60% of the amount saved, up to 15% of the TCOC. AC average TCOC must be below its benchmark by 2% or 2.5%, depending on the size of the entity. In order to qualify for these payments, however, ACs must also meet quality benchmarks. Model II ACs are subject to shared losses up to 5% in their second year and 10% in the third year.

Minnesota Integrated Health Partnerships (IHPs): Minnesota also uses a risk-adjusted TCOC as a benchmark. There are two different models of ACOs: Virtual IHPs and Integrated IHPs. Both models will only be eligible for shared savings if they meet a 2% minimum performance threshold. This means that actual TCOC must be below 98% of the benchmark TCOC to qualify. Virtual IHPs share savings with the state at a 50-50 rate. Integrated IHPs are eligible to share savings 50-50 in the first performance period. Thereafter, the IHP is not only eligible for shared savings but also takes the risk of a loss. IHPs can choose how much risk it wants to be exposed to. Again, plans must also meet certain quality benchmarks to be awarded shared savings.

### Quality measures

Quality measures are a key part of the ACO model. They are intended to improve the quality of care the ACO provides and health outcomes of enrollees. They also are intended to discourage care delivery methods that simply cut costs without regard to the quality of care.

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<sup>30</sup> Maine Dep't of Health and Human Servs., Request for Applications, MaineCare Accountable Communities Initiative at 15-17; Office of MaineCare Services: maine Accountable Communities Initiative Shared Savings Methodology, Slide 13 (Feb. 26, 2004), [http://www.maine.gov/dhhs/oms/pdfs\\_doc/vbp/AC/February26SharedSavingsPPT.pdf](http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/AC/February26SharedSavingsPPT.pdf) ; Minnesota, Minnesota Dep't of Health & Human Servs. Request for Proposals to Provide Health Care Services Through the Integrated Health Partnerships (IHP) Demonstration at 11- 13

ACOs must meet quality measures as well as hit savings targets in order to share in savings. For example, in Minnesota's IHPs, more emphasis is placed on quality measure compliance as time goes on. Savings are phased in over the three year demonstration as follows:

- Performance Period 1: 25% of IHP portion of shared savings based on compliance with reporting measures;
- Performance Period 2: 25% of IHP portion of shared savings based on performance (overall quality score);
- Performance Period 3: 50% of IHP portion of shared savings based on performance (overall quality score).<sup>31</sup>

States draw upon different sources for their quality measures. In some cases, ACOs use measures from the HealthCare Effectiveness Data and Information Set (HEDIS). HEDIS is a set of quality indicators used to measure performance on aspects of care and services provided by health plans. Currently, there are 81 HEDIS measures related to 5 healthcare domains, including effectiveness of care, access/availability of care, and use of services. Measures include: (1) asthma medication use; (2) breast and cervical cancer screening; (3) childhood and adolescent immunization status; (4) various aspects of diabetes care; and (6) antidepressant medication management.<sup>32</sup> Most HEDIS measures report the percentage of eligible individuals who received a certain type of care. HEDIS measures are widely used in Medicaid managed care plans. In contrast to ACOs, however, where use of measures is required, Medicaid managed care plans are merely encouraged, but not required to use HEDIS measures.

ACOs also use some of the measures authorized by the Children's Health Insurance Program Reauthorization Act (CHIPRA). Still others are formulated by the state Medicaid agency itself.

Advocates and commentators have raised concerns about whether HEDIS measures accurately reflect the quality of care provided.<sup>33</sup> Among other things, there are concerns that beneficiaries who are not enrolled for an entire year are not included in the percentage, artificially inflating the total. Moreover, HEDIS includes very few measures

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<sup>31</sup> Minnesota Request for Proposals at 13.

<sup>32</sup> NCQA, "What is HEDIS?", <http://www.ncqa.org/HEDISQualityMeasurement/WhatIsHEDIS.aspx>

<sup>33</sup> See, e.g., Andrea Ohldin and Adrienne Mims, *The Search for Value in Health Care: A Review of the National Committee for Quality Assurance Efforts*, 94 JAMA 344 (2002); Alan M. Zaslavsky and Arnold M. Epstein, *How Patients' Sociodemographic Characteristics Affect Comparisons of Competing Health Plans in California on HEDIS Quality Measures*, 17 INT'L J. FOR QUALITY IN HEALTH CARE 67 (2005).

focusing on people with disabilities and none that focus on long term care. The same appears to be true of the measures that these ACOs are using. Most focus on acute and primary care.

For examples of ACO quality measures, see Appendix One.

### **Conclusion and Advocate's Tips**

CMS is strongly boosting ACOs in Medicaid, so advocates are likely to see more of them. There are some aspects of ACOs that are promising, including the use of health home models and the emphasis on quality measures. The shared savings and risk incentives, however, are cause for concern. Advocates have seen how risk-based capitated managed care can lead to limitations on services and have been particularly concerned about the rush to move people with disabilities into these systems because of the obvious incentives to deny care to save money. ACOs will be providing services to many enrollees with disabilities as well. Moreover, in contrast to MCOs, providers themselves make up the ACO and have direct incentives to cut costs. This may mean that enrollees lose a natural ally – the provider who may be focusing on what treatment is least costly, rather than medically necessary. ACOs are required to meet certain quality benchmarks, however, which should discourage ACOs from rationing care in a way that harms beneficiaries. And, CMS has repeatedly discouraged models limit access to eligible beneficiaries. Even so, advocates must monitor for patterns of limiting care in ways that harm patients. Accordingly, it will be crucial to have quality measures that truly safeguard against limitations on care, as well as having robust grievance and appeal systems.

Many ACOs will be responsible for providing behavioral health and some are required to provide long term care services, but there few available quality measures focus on these issues. Advocates need to press for development and inclusion of measures related to quality of these types of services.

Like any other Medicaid beneficiaries, those receiving care through ACOs are entitled to notice and an opportunity for a state administrative hearing when services are denied, delayed, suspended, or terminated. In some cases, such as when when the ACO is also an MCO, they are also entitled to file internal grievances for other matters. Advocates should work to ensure that ACO enrollees are aware of their due process rights despite changes in their service delivery system.

## Resources

The Center for Health Care Strategies (CHCS) and the National Academy for State Health Policy (NASHP) have many resources on Medicaid ACOs. Because these organizations are closely affiliated with states and, in some cases, directly working with states to create and implement ACOs, their materials have valuable information that is easily obtainable.

- Center for Health Care Strategies, Inc., *Medicaid Accountable Care Organizations: Program Characteristics in Leading Edge States* (Feb. 2014), <http://www.chcs.org/resource/medicaid-accountable-care-organization-program-design-characteristics-review-of-six-states/>.
- Center for Health Care Strategies, Inc., *Accountable Care Organizations in Medicaid: Emerging Practices to Guide Program Design* (Feb. 2012), [http://www.chcs.org/usr\\_doc/Creating\\_ACOs\\_in\\_Medicaid.pdf](http://www.chcs.org/usr_doc/Creating_ACOs_in_Medicaid.pdf).
- Center for Health Care Strategies, Inc., *Core Considerations for Implementing Medicaid Accountable Care Organizations* (Nov. 2012) [http://www.chcs.org/usr\\_doc/CoreConsiderationsforMedicaidACO\\_Final.pdf](http://www.chcs.org/usr_doc/CoreConsiderationsforMedicaidACO_Final.pdf).
- Center for Health Care Strategies, Inc., *Delivery System Reform*, [http://www.chcs.org/info-url\\_nocat5108/info-url\\_nocat\\_list.htm?attrib\\_id=16204](http://www.chcs.org/info-url_nocat5108/info-url_nocat_list.htm?attrib_id=16204).
- National Academy for State Health Policy, *Accountable Care Activity Map (Interactive)*, <http://nashp.org/state-accountable-care-activity-map>.

Appendix One: Quality Measures from Five States  
*(Measures directly related to people with disabilities in bold)*

STATE	QUALITY MEASURES
Illinois <sup>34</sup>	<ul style="list-style-type: none"> <li>• Adults' Access to Preventive/Ambulatory Health Services</li> <li>• Children and Adolescents' access to primary care providers</li> <li>• Ambulatory care – ED visits only</li> <li>• Ambulatory care follow up with a provider within 14 days of ED visit or inpatient discharge</li> <li>• Well child and adolescent visits</li> <li>• Inpatient hospital and mental hospital 30 day readmission rates</li> <li>• Adult BMI assessment</li> <li>• Weight assessment and counseling for nutrition and physical activity for children and adolescents</li> <li>• Childhood and adolescent immunizations, including HPV</li> <li>• Breast, cervical, and colorectal cancer screening</li> <li>• Developmental screening in the first three years of life</li> <li>• Comprehensive diabetes care</li> <li>• Annual pediatric hemoglobin testing</li> <li>• Medication management for people with asthma</li> <li>• Pharmacotherapy management of COPD</li> <li>• Persistence of beta blocker treatment after a hard attack</li> <li>• Congestive heart failure</li> <li>• Follow up after hospitalization for mental illness</li> <li>• Antidepressant medication management</li> <li>• Adherence to antipsychotics for individuals with schizophrenia</li> <li>• Initiation and engagement of alcohol and other drug dependence treatment</li> <li>• Prenatal and postnatal care</li> <li>• Frequency of ongoing prenatal care</li> </ul>
Louisiana- 35	<ul style="list-style-type: none"> <li>• At least 95% of PCP practices provide verified 24/7 phone access</li> </ul>

<sup>34</sup> Illinois, Solicitation for ACEs, Quality Measures, at Attachment C-1

<sup>35</sup> Louisiana Dep't of Health & Hospitals, CCN-Shared Savings Request for Proposals, Appendix H: Louisiana Administrative Performance Measures, p. 427; Louisiana Dep't of Health & Hospitals, CCN-Prepaid Appendix J, Quality Measures, [http://new.dhh.louisiana.gov/assets/docs/Making\\_Medicaid\\_Better/RequestsforProposals/CCNP\\_Appendices/AppendixJ\\_PerformanceMeasures04112011.pdf](http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/RequestsforProposals/CCNP_Appendices/AppendixJ_PerformanceMeasures04112011.pdf); [http://new.dhh.louisiana.gov/assets/docs/Making\\_Medicaid\\_Better/RequestsforProposals/CCNP](http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/RequestsforProposals/CCNP)

	<p>and ability to speak with PCP practice clinician within 30 minutes</p> <ul style="list-style-type: none"> <li>• At least 95% of regular and expedited service authorization requests processed in timeframes in the contract</li> <li>• No more than 5% of pre-processed claims take more than 2 days to submit to the FI ?</li> <li>• At least 99% of rejected claims are returned to provider with reason code within 15 days of receipt of claim submission</li> <li>• At least 90% of Call Center calls answered by a live person within 30 seconds</li> <li>• Average speed of call center answer of 30 seconds</li> <li>• Less than 5% call center abandonment rate</li> <li>• At least 95% of grievances received by the CCN are resolved within contract time frame</li> <li>• HEDIS/CHIPRA Access to Care measures: adult access to preventive/ambulatory health services; children and adolescents access to PCP; timeliness of prenatal and postpartum care.</li> <li>• HEDIS/CHIPRA Effectiveness of Care Measures: diabetes care, Chlamydia screening in women; childhood immunization status; weight assessment and counseling for nutrition and physical activity in children/adolescents; immunizations for adolescents; use of medications for people with asthma; comprehensive diabetes care; cervical and breast cancer screening; Follow up care for children prescribed ADHD medication; cesarean rate for low-risk first birth women</li> <li>• Otitis medical effusion; appropriate testing for children pharyngitis; Controlling high blood pressure; pediatric central line bloodstream infections; percent of live births weighing below 2,500 grams.</li> <li>• HEDIS/CHIPRA Use of Services measures: well child visits in the third, fourth, fifth and sixth of life; adolescent well care visits well child visits in the first 15 months; Ambulatory care utilization; average number of ED visits per member; annual number of asthma patients with one asthma related ED visit; frequency of ongoing prenatal care.</li> <li>• State effectiveness of care measures: percent of pregnant women screened for tobacco use and secondhand smoke exposure offered an appropriate and individualized intervention; total number of women receiving progesterone during pregnancy and percentage</li> </ul>
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[Appendices/AppendixJ\\_PerformanceMeasures04112011.pdf](#) Note that these performance measures are from 2011 and may have changed.

	<p>of preterm births at fewer than 37 and 32 weeks in those recipients.</p> <ul style="list-style-type: none"> <li>• AHRQ prevention indicators: adult asthma admission rate; CHF admission rate; uncontrolled diabetes admission rate.</li> <li>• EPSDT Screening Rate.</li> <li>• CAHPS survey questions.</li> </ul>
Maine <sup>36</sup>	<ul style="list-style-type: none"> <li>• Percentage of adults and children with persistent asthma appropriately prescribed controller medications</li> <li>• Percentage of adults with diabetes with HbA1c less than 8%</li> <li>• Percentage of adults with diabetes who had a retinal eye exam in past 1-2 years</li> <li>• Diabetes HbA1c testing and control (adults and children)</li> <li>• Percentage of adults with diabetes who had LDL screening performed in the previous 12 months</li> <li>• Neuropathy testing</li> <li>• Percentage of children and adults who had a follow up visit with mental health practitioner after hospitalization for mental illness</li> <li>• Percentage of adolescents and adults for whom alcohol or other drug treatment initiated and engaged</li> <li>• Number of behavioral health residential treatment bed days per member per months for adults and children</li> <li>• Percentage of adults with COPD who received spirometry testing to confirm diagnosis</li> <li>• Non-emergent ED use</li> <li>• Percent of primary care physicians who qualify for an EHR incentive</li> <li>• Number of acute inpatient stays that were followed by acute readmission within 30 days</li> <li>• Percentage of members over age 65 who received high risk medication</li> <li>• Percentage of patients with schizophrenia or bipolar disorder who are prescribed anti-psychotic medication who received cardiovascular screening</li> <li>• Percentage of members with primary diagnosis of low back pain who received imaging Within 28 days</li> <li>• Clinician and group Consumer Assessment of HealthCare Providers and Systems (CAHPS)</li> </ul>

<sup>36</sup> Maine, Accountable Communities Initiative, Accountable Communities Proposed Metrics, (rev'd March 7, 2014), <http://www.maine.gov/dhhs/oms/vbp/accountable.html>.

	<ul style="list-style-type: none"> <li>• Percentage of children receiving well child and adolescent well care visits</li> </ul>
Minnesota	<ul style="list-style-type: none"> <li>• Optimal diabetes care (ODC) composite (HbA1c and LDL control, blood pressure, tobacco cessation and aspirin use)</li> <li>• Optimal vascular care composite (LDL and blood pressure control, tobacco cessation, and aspirin use)</li> <li>• Depression remission at 6 months</li> <li>• Optimal asthma care composite (children and adult)</li> <li>• Child/adolescent asthma</li> <li>• CAHPS results (timely appointments, care, and information; how well providers communicate; helpful, respectful, and courteous office staff; patient rating provider at 9 or 10)</li> </ul>
Oregon <sup>37</sup>	<ul style="list-style-type: none"> <li>• Adolescent well care visits at 2013 national Medicaid 75<sup>th</sup> percentile <ul style="list-style-type: none"> <li>• Alcohol and drug misuse</li> <li>• Ambulatory care – emergency department utilization at national Medicaid 90<sup>th</sup> percentile</li> <li>• CAHPS access to and satisfaction with care at national Medicaid 75<sup>th</sup> percentile</li> <li>• Colorectal cancer screening</li> <li>• Developmental screening</li> <li>• Early elective delivery at 5% or below?</li> <li>• EHR adoption</li> <li>• Follow up after hospitalization for mental illness at national Medicaid 90<sup>th</sup> percentile</li> <li>• Follow up for children prescribed ADHD medication at national Medicaid 90<sup>th</sup> percentile</li> <li>• Mental and physical health assessments for children in DHS custody</li> <li>• Patient centered Primary Care Home enrollment at 100%</li> <li>• Timeliness of prenatal care at national Medicaid 75<sup>th</sup> percentile</li> <li>• Heart failure LVEF assessment consistent with CMS/ JAHCO specs</li> <li>• Initial antibiotic selection for pneumonia consistent with CMS/ JAHCO specs</li> <li>• CAHPS communication with nurses, communication with doctors, responsiveness of staff, pain management, communication about medications, cleanliness of hospital environment, quietness of</li> </ul> </li> </ul>

<sup>37</sup> Oregon Health Plan, 2014 CCO Incentive Measure Benchmarks (Jan. 13, 2014), available at <http://www.oregon.gov/oha/CCODData/2014%20Benchmarks.pdf>.

	hospital environment, discharge information, overall hospital rating, recommendation of the hospital at 9 or 10
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