Delineating Responsibilities across Accountable Care Organizations and Managed Care Organizations

States introducing accountable care organization (ACO) programs into an existing Medicaid managed care environment will need to effectively delineate responsibilities between ACOs and managed care organizations (MCOs). Successful delineation can provide opportunities for the two types of organizations to complement one another and improve care delivery for Medicaid enrollees. This tool, made possible by the Medicaid ACO Learning Collaborative sponsored by The Commonwealth Fund, identifies five responsibilities that both ACOs and MCOs may share and outlines which entity may be better suited to perform each function. This tool can help state Medicaid agencies, as well as ACOs and MCOs, define roles and responsibilities across these organizations. For more information on the relationship between ACOs and MCOs in Medicaid and how states can help coordinate these efforts, please see: The Balancing Act: Integrating Medicaid Accountable Care Organizations into a Managed Care Environment.

- **Care Coordination**: ACOs are well-suited to coordinate care for their patients since providers are clinically trained, have direct contact with patients, and can facilitate warm handoffs among physicians and facilities.
- **Data Sharing & Analytics**: MCOs and ACOs both need data analytics to coordinate care and manage their patients’ health, and should work together to share information. MCOs have access to claims data and use them to manage utilization and risk, while ACOs have access to patient health records and benefit from the ability to act quickly and effectively with these data.
- **Utilization Management**: MCOs are experienced in evaluating the medical necessity and efficiency of the use of health care, and are usually better suited for this task. As ACOs develop expertise with data analytics and risk management, they may be able to assume more responsibilities in this area.
- **Quality Improvement**: ACOs are responsible for quality improvement through their ACO contracts, and in many cases, quality results are tied to financial compensation. ACOs may also be better positioned to improve care due to their proximity to patients. However, since ACOs are rarely statewide, MCOs will still drive quality improvement where ACOs are not active, or among populations they do not serve.
- **Evidence-Based Guidelines**: While ACOs are closer to the provision of care to patients, MCOs have clinical advisory boards with knowledge of up-to-date guidelines and best practices across a broad spectrum of the health care field, and thus, may have a greater ability to create such guidelines.
States can use the table below to outline potential responsibilities among ACOs and MCOs. Examples of potential activities, some of which are drawn from Minnesota and Vermont’s programs, are shown below. Note, these examples are not necessarily recommendations for how to delineate these activities, as these roles and responsibilities may vary from state to state.

<table>
<thead>
<tr>
<th>Responsibility</th>
<th>Care Coordination</th>
<th>Quality Improvement</th>
<th>Data Sharing and Analytics</th>
<th>Evidence-Based Guidelines</th>
<th>Utilization Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ACO Responsibilities</strong></td>
<td>▪ Employ multi-disciplinary care teams</td>
<td>▪ Provide quality performance and patient data to the state</td>
<td>▪ Collect information directly from patients and partner organizations</td>
<td>▪ Develop and disseminate reports on patient utilization and outcomes</td>
<td>▪ Assume some responsibility for utilization management</td>
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<tr>
<td><strong>MCO Responsibilities</strong></td>
<td>▪ Provide admission notifications from claims data</td>
<td>▪ Audit care plans across providers to ensure consistency</td>
<td>▪ Collect and disseminate expenditure data to ACOs</td>
<td>▪ Disseminate existing clinical guidelines to ACOs</td>
<td>▪ Use expertise with medical necessity determinations to manage utilization</td>
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</table>

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