Comparing State Medicaid Accountable Care Organization Governance Models

Medicaid accountable care organization (ACO) models vary by state, reflecting the characteristics of the state's health care market and stakeholder influence, causing the models' governance structures to differ substantially. As part of the *Medicaid Accountable Care Organization Learning Collaborative*, made possible by The Commonwealth Fund, the Center for Health Care Strategies (CHCS) reviewed existing state Medicaid ACO models and identified key differences across programs. Key areas to consider for governance models include whether programs are:

- Provider- or payer-led;
- Existing or newly created organizations; and
- Inclusive of community stakeholders.

> Medicaid accountable care organizations have a uniform goal of providing higher quality, more cost-effective care for safety net populations. However, Medicaid ACO governance models vary widely depending on the local health care market, community stakeholders, and unique financing issues. This resource examines the governance structures, including community involvement, of ACO programs in nine states: Colorado, Iowa, Illinois, Maine, Minnesota, New Jersey, Oregon, Utah, and Vermont.

Below is a description of these considerations, followed by a matrix outlining governance approaches in the Medicaid ACO models of nine states: Colorado, Iowa, Illinois, Maine, Minnesota, New Jersey, Oregon, Utah, and Vermont. Lessons from these states can inform additional states in designing a Medicaid ACO approach to meet the needs of their communities.

Provider- or Payer-Led

When putting together an ACO program, a state must decide whether the ACOs will be led by provider groups or payers. The eventual goal of many Medicaid ACO models is for providers to manage more risk and perform utilization management functions, which are traditionally performed by payers, such as managed care organizations (MCOs). Since provider groups generally have direct control over care decisions, their accountability for a patient's costs may be more accurately reflected in health outcomes and costs.

Most states that have developed ACO programs have chosen provider-led models. Maine's Accountable Communities (ACs) are provider-led, and the state contracts directly with a lead entity that must be a provider or provider group. Similarly, ACOs in Vermont, New Jersey, Illinois, and Iowa are provider-led. Minnesota's Integrated Health Partnerships program features a two-track system for: (1) primary care providers or multi-specialty groups that are not integrated with a hospital; and (2) integrated delivery systems that include both inpatient and outpatient care. Oregon's Coordinated Care Organizations (CCOs) are payer-led organizations that manage the care of *all* Medicaid patients attributed to their geographic area, and Utah's payer-led ACOs manage the care of patients who elect to participate in their ACOs.

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New or Existing Structure

State policymakers must also decide whether to require new legal entities to be established for ACOs, to allow already existing entities to run ACO programs, or to provide avenues for both new and existing entities. Existing entities may already have relationships with patients and other community resources, which could help an ACO in its initial efforts to serve patients. Conversely, by requiring establishment of a new organization, states can require that an ACO include services, establish leadership roles, and/or contract with necessary organizations, thereby closely aligning the ACO's goals with the state's overall goals.

Vermont, building on the framework established in the Medicare Shared Savings Program, requires that its Medicaid ACO governing boards be "separate and unique to the ACO," and that the members of the board reflect the types of providers in the community. Other states, such as New Jersey and Maine, allow for existing organizations to serve as ACOs provided the organizations fulfill all ACO requirements. Iowa requires a separate entity only if the ACO is made up of several independent ACO participants; if the ACO is made up of just one participant, it may choose not to establish a separate entity.

Community Inclusion

Many states have made it a priority to involve members of the enrollee population in the governance of ACOs. Maine's ACs are required to have two of the members of the AC's governing structure be individuals "served by the AC program or their caregivers or guardians." Similarly, New Jersey's ACOs require that two members of the ACOs' governance boards be members of consumer organizations serving the attributed population. Oregon's CCOs maintain a community advisory council made up of stakeholders in the CCO's service area, the majority of whom must be consumer representatives. Illinois also requires the development and maintenance of a consumer advisory board that advises ACOs on cultural competency, outreach plans, and enrollee education materials. Colorado's second round of Regional Care Coordination Organizations (RCCO) procurement seeks to strengthen the input from enrollees and their advocates.

ACOs are by nature complex, and designing Medicaid ACO programs requires states to make many choices. The state's decisions in shaping the ACO governance structure can influence stakeholder buy-in, as well as require inclusion of groups that may until then have not been historically involved in the health care system. By requiring various types of providers to work together, governance can also influence the coordination and integration of care essential to an ACO's success. There is no one governance model that a state can use, but how a state chooses to construct its Medicaid ACO program will have a substantial effect on the program's operations and success.

State Medicaid ACO Program Governance Model Characteristics

State/Name	Description	Structural Requirements	Community Involvement
Colorado[1] **Regional Care Coordination Organizations (RCCOs)**	Regionally-based organizations that coordinate providers	• RCCOs provide data and care coordination support to primary care medical providers that agree to participate in the program	• Colorado's next round of RCCO procurement seeks to strengthen enrollees' and their advocates' roles in the RCCOs' governing structure
Iowa[2] **Accountable Care Organizations (ACOs)**	Provider-led organizations	• ACOs are made up of patient managers, defined as providers responsible for establishing a care model and coordinating patients' care • If ACO is made up of several participants, it must form a new legal entity • If ACO consists of only one provider, it may choose not to establish a separate entity	• The state contract requires ACOs to have a consumer advisory board that meets monthly; the care team must engage members in formulating a care plan
Illinois[3] **Accountable Care Entities (ACEs)**	Provider-led organizations	• ACEs must define a lead entity, which cannot be an MCO and need not be non-profit • Lead entity may be a single provider, but if so, the governing board must include providers not employed by the lead entity • The ACE must include participation from primary care, specialty care, hospitals, and behavioral health care providers • ACE governance must include meaningful participation from the medical director and practicing providers	• Statute requires a consumer advisory board to advise on cultural competency, outreach plans, and enrollee education materials • 50 percent of the consumer advisory board members must be Medicaid enrollees
Maine[4] **Accountable Communities (ACs)**	Provider-led organizations	• ACs must define a lead entity, which must be, employ, or contract with primary care provider(s) that meet federal primary care case management requirement • Lead entities must have contractual or other documented relationships or policies to ensure coordination with all hospitals in the entity's service area and at least one provider in the following four categories, if there is such a provider serving members in the entity's service area: care for chronic conditions; developmental disabilities; behavioral health; and a public health organization	• Two of the members of a MaineCare Accountable Community must be enrollees or their caregivers or guardians
Minnesota[5] **Integrated Health Partnerships (IHPs)**	Provider-led organizations	• IHPs must provide the full scope of primary care and coordinate with specialty providers and hospitals • "Virtual" model for non-integrated (i.e., systems that do not include an embedded hospital) providers of 1,000 to 1,999 enrollees, upside-only • "Integrated" model for large provider groups (2,000+ enrollees, offering a broad spectrum of out- and inpatient care), upside and downside risk phased in across the three-year demonstration period • Medicaid MCOs participate in IHPs through managed care contracts with the State; the State contracts with the IHP/provider, performs all calculations, and requires the MCO to pay its share of the payment to each IHP • The IHP program allows for flexibility in governance structure and care models to encourage innovation and local solutions	• IHPs must demonstrate how they will partner with community organizations and social service agencies and integrate their services into care delivery; the model allows for flexibility in how an IHP can formalize these partnerships
Oregon[6] **Coordinated Care Organizations (CCOs)**	Locally-governed regional organizations	• May be "local, community-based organizations or statewide organizations with community-based participation in governance or any combination of the two" • The CCO's governing body must include any persons that share in the financial risk, and at least two providers in active practice, including one primary care provider and one mental health or chemical dependency treatment provider	• The CCO's governing board must also include two members of the community at large • CCOs must also convene community advisory councils with a majority of members who are Medicaid enrollees, one member of which must be on the CCO's governing board

State/Name	Description	Structural Requirements	Community Involvement
***New Jersey*[7]** **Accountable Care Organizations (ACOs)**	Provider-led geographically-based organizations	• Existing nonprofit organizations can serve as ACOs if they meet all other requirements • ACOs must serve a defined geographic area • The ACO application must have the support of all hospitals, 75 percent of other providers, and four qualified behavioral health providers in the defined geographic area	• New Jersey requires that two members of the ACO's governing board be representatives of organizations representing the community served
Utah **Accountable Care Organizations (ACOs)**	Payer-led organizations	• Four payers manage full-risk capitated contracts with some geographic overlap • Must be able to contract for full range of Medicaid benefits, meet quality measures, and accept risk	• ACO quality measures are developed by a community stakeholder panel • A Medical Care Advisory Council advises the Medicaid agency on all facets of the Medicaid program
***Vermont*[8]** **Accountable Care Organizations (ACOs)**	Provider-led organizations	• Requires that the ACO be governed by an entity "separate and unique" from a provider in or provider group serving as the ACO • 75 percent of the board must be chosen by ACO participants • The ACO's governing board must be representative, though not necessarily proportional, of the variety of practitioners participating in the ACO	• The ACO's governing board must include a Medicaid beneficiary

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. This resource was developed through CHCS' *Medicaid Accountable Care Organization (ACO) Learning Collaborative*, a national initiative made possible by The Commonwealth Fund. The Collaborative is helping states advance new ACO models designed to improve patient outcomes and control costs by shifting accountability for risk and quality to providers. For more information, visit **www.chcs.org**.

ENDNOTES

[1] Colorado Accountable Care Collaborative Request for Information, 2014: https://www.colorado.gov/pacific/sites/default/files/ACC%20Request%20for%20Information.pdf.
[2] Iowa Medicaid ACO Agreement, January 2015: https://dhs.iowa.gov/sites/default/files/470-5218.pdf; Iowa Wellness Plan ACO Readiness Application, May 2014: http://dhs.iowa.gov/sites/default/files/470-5264.pdf.
[3] Illinois Solicitation for Accountable Care Entities, 2014: http://www2.illinois.gov/hfs/SiteCollectionDocuments/HFS%20ACESolicitation_080113.pdf.
[4] Maine 2014 State Plan Amendment, Coverage Section: http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/AC/Coverage_Section3_1A_AC_SPA5914.pdf; Maine 2014 State Plan Amendment, Reimbursement Section: http://www.maine.gov/dhhs/oms/pdfs_doc/vbp/AC/Reimbursement_Section4_9%20AC_SPA%205%2012%20.pdf.
[5] Minnesota Department of Human Services Request for Proposals, February 2014: http://www.dhs.state.mn.us/main/idcplg?IdcService=GET_FILE&RevisionSelectionMethod=LatestReleased&Rendition=Primary&allowInterrupt=1&noSaveAs=1&dDocName=dhs16_192599.
[6] Oregon Health Authority, CCO Model Contract, 2015: http://www.oregon.gov/oha/OHPB/docs/2015_CCO_Model_Contract.pdf; Oregon Legislature, CCO regulations: http://www.oregonlaws.org/ors/414.625.
[7] New Jersey Medicaid ACO Demonstration Project Legislation: http://www.njleg.state.nj.us/2010/Bills/PL11/114_.pdf.
[8] Green Mountain Care Board, Medicaid ACO Shared Savings Program Pilot Standards, 2013: http://gmcboard.vermont.gov/sites/gmcboard/files/Medicaid_ACO_Standards_Draft.pdf.