Medicaid ACO Checklist for Advocates

Introduction

Medicaid Accountable Care Organizations (ACOs) have become more widespread as states look for innovative ways to improve health outcomes and control rising costs for Medicaid beneficiaries. However, as states move toward shifting financial risk to providers it is important that advocates play a central role in the design, implementation and oversight of Medicaid ACO programs in order for these programs to achieve their potential for advancing person-centered and community-responsive care. It will be particularly important to monitor Medicaid ACO implementation in the new post-election landscape, as changes may be occurring with the Medicaid program at the federal level.

To guide advocates in this work, the Center for Consumer Engagement in Health Innovation provides in each section of this toolkit a list of questions to consider when assessing a state's Medicaid ACO program. These questions can help advocates assess Medicaid ACOs in a variety of settings that include, but are not limited to, stakeholder meetings, comments on RFIs and contracts, and review of member communications. While each of the components below are important to create a person-centered system of care, creating that type of system takes time; it is an evolving process. The most fundamental part of each component is to ensure that the consumer voice is present.

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Meaningful Consumer Engagement

Consumer engagement is integral to the design, implementation and oversight of Medicaid ACO programs. It is important to consider the role of consumers and advocates at three levels: policy, delivery system and in the clinical setting.

At the state level, does your state Medicaid ACO program do the following?

- ☐ Host regular public meetings to gather input on the design, implementation and oversight of the ACO from consumers and advocates.
- ☐ Include consumer and consumer advocate representation on implementation and oversight committees and provide ongoing appropriate training and support to participate meaningfully.
    - *For example, in Colorado, the Program Improvement Advisory Committee (PIAC) of the Accountable Care Collaborative provides recommendations to the state Medicaid agency on how to improve Colorado's Medicaid ACO program. A consumer advocate serves as the chair of the PIAC.*
- ☐ Monitor consumer engagement in Medicaid ACOs, including evaluation activities.
    - *For example, in Oregon there is a requirement that members of the Consumer Advisory Council be surveyed annually to assess their satisfaction with the level and quality of their engagement.*

As a part of oversight of the program, does your state do the following?

- ☐ Report to the public information regarding the state agency's capacity to oversee the ACO program in order to ensure they have sufficient state staff, resources and means to enforce contract compliance.
- ☐ Conduct ongoing reviews of ACOs, including payment, incentive and penalties review.
- ☐ Ensure that information about public meetings and public reports are easily accessible to the public and shared in a timely manner.

At the delivery system level, does your state require Medicaid ACOs to do the following?

- ☐ Include consumers and consumer advocates on ACO governing boards. Governing board membership should reflect the community served and include adequate member representation. Member representation needs to be diverse as individual consumers cannot represent the views of an entire community. In addition, the ratio of member representation to provider representation should be at least equal. Consumer members could be consumer advocates and/or consumers enrolled in the ACO or a family member or caregiver.
    - *For example, Maine requires at least two MaineCare members on each ACO governing board. Oregon requires at least one member from the Community*

Advisory Council and at least two members from the community at large on their CCO governing boards.

- ☐ Create consumer advisory councils (CACs) or patient family advisory councils (PFACs) and provide ongoing training and funding for consumers to participate so that the opportunity is accessible to all interested members.
    - *In Massachusetts, all hospitals are required to establish PFACs.*
    - *In Oregon, the Oregon Health Authority Transformation Center supports the CACs through resources, meetings and funding to attend conferences.*
- ☐ Solicit beneficiary feedback using a variety of methods such as focus groups, member meetings, PFACs and surveys.
- ☐ Offer a "ladder of engagement" so that consumers can engage with the ACO in increasingly active ways, such as by moving from focus group participant to advisory council member.
- ☐ Create partnerships with community-based organizations (CBOs) that can provide valuable input on the needs and preferences of the communities being served and can help recruit, train and support consumers who are participating in governance or advisory roles.
- ☐ Partner with consumer advocacy organizations to create and maintain an infrastructure for consumer and community engagement.

At the clinical level, does your state require Medicaid ACOs do the following?

- ☐ Support the use of shared decision-making tools with patients.
- ☐ Use patient engagement measures such as the patient activation measure or a health confidence measure.
- ☐ Encourage the use of evidence-based self-management programs such the Stanford Chronic Disease Self-Management Program (CDSMP).
- ☐ Make individual care plans a core requirement and actively engage patients and caregivers in the development and regular updating of the care plan.
- ☐ Develop a plan for involving enrollees in care transitions to improve the continuity and quality of care across settings, with case manager follow up.
    - *For example, Oregon is working to hold its Coordinate Care Organizations (CCOs) accountable for care transition and measures the quality of patient readiness for transitions.*

See the care coordination section for additional suggestions on engaging patients in care.

Access to Provider Networks and Covered Services

The success of an ACO is contingent upon ensuring members have reliable access to both a sufficient numbers of providers who can meet their needs as well as the full continuum of services they need to achieve optimal health without disruption.

Does your state Medicaid ACO program do the following?

- ☐ Ensure that members have access to care across the continuum, including a broad range of long-term services and supports, behavioral health services and oral health services.
- ☐ Ensure access to a sufficient number of primary care and specialty care physicians, facilities and a full range of non-physician providers such as community health workers, nurse practitioners, dentists and recovery coaches.
- ☐ Ensure minimum member/provider ratios.
- ☐ Fully integrate services for substance use disorders, mental illness, other medical conditions and long-term services and supports.
- ☐ Integrate oral health services including dental care.
- ☐ Have a mechanism for ensuring sufficient providers to serve special populations such as children with special health care needs and people with substance use disorders and/or mental illness.
- ☐ Take into account travel time and public transportation access when determining network adequacy.
- ☐ Have clear policies on how consumers may access providers outside of the ACO network.
- ☐ Provide protections to ensure continuity of care when a provider leaves an ACO network, including notifying the member in advance of the change and providing an option to continue seeking treatment from the provider out-of-network.
- ☐ Ensure continuity of care when a consumer joins an ACO, including allowing consumers to maintain relationships with their existing providers for a minimum of 180 days and, if there are complex needs, allowing for up to one year. ACO and the provider can enter into a single-case agreement to allow for this continuity and for the provider to get reimbursed.
- ☐ Implement strategies to encourage safety net provider participation.
- ☐ Ensure provider networks are compliant with the Americans with Disabilities Act (ADA). This means ensuring physical accessibility as well as programmatic accessibility; such as appropriate scheduling, communication on medical information, and provider staff training and knowledge. For more on disability competent care, click here.
- ☐ Regularly assess patient's access to needed services as part of a robust quality strategy that includes patient reported information.

Strong Consumer Protections

It is vitally important to "bake in" consumer protections in the design of Medicaid ACOs. While this list is not exhaustive, below are a few key priorities.

Compliance

Does your state Medicaid ACO program do the following?

- ☐ Establish policies and procedures for complying with the ADA. This includes requiring Medicaid ACOs to hire staff that monitor and enforce those policies.
- ☐ Establish policies and procedures for complying with the Mental Health Parity and Addiction Equity Act.
- ☐ Ensure that polices are in place to protect a consumer's health information when he or she transitions from one ACO to another.
- ☐ Ensure there are policies in place to protect consumers in case the ACO faces financial losses.
    - *For examples, in Massachusetts, organizations that want to take on financial risk must certify to the Department of Insurance that they have sufficient capital and reserves to do so.*
- ☐ In terms of protecting consumers, it will be important to ensure that if an ACO is facing financial loss and at risk of closing, consumers face the least disruption possible in their care. This can range from providing generous continuity of care to education and outreach to consumers to ensure they are aware of changes ahead of time. Consumer assistance must be made available to help consumers navigate changes and make decisions about their care.

Enrollment Attribution

In an ACO model, patients are attributed to an ACO and a specific provider within an ACO. Advocates should ensure that consumers have the opportunity to proactively opt in to the program or that the state is moving in that direction to ensure choice.

Does your state Medicaid ACO program do the following?

- ☐ Provide consumers with comprehensive, accessible information about attribution that includes:
    - What an ACO is and what it means to be attributed to one.

- Information about what it means to affirmatively opt into an ACO and a choice between ACOs if there is more than one ACO operating in a given area.
- Whether and how providers in an ACO are incentivized and how that might affect the care consumers receive.
- The rights and protections of ACO participants.
- Details about the provider network, such as language spoken by providers, details about the pediatric network, the behavioral health network and information about physical accessibility.

- ☐ Present information in culturally and linguistically appropriate ways, taking into account the health literacy levels of consumers and their caregivers and assistance of alternative communications needs.
- ☐ Clearly describe the process for opting-out of attribution to an ACO and remaining in traditional fee-for-service.
- ☐ Prohibit lock-in periods that prevent consumers from leaving an ACO.
- ☐ Contract with community-based organizations (CBOs) for outreach and education efforts to consumers to provide independent, conflict-free counseling services to help consumers/caregivers make decisions about their care.

Grievances and Appeals

A robust grievance and appeals system is an important component of an ACO. Does your state Medicaid ACO program do the following?

- ☐ Have a formal grievance and appeals system that is easily understandable and accessible both online and on paper for consumers and caregivers.
- ☐ Provide comprehensive information to consumers on their rights related to grievances and appeals.
- ☐ Establish mechanisms to track and maintain records of all grievances received. This information should be aggregated, analyzed for patterns of problems that show a need for policy or practice change, publicly reported, and shared with the ombudsman and oversight agencies
    - *For example, Vermont recently passed a law, Act 113 of 2016, which includes significant ACO-related consumer protections that may serve as a model for other states. The law requires ACOs to maintain a hotline for complaints and grievances; provide members with contact information for the Office of the Health Care Advocate, an organization in Vermont that provides consumer assistance; and requires ACOs to share complaint and grievance information with the Office of the Health Care Advocate at least twice annually.*
- ☐ Provide continuation of service provision in the same amount, duration and scope during appeals.

Ombudsman

An ombudsman program is a critical protection for ACO enrollees and should also provide feedback to the state on systemic issues. Does your state Medicaid ACO program do the following?

- ☐ Contract with and fully fund an independent, conflict-free entity to serve as the ombudsman. This entity could include CBOs.
- ☐ Provide consumers and stakeholders with information on how this new role will function and the criteria by which its success will be measured.
- ☐ Provide sufficient funding in order for the ombudsman to meet the needs of consumers and provide timely trend reports.
- ☐ Require that the ombudsman both report to and collect information from state and ACO stakeholders in addition to consumers.

Does your state ombudsman do the following?

- ☐ Provide accurate and up-to-date information for members on how to navigate the ACO enrollment process and troubleshoot issues with enrollment and provision of care.
- ☐ Coordinate with other entities and individuals in the community and within provider organizations, including enrollment assisters, who already provide enrollment and provider navigation assistance to members.
- ☐ Track and report systemic issues, reporting data in real time and conducting outreach and training for members about their rights and responsibilities. Reporting should be stratified by race, ethnicity, primary language, gender identity, sexual orientation and disability status to track system-wide trends that identify and measure gaps in service.
- ☐ Track and document an enrollee's case from start to final outcome and report aggregated data to ACO advisory bodies and the state. This data should also be presented in the form of a public-facing dashboard that provides objective comparisons of enrollee complaints, resolutions and outcomes across ACOs.

Consumer-Oriented Quality Measures

In ACOs, quality measurement directly affects how providers are paid, which can improve how care is delivered to beneficiaries. In order to ensure that ACO quality measurement is truly centered on what consumers' value, does your state Medicaid ACO program do the following?

- ☐ Include consumers and consumer advocates in the process of developing and deciding which quality measures ACOs will use through public forums, advisory groups and surveys to understand what they value in quality measurement.
- ☐ Focus on outcome measures (over process measures), functional status, patient experience measures, patient-reported outcome measures and patient goals-directed measures. Measures should be developed that move toward reducing health disparities by

collecting data that is disaggregated and stratified by race, ethnicity, primary language, gender identity, sexual orientation and disability status.

- ☐ Include measures which reflect the populations being targeted. For example, if the ACO is serving a population with high behavioral health needs, then measures should be reflective of those needs. Similarly, if long-term services and supports (LTSS) are included, then LTSS measures should be incorporated. If children are part of the ACO, consider the use of a separate measure set for children that draws on the CHIP core set, which can be found here.
- ☐ Include measures that assess problems consumers are having with their care, such as patterns in consumer appeals and grievances and disenrollment from the program.
- ☐ Present quality measures data publicly in an easily accessible and intelligible way on an annual basis and stratify data collected by race, ethnicity, primary language, gender identity, sexual orientation and disability status. Stratification of results will allow for disparities to be identified and potentially addressed.
- ☐ Use population-based measures, such as the Institute of Medicine's *Vital Signs* recommendations around to help measure whether the ACO model is improving the health of the population served.

Payment Arrangements Incentivizing Better Health Outcomes

Payment arrangements in Medicaid ACO programs should incentivize people-centered care and ensure the most complex patients' needs are being appropriately met.

Does your state Medicaid ACO program do the following?

- ☐ Develop payment models with community input.
    - *For example, in New Jersey, the Camden Coalition ACO requires community input in its shared shavings reinvestment process.*
- ☐ Reinvest savings into the community and potentially use them for priorities identified by the community such as health literacy, prevention activities, workforce enhancements and infrastructure building.
    - *For example, the Trenton Health Team ACO, one of the first Medicaid ACOs in New Jersey, reinvests its savings to use toward the community it serves.*
    - *Hennepin Health, a safety-net accountable care organization (ACO), also reinvests savings in the community by hiring community health workers and deploying community paramedics in homeless shelters, among other activities.*
    - *States could consider pooling savings into a prevention fund, modeled loosely on the Massachusetts Prevention and Wellness Trust Fund. This Fund, which is supported by health provider assessments, supports programs to prevent chronic conditions, increase healthy behaviors and address health disparities.*

- ☐ Ensure that providers, especially small provider practices and those in rural areas, have the adequate financial foundation to take on risk and provide some measure of protection against financial losses, particularly in the early years of the program. Another option to consider is allowing for multiple payment tracks that accommodate different provider types.
    - *For example, Minnesota has a "virtual Integrated Health Partnership (IHP)" ACO that has upside risk only and gives an option for small or rural providers to participate. This means that for the first three years, the payer and the delivery system will share in the savings 50/50.*
- ☐ Use risk adjustment strategies to ensure that complex patients' needs are being met and account for factors that affect health outcomes such as socioeconomic status and functional status. There should be adequate payment to providers, based on the characteristics of the community they serve, in order to meet quality goals. While Massachusetts is implementing something similar in its ACO program, it is too early to know how well it is working.
- ☐ Use payment models that incentivize community based services, especially for long-term services and supports.

Care Coordination

Care coordination is vital to managing an individual's care, especially for beneficiaries with complex care, and should be a core component of all ACOs. When done well, care coordination can reduce fragmentation and improve outcomes, but only if care coordination efforts are well-organized and consumer-focused.

Does your state Medicaid ACO program do the following?

- ☐ Require the use of a team-based approach that is centered on the needs, preferences and circumstances of patients and their families and caregivers and encourages collective processing of patient information and joint problem solving by clinicians.
- ☐ Require that a team member be responsible for overseeing staff care coordination efforts to ensure patients aren't being asked duplicative questions and have the appropriate people involved in their care.
- ☐ Ask ACOs to clearly document in the certification application how they are pursuing a team-based approach to care, with attention paid to coordination of behavioral health services, oral health services and LTSS.
- ☐ Include quality measures focused on care coordination, including patient and caregiver experiences around care coordination.
    - *For an example of quality measures that include patent satisfaction around care coordination, see New Jersey's ACO demonstration project quality metrics.*
- ☐ Require assessment and reassessment by a care manager, using a standardized assessment tool.

- ☐ Include a plan for involving members and their families and caregivers in care transitions to improve the continuity and quality of care across settings, with case manager follow up. Note that care transition plans are important not just for patients moving from one physical setting to another, but also for patients moving from one type of care to another, for example, children with complex care needs transitioning from pediatric to adult care.
    - *For example, Oregon holds CCOs accountable for care transition and measures the quality of patient readiness for transitions.*
    - *Another example is Maryland's Faith Health Network. In this model, hospitals form partnerships with existing local faith networks that provide resources that cater to the physical, emotional and spiritual well-being of members of their community.*
- ☐ Define how ACOs will ensure care coordination and engage members in their home setting through methods such as home visits or telemedicine.
- ☐ Include care plans as a core requirement and, when appropriate, shared care plans, which are jointly maintained and updated by enrollees, family caregivers (with member consent) and members of the care team.
- ☐ Maintain networks of providers who are familiar with and trained in care coordination and ensure ongoing training of providers to ensure they are well-versed and up-to-date in best practices for providing coordinated care.

Population Health

Population health aims to improve health by focusing on prevention and wellness. ACOs have the potential to improve population health by helping to address the factors – such as food, housing and safety – that keep people healthier, thus reducing health care costs in the longer term.

Does your state Medicaid ACO program do the following?

- ☐ Partner with state and local public health departments. (*For more information, see the CDC's issue brief on ACO and public health partnership or the Millbank Memorial Fund issue brief on Population Health in Medicaid Delivery System Reforms.)*
    - *For example, in Oregon, CCOs are encouraged to partner with local public health authorities to develop a community health assessment and community health improvement plan.*
- ☐ Leverage existing state data sources across departments to determine population health needs.
- ☐ Incorporate population health metrics into the list of quality outcome measures.
- ☐ Include comprehensive preventive benefits under covered services.
- ☐ Reinvest savings into the community and use them for priorities identified by the community such as health literacy, prevention activities, workforce enhancements and infrastructure building.

- *For example, the Trenton Health Team ACO, one of the first Medicaid ACOs in New Jersey, reinvests its savings to use towards the community it serves.*
- *Hennepin Health in Minnesota also reinvests savings into the community by hiring community health works and deploying community paramedics to homeless shelters, among other activities.*

Address the Social and Economic Determinants that Affect Health

Medicaid ACOs can address the social and economic determinants of health at three separate, but often overlapping levels: the clinical or encounter level, the organizational level, and the broader community level.

Encounter level:

- ☐ Include social services in members' care plans.
- ☐ Regularly assess individual patients' social and economic needs and provide appropriate referrals to social service organizations, navigational assistance for accessing social services, and follow up to see if patients received the needed services.

Organizational level:

- ☐ Utilize payment models that incentivize ACOs to provide and coordinate social services, such as enhanced per-member per-month payments or including social services in shared savings arrangements.
    - *Hennepin Health in Minnesota has flexibility to include non-medical services in the total cost of care, allowing them to better address patients' social and economic needs. For example, they provide housing to homeless patients with complex care needs.*
    - *Oregon's CCOs are able to use Medicaid dollars for non-medical services such as housing supports. A survey of 15 of Oregon's 16 CCOs found that they were all providing some form of housing supports such as housing application assistance, move-in costs, eviction prevention and utilities assistance.*
    - *Massachusetts' Medicaid ACO will begin partnering with community organizations and offering "flexible services" to help address members non-medical social needs. While the program is still in the early stages, it could serve as a potential model for other states.*
- ☐ Include requirements that ACOs implement a certain number of specific programs that directly address social determinants of health, such as supportive housing or food and nutrition interventions.
- ☐ Include quality measures related to the social determinants of health.
- ☐ Implement systems that integrate social and medical needs data.

Community level:

- ☐ Regularly assess the social service needs of the community, including using a community health needs assessment and community health improvement plan.
    - *For example in Oregon, CCOs are encouraged to establish agreements with local public health authorities to develop a community health needs assessment and community health improvement plan. The Consumer Advisory Council (CAC) of the CCO oversees the community health needs assessment and the community health improvement plan, and provides guidance to the CCO governing board on how to invest its resources.*
- ☐ Collaborate with community and social service organizations and regularly assess effectiveness of that collaboration. Organizations could include those that provide community-based mental health services; mental health and substance use disorder services; Medicaid funded long-term services and supports; housing crisis management services; transportation services; and food assistance services.
    - *Hennepin Health in Minnesota provides a good model for partnering with community organizations to help meet patients' non-medical needs. For example, Hennepin partners with local substance use disorder treatment non-profits and a non-profit organization that provides vocational and career support to members.*

Health Equity

ACOs have the potential to address health disparities and promote health equity but advocates must work to ensure that Medicaid ACOs are designed in a way that is culturally appropriate, responsive to patients' diverse needs and mindful of the important role upstream factors (such as housing, food security and economic status) play in health outcomes. While health equity is included here as a separate section in order to make this toolkit user-friendly and easily searchable, health equity should be considered and embedded in all aspects of a Medicaid ACO and this list should not be viewed as exhaustive.

Does your state Medicaid ACO program do the following?

- ☐ Include requirements for cultural appropriateness, health literacy and implicit bias training for ACO providers.
- ☐ Provide opportunities to train providers in caring for people with disabilities, including independent living principles.
- ☐ Include strong health literacy standards for all communications with beneficiaries.
    - *For examples, please see Health Literacy Missouri's issue brief "Health Literacy Essential to Successful Implementation of Accountable Care Organizations."*
- ☐ Ensure written materials are accessible and understandable to all members by requiring written materials to be printed in multiple languages and offered in alternative formats for blind and visually impaired members.
- ☐ Provide oral interpretation for all members with limited English proficiency and assistance for people who are deaf and need American Sign Language.

- ☐ Define how they will evaluate health literacy, language access, and cultural appropriateness and include quality measures focused on these principles.
- ☐ Implement strategies to encourage safety net provider participation.
- ☐ Demonstrate how they will incorporate diverse providers, such as community health workers and peer specialists, into their care teams. ACOs should also provide opportunities for team building and training and ensure all care team members feel empowered and engaged.
- ☐ Collect and stratify data on key demographic and socioeconomic measures in order to appropriately target population health interventions, address and reduce health disparities, and improve how ACOs deliver care.
- ☐ Develop plans to address health disparities.