



# 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, control rising costs for Medicaid beneficiaries and improve health care quality. Consumer advocates can play a role in the design, implementation and oversight of Medicaid ACOs. Advocates can help ensure that ACOs meet the needs of and are accountable to the communities they serve, and that ACOs do not limit patients' access to care as they seek to control cost.

Through ACOs, states are shifting [financial risk and responsibility for patient outcomes](#) to providers. Advocates should work to ensure this model of care is person-centered and community-responsive.

The Center for Consumer Engagement in Health Innovation has created a toolkit to guide advocates as they assess and work with state's Medicaid ACOs. Each section contains a list of items to consider as Medicaid ACOs are designed and implemented. Creating this type of system takes time and 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

Diverse and meaningful consumer engagement is integral to the design, implementation and oversight of Medicaid ACO programs. While transitioning to value-based payment methods, consumers and their advocates and caregivers must have a voice in their health care so community members can improve their health. We focus on opportunities to engage consumers and advocate at two levels: engagement with state policymakers, and engagement with organizational leadership of the Accountable Care Organizations. At both levels, it is crucial to engage a diverse group of consumers who represent the community served by the ACO, including people with disabilities, people with substance use disorders and mental illness, and people with complex health and social needs. For more examples, see [Consumer Engagement in Medicaid Accountable Care Organizations: A Review of Practices in Six States](#).

At the state level, does your state do the following?

- Ensure regular public- and consumer-advocate representation on implementation and oversight committees. Committee members should be provided with ongoing and appropriate training and support, so they may participate meaningfully.
  - 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. This could be done within the ACO evaluation process.
  - Oregon requires that members of their [Consumer Advisory Council](#) be surveyed annually to assess their satisfaction with the level and quality of their engagement.*
- Explain what ACOs are in a consumer-friendly way and provide user-friendly materials for consumers to access so they understand how their care will change under an ACO model.
  - Oregon issued a [user-friendly video](#) that explains how their version of an ACO, the Coordinated Care Organization (CCO), provides value-based care to Medicaid beneficiaries*
- Include payment, incentive and penalties review, as part of the state's oversight of the ACO.
  - Oregon publishes [performance reports](#) for all of their Coordinated Care Organizations (CCOs).*
- Ensure that information about public meetings and public reports are easily accessible to the public and shared in a timely manner.

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

- Include consumers, consumer advocates or caregivers on ACO governing boards to help ensure that the ACO's decisions are made in the best interest of the community. Governing board membership should reflect the demographics of the community it serves and should include adequate member representation. Member representation needs to be diverse, as individual consumers cannot represent the views of an entire community. 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.

- ❑ *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). Provide ongoing training and funding for consumers to participate so that the opportunity is accessible to all interested members.
  - ❑ *In [Massachusetts](#), ACOs are required to have at least one patient or consumer advocate within their governance structure and establish a Patient and Family Advisory Committee.*
  - ❑ *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 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). CBOs can provide valuable input on the needs and preferences of the communities being served. They can also help recruit, train, and support the consumers who participate in governance or advisory roles.
  - ❑ *In Massachusetts, [Health Care for All](#) (HCFA) operates a helpline that consumers can call for questions related to their health insurance. HCFA then uses this information to advocate to the ACO different solutions to addressing consumers’ needs.*
- ❑ Partner with consumer advocacy organizations to create and maintain an infrastructure for consumer and community engagement.

## Access to Provider Networks and Covered Services

Successful ACOs ensure that members have reliable access to a sufficient provider network and that providers can meet members’ needs, as well as ensuring members have access to care across the continuum, including a full range of long-term services and supports, substance use disorders and mental illness services, peer recovery supports and oral health services.

Does your state Medicaid ACO program do the following to ensure members can consistently access their chosen providers?

- ❑ Ensure that members can choose their primary care provider.
- ❑ Create clear policies on how consumers may access providers outside of the ACO network.
- ❑ Provide protections to allow for continuity of care when a provider leaves an ACO network. If this occurs, consumers should be notified in advance of the change and provided with an option to continue seeking treatment from the provider out-of-network.
- ❑ Ensure continuity of care when a consumer joins an ACO. While many Medicaid ACOs allow Consumers to maintain relationships with their existing providers for 60 days, our experience working with complex populations suggests this is not enough time for people who depend on an existing provider to help them manage their complicated health and social needs. We suggest

ACOs allow consumers to maintain a relationship with an existing provider for a minimum of 180 days or up to one year, for consumers with complex health and social needs.

Does your state Medicaid ACO program do the following to ensure a sufficient number of easily accessible providers?

- Implement strategies to [encourage safety-net provider participation](#).
- Regularly assess patient's access to needed services as part of a robust quality strategy that includes patient-reported information.
- Take into account travel time and public transportation access when determining network adequacy, the ability of a health plan to meet its enrollees' medical needs through in-network health care providers and services. Time and distance standards help guarantee that consumers can access conveniently located health care providers. In an "inadequate" network, consumers must travel long distances or wait for long periods of time before they can receive care from an in-network provider.
  - Communities of color face additional barriers in accessing health care. [To meet the needs of these communities](#), network adequacy standards beyond time and distance should be enacted. These additional standards could include: offering a variety of providers including essential community providers; providers serving the community where members live; operating services during accessible hours; providing culturally sensitive care.
  - People with substance use disorders and/or mental illness also face significant barriers in accessing care. Accessing care quickly can be a matter of life and death, and delayed access can mean a lost opportunity for engagement in treatment. Network adequacy standards must take this into account. For further specific recommendations, see [this report](#) from the National Council on Behavioral Health
  - Distance standards are often not appropriate for long-term services and supports provided in the home. In these cases, time standards may be more important, along with measurement of service gaps. States should solicit stakeholder input in devising network adequacy standards for long-term services and supports, and ensure those standards support consumer choice of providers and community living.
  - [Consumer protections for network adequacy standards](#) help ensure that consumers have access to the full range of benefits their health plans promise.

Does your state Medicaid ACO program do the following to ensure members can access health services that meet their needs?

- Fully integrate services for substance use disorders, mental illness, long-term services and supports, oral health, vision health, and other medical conditions
- Ensure that consumers can access [health care providers who speak their language](#), or that medical translation services are available.
- Ensure provider networks are compliant with the Americans with Disabilities Act (ADA). This means ensuring [physical and programmatic accessibility](#), including appropriate scheduling, communication on medical information, and provider staff training and knowledge. [The Disability Competent Care Self-Assessment Tool](#) can be used to determine the accessibility of services.

- ❑ [\*Partners for Kids\*](#), an Ohio ACO serving children with disabilities and complex health needs, has found innovative ways to provide care coordination and health services for this population.

## Strong Consumer Protections

It is vitally important to ensure [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 federal law, including the the Americans with Disabilities Act (ADA) and the [Mental Health Parity and Addiction Equity Act \(MHPAEA\)](#).
- ❑ Ensure that policies are in place to protect consumers' health information when they transition from one ACO to another.
- ❑ Implement policies to protect consumers and ensure continuity of care in case the ACO faces financial losses or closure
  - ❑ *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.*

### ***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 into 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 the opportunity to proactively opt in to the program
- ❑ Prohibit lock-in periods that prevent consumers from leaving an ACO.
- ❑ Clearly describe the process for opting out of attribution to an ACO and remaining in traditional fee-for-service.
- ❑ Provide consumers with comprehensive, accessible information about attribution that explains what an ACO is and what it means to be attributed to one. Including:
  - ❑ 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.
  - ❑ The rights and protections of ACO participants.
  - ❑ Details about the provider network, such as language spoken by providers, details about the pediatric network, the network for substance use disorders and mental health providers, including the specific type of service, and information about physical accessibility.

- Present information in culturally and linguistically appropriate ways. Take the health literacy levels of consumers and their caregivers into account.

### ***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 online and on paper for consumers and caregivers.
- Provide comprehensive information to consumers on their rights related to grievances and appeals. This includes how to file a grievance, who to file with, and if there are consumer assistance programs like an ombudsman that will assist them through the process.
- Provide continuation of service provision in the same amount, duration and scope during appeals.
- Establish mechanisms to track grievances, 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
  - A Vermont law, [Act 113 of 2016](#), 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; provides 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.*

### ***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 be a community-based organization. .
- Provide consumers and stakeholders with information on how the ombudsman will function and the criteria by which its success will be measured.
- Provide sufficient funding to allow the ombudsman to meet the needs of consumers and provide timely trend reports. Require that the ombudsman report to and collect information from state, ACO stakeholders, and consumers.
  - MassHealth has specific [ombudsman programs](#) for different health care plans, including its Medicaid ACO, assisted living, community care, and long-term care plans.*
  - Ensure the ombudsman is trained in the requirements of mental health and substance use parity, the Americans with Disabilities Act, and other anti-discrimination laws and regulations.*

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, report data in real time, and conduct 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

These measurements are important to ensure that ACOs are delivering quality care to consumers. States should require ACOs to report or achieve outcomes on [quality measures](#) to continue receiving funding or incentive payments. By tying together quality measurement and funding, ACOs are incentivized to provide quality, coordinated care that improves consumer outcomes.

Does your state Medicaid ACO program do the following?

- ❑ Solicit the feedback of consumers, consumer advocates and other community stakeholders when quality measures are developed and chosen to ensure that community priorities are reflected in the ACO's performance evaluation. Communities can provide input through public forums, advisory groups and/or surveys.
- ❑ Focus on outcome measures, particularly patient-reported outcomes, which provide information on consumers' health and functioning. Measures should include [patient experience measures](#), [patient-reported outcome measures](#) and [patient goals-directed measures](#).
- ❑ Quality measurement should include information on health disparities. Data should be disaggregated and stratified by race, ethnicity, primary language, gender identity, sexual orientation, and disability status to measure progress on reducing disparities.
- ❑ Quality metrics should not solely focus on measuring reductions in the use of health care services or spending. An overemphasis on reducing spending or service utilization can encourage ACOs to deny treatment to consumers based on a desire to reduce costs.
- ❑ Measures should be customized for the targeted populations. If the ACO serves a population with high substance use disorders and mental health needs, the measures should reflect 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](#).
- ❑ Include measures that assess problems consumers have with their care, such as patterns in consumer appeals and grievances and disenrollment from the program. See the Ombudsman section for more information.
- ❑ Present quality measures data publicly in an easily accessible and intelligible way on at least an annual basis.

# Payment Arrangements Incentivizing Better Health Outcomes

Setting an appropriate payment amount is one of the most fundamental aspects of designing a well-functioning ACO. And these decisions have important implications for consumers, as payment arrangements are an important lever for encouraging providers to focus on particular aspects of care improvement and efficiency. It's important for states to design payment arrangements so that they drive providers to address services that are important for patient outcomes, without incentivizing providers to reduce necessary services. For this reason, it is important that payment arrangements are considered in conjunction with strong, consumer-oriented quality measures, which are detailed in the previous section.

In addition to engaging in conversations around the overall [payment models](#) and amounts, consumer advocates should ensure their state Medicaid ACO program does the following:

- ❑ Use community input to help develop payment models.
  - ❑ *In New Jersey, [the Camden Coalition ACO](#) requires community input in its shared savings reinvestment process.*
- ❑ Reinvest savings into areas previously identified by the community. These could include health literacy, preventative services, community-based services, workforce enhancements or infrastructure.
  - ❑ *The [Trenton Health Team in New Jersey](#) used quantitative data and community forums during their last [community health needs assessment](#), to find out what health issues were most important to their community. Their Community Advisory Board (CAB), whose members include 50 community-based organizations, oversees each CHNA process. The CAB also directs grants to improve the community's health, based on the needs identified in the CHNA.*
  - ❑ *Hennepin Health [uses its savings](#) to hire community health workers and deploy community paramedics in homeless shelters, among other programs.*
  - ❑ *States could consider pooling savings as a way to finance a prevention fund to increase access to preventative health services, promote healthy behaviors, and address health disparities. Although not funded through shared savings arrangement, Massachusetts's [Prevention and Wellness Trust Fund](#) provides a good model of what a fund like this might look like.*
- ❑ Use risk adjustment strategies to ensure that complex patients' needs are met. Account for [factors](#) that affect health outcomes, such as [socioeconomic status or functional status](#). Payment to providers should be based on the characteristics of the community they serve.
  - ❑ *Minnesota and Massachusetts have implemented risk-adjustment strategies that encourage ACOs to better address the SDOH. [Both models show promise.](#)*
- ❑ Use a [value-based payment model](#) to incentive ACOs to offer substance use disorders and mental illness services and improve the quality of those services.
  - ❑ *Maine includes spending on substance use disorders and mental illness services in its total cost of care benchmark. This incentivizes the ACO to provide these services and to coordinate them with physical health services.*

# 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 efforts are well-organized and consumer-focused. The suggestions that follow apply to the general population attributed to an ACO and should be considered a floor, with additional requirements necessary for more complex populations, such as dual eligibles.

Does your state Medicaid ACO program do the following?

- Foster a team-based approach that is centered on the needs, preferences, and circumstances of patients, their families and caregivers.
- In the certification application, ask ACOs to clearly document how they will pursue a team-based approach to care, with attention paid to coordination of community-based care such as substance use disorders and mental illness services, oral health services and LTSS.
- Include quality measures focused on care coordination, including patient and caregiver experiences around care coordination.
  - [New Jersey's ACO demonstration project quality metrics](#) include metrics around patient satisfaction with care coordination.*
- Focus on quality improvement in care transitions.
  - Oregon holds CCOs accountable for [care transition and measures the quality of patient readiness for transitions](#).*
- Define how ACOs will ensure care coordination and engage members in their home setting through methods such as home visits or telemedicine.
- Ensure care coordinators receive [ongoing training](#) in best practices for providing coordinated care and are trained on care for mental illness and substance use disorders.
- Share patient data during care transitions. This is especially important for care transition across multiple health systems, as it prevents consumers from having to undergo duplicative medical testing and allows providers to better understand consumers' needs. Confidentiality and data security must be maintained.
  - Vermont's Medicaid ACO originally included three different health care systems. The state obtained a grant to allow all three systems to collaborate with the state's health insurance information exchange, Vermont Information Technology Leaders, to build one IT infrastructure. This system allowed all providers across health systems to track patient data, provide notices ahead of care transitions, and report on system-wide quality measures.*
  - The Trenton Health Information Exchange gives providers one patient record that compiles each consumer's health information.*

# Addressing the Social Determinants of Health

Medicaid ACOS provide an exciting [opportunity](#) to [address the social determinants of health](#) (SDOH) among the Medicaid population. The SDOH are the conditions - such as food, housing, and safety - in the places that people live, learn, work, and play. Addressing these factors improves health, reduces disparities in health care and access to care, and reduces long term health care costs.

Does your state Medicaid ACO program do the following?

Encounter level:

- Regularly assess individual patients' social and economic needs. Provide appropriate referrals to social service organizations, navigation assistance for accessing social services, and follow-up to see if patients received the needed services.
  - [North Carolina's](#) Prepaid Health Plans (PHPs) are required to conduct social needs screenings using ten standardized questions that cover four domains: food security, housing and utilities, transportation and interpersonal safety.
  - For more information and examples of screening tools see [Screening for Social Needs](#)

Organizational level:

- [Utilize payment models that incentivize ACOs to provide and coordinate social services.](#)
  - [Hennepin Health](#) in Minnesota can include non-medical services in the total cost of care, which allows them to better address patients' social and economic needs. For example, they provide housing to homeless patients with complex care needs.
  - Oregon's CCOs can use Medicaid dollars for non-medical services including housing supports. A [survey](#) of 15 of Oregon's 16 CCOs found that they all provide some form of housing supports, such as assistance with housing applications, move-in costs, eviction prevention or utilities assistance.
- Include requirements that ACOs implement a range of specific programs that directly address social determinants of health, such as [supportive housing](#) or [food and nutrition interventions](#).
  - Massachusetts [developed a guidebook](#) to help ACOs determine how to address housing, income insecurity, nutrition, domestic violence, education, physical activity and transportation.
  - [New York](#) requires any provider in a value-based purchasing arrangement, including ACOs, to implement at least one SDOH intervention. The state provides a menu of options, including Housing-first programs to address homelessness, child-care support, or prescriptions for healthy food.
- Include quality measures related to addressing the SDOH.
  - In Minnesota's [Integrated Health Partnerships \(IHPs\)](#), quality measurement includes requiring the IHP to form community partnerships that address the SDOH. IHPs identify at least one [quality measure](#) that is aimed at reducing health disparities.
  - In [Rhode Island and Massachusetts](#), ACOs are required to report on the rate of screening for SDOH and this is factored into their overall quality score.
- Improve information exchange between health systems and social service organizations to provide better care to consumers.

Community level:

- ❑ Regularly assess the social service needs of the community, including using a [community health needs assessment](#) (CHNA) and community health improvement plan.
  - ❑ *The [Trenton Health Team in New Jersey](#) used quantitative data and community forums during their last [community health needs assessment](#), to find out what health issues were most important to their community. Their Community Advisory Board (CAB), whose members include 50 community-based organizations, oversees each CHNA process. The CAB also directs grants to improve the community's health, based on the needs identified in the CHNA.*
  - ❑ *[Oregon](#) requires all Coordinated Care Organizations (CCOs) to conduct community health needs assessments. The state provides trainings to teach CCO administrators how to develop CHNAs and community health improvement plans.*
- ❑ Require your Medicaid ACO to form community partnerships. Advocates should ensure that the partnering organization meets the needs of the community that the ACO serves.
  - ❑ *Oregon's CCOs must have agreements with particular community emergency and mental health programs. These are often local government offices, such as an Area on Aging office. The CCOs are also encouraged to form partnerships with community-based organizations that provide services like crisis management or community prevention.*
  - ❑ *To provide mental health and substance abuse services to MassHealth members. The [Massachusetts Behavioral Health Partnership](#) works with a network of community-based clinics, primary care physicians, and other organizations.*
  - ❑ *Colorado's ACO requires contractors to establish relationships with community-based organizations and includes medical and non-medical services within care coordination. Organizations such as [Centura Health](#) partner with faith-based organizations to provide mental health and spiritual care services. Colorado's ACO also has an employee who assesses the demographics of high-risk members and refers them to social services.*
- ❑ Assess the effectiveness of the ACO's community partnerships.
  - ❑ *[Massachusetts](#) measures ACOs on social service screenings and use of state certified community partners.*

## Health Equity

ACOs have the potential to address health disparities and promote health equity. 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. Furthermore, ACOs should define how they will evaluate these requirements; quality measures could focus on [these principles](#).

- ❑ Provide opportunities to train providers in caring for diverse groups. A training for caring for people living with disabilities could focus on independent living principles; a training for caring for LGBTQ populations could include preventing discrimination based on sexual orientation or gender identity.
- ❑ Include strong health literacy standards for all communications with beneficiaries. This will ensure that all patients, regardless of literacy level, are able to [understand health care information, ask questions, and make the right decision for themselves](#).
  - ❑ For more on how health care organizations can tackle health literacy, please see [Attributes of a Health Literate Health Care Organization](#).
  - ❑ Health literacy standards include ensuring written materials are accessible and understandable to all ACO members. Written materials should be printed in multiple languages and offered in alternative formats for blind and visually impaired members.
  - ❑ Oral interpretation should be available for all members with limited English proficiency, as should assistance for people who are deaf and need American Sign Language.
- ❑ Implement [strategies](#) to encourage safety-net provider participation
- ❑ [Demonstrate](#) how ACOs will employ a variety of health care providers, such as community health workers and peer specialists, into their care teams. Diverse providers are often attuned to the culture and needs of specific populations, and may be effective at connecting consumers to social services or at teaching healthy habits.
- ❑ ACOs should also provide opportunities for team building and training and ensure all care team members feel empowered and engaged.
- ❑ Develop plans to address health disparities. 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.