Mass Home Care

ACO Certification Standards: Mass Home Care Comments To The Health Policy Commission

Introduction:

ACOs are likely to be networks of medical care providers, or health insurance entities that have little experience with the provision of Long Term Services and Supports (LTSS). These entities have focused on the "triple aim" of improved patient experience, improved health outcomes, and lowered medical costs. In the LTSS culture, the triple aim is : 1)preserving independence (care in the "least restrictive setting,"2) maintaining control over services (patient-directed care) and 3) choice of care plan services (open network of medical and functional support options).

Advocates for LTSS services want ACOs to have the capacity to provide consumers with an integrated care plan of medical and functional LTSS supports that addresses not just medical, acute care needs---but also ADL/IADL/social determinant needs, and to avoid the "medicalization" of LTSS care. ACOs should be able to demonstrate the ability to give consumers the care that meets their aspirations and desires. CMS has created the concept of an "independent agent" on the Interdisciplinary Care Team who performs the assessment and care coordination of the LTSS care needs of the member. This agent helps the member articulate what supports are needed, which the agent can purchase from 3rd parties without

any financial conflict of interest. The independent agent model also has been used by the Commonwealth for the elderly home care program (MGL Ch. 19A,4b), as well as the Senior Care Options Plan (MGL Ch. 118E, 9D), and the One Care plan (MGL Ch. 118E, 9F. ACOs should demonstrate that their members' benefit includes an initial assessment and ongoing LTSS care coordination by an independent conflict free care coordinator.

In the CMS Final Rules for the provision of Home and Community Based Services, there is a section on Independent Assessments (§ 441.720), which requires that states use assessor who "must be independent; that is, free from conflict of interest with regard to providers, to the individual and related parties, and to budgetary concerns." CMS requires the " independence of the assessor in accordance with section 1915(i)(1)(H)(ii) of the Act, and we will apply these also to the evaluator and the person involved with developing the person-centered service plan, where the effects of conflict of interest would be equally deleterious." CMS says that "states have the flexibility to determine the entity that can perform this function, consistent with t he requirements at § 441.730 regarding qualifications and § 441.720 regarding the independent assessment."

The function of the conflict free independent agent is critical to the success of the ACO demonstration, and ACO certification standards need to include this design element. Our comments below seek to add the independent agent to HPC's standards. EOHHS, in its agreement with CMS for the Balancing Incentive Payment program (BIP), agreed to create No Wrong Door access system for LTSS, and a "conflict free model" for LTSS care coordination. Our comments are consistent with this agreement.

In addition, ACOs need to be committed to the cornerstone mission of MassHealth found in MGL Chapter 118E, S. 9 that members should be cared for "in the least restrictive setting," and this principle must be embedded in the HPC Certification standards for ACO.

Finally, it is critical to the analysis of ACO performance that the state mandate a set of uniform standards, clinical metrics, process protocols, EHRs, and quality measures that are universally used by all ACOs, so that members and policymakers can evaluate the success of this demonstration across all ACO.

Our specific comments on the proposed ACO certification standards are shown below. Any domains not listed indicates that Mass Home Care is substantially in agreement with the HPC direction as presented.

Domain #	Criterion	Documentation
3	**ACO governance structure**: having one patient/consumer on the ACO board will not make a difference in governance. The ACO should have at least 3 consumer seats, and several seats for community group stakeholders, like BH, LTSS entities, or other groups that will be affected by the work of the ACO.	ACOs should be required to annually submit their board list to the state, with board members identified as consumers or community groups.
4	**ACO governance**: this list does not include LTSS specialists. LTSS should be added to BH, specialist list if the ACO is providing LTSS as part of its capitation.	ASAPs for example, are required by statute to have a governing board comprised of 51% people over the age of 60, and 51% members appointed by local Councils on Aging. Assures community control.
5	**Advisory Council:** The group DAAHR has suggested an "implementation council" for the ACOs. This council can have, among its responsibilities, gathering the perspectives of patients, reviewing outcomes of patient surveys, etc.	ACOs should conduct at least one broad consumer satisfaction survey, approved by its implementation council, to demonstrate that it has gathered patient perspective and reviewed outcomes.
6 5	**Quality Committee:** LTSS measures have been omitted from the list. LTSS should not be integrated into ACOs until the state has agreed upon a series of LTSS quality metrics, not just health metrics that LTSS	ACOs should all be working from the same page of medical, BH, and LTSS quality metrics, and these metrics should be set by the HPC with ACO input. Until LTSS standards are put in

	participate in meeting.	place, ACOs should not certified to expend LTSS dollars.
7	**Risk Stratification:** Functional status and LTS outcomes must be included in the risk stratification approach. This is not a 'may' proposition. LTSS is as critical to wellness as BH and the number of medical chronic condtions.	The ACO plan must have a standard, universal risk stratification process to allow plans and their outcomes to be compared in a uniform way.
8	**Improving outcomes:** All ACOs that provide LTSS as a member benefit must have in place the standard LTSS expected of ACOs.	It is the state's responsibility to put in place standard LTSS metrics and outcomes, such as "community tenure" and other outcomes that are not purely medical placeholders.
9	**Access to BH & LTSS Providers:** ACOs need to have more than just "collaborations" with post acute care providers, like LTSS agencies. ACO care delivery must be able to demonstrate signed agreements/contracts with LTSS providers to demonstrate that members will have a wide range of LTSS services available to them, and not just a "narrow network" of "preferred providers."	Members have the right to choose service providers that have been qualified by the state, not just providers "preferred" by the ACO. The list of providers available through the ACO should be filed on a state website so members can check the provider list to choose which provider they want.
10	**Agreements with Providers: ACO must be able to demonstrate agreements with independent, conflict free LTSS care coordinators.** **Agreements for Access and Date Sharing:** All ACOs and their network of providers should work off one standard IT data system, and one data sharing agreement, so that data is uniform and consistent regardless of ACO.	The list of providers in this domain should be amended to add, afater "LTSS providers," these words: "and Independent, conflict free LTSS care coordinators." All EHRs should be "owned" by the member and availability to providers of the EHR should be determined by the member. The database for the EHR must be a single, uniform application for all ACOs.

13	**Analytic Capacity:** The state needs to oversee and monitor the production of monthly or quarterly standard cost, utilization and quality analyses, which must be open to consumers, and providers alike. The SCO and One Care programs are not managed this way, and access to data is very limited. Each SCO plan has its own proprietary data collection, even laptops, and the general public gets little transparency of how these public funds are invested.	The state should over see the selection of an IT system for data collection, and reporting system, that has a clear dashboard that members can be trained to use, and that in the aggregate level is available for public analysis.
14	**Patient Experience Evaluation**: data from this must be uniform and consistent across ACOs. Tool should be a state product with public input.	Whatever patient experience survey is adopted, and there are a number to choose form, it needs to be a standard survey instrument used by all ACOs.
15	**Social Determinants of Health:** this should be a standard protocol present in initial assessments and ongoing care coordination efforts for all ACO members.	ACOs should be required to demonstrate the capacity it has to assess the social determinant needs of all its members, using entities that have the expertise in determining social determinant factors to be included in care plans. These community partners should be conflict free, and they should exist for all members, not just in one or two communities, and every care plan should reflet SD needs.
20	**Quality and Financial Performance Reporting**: There are not yet any agreed-upon LTSS quality measures. The state needs to finalize measures, and ensure that all ACOS are operating on the same measures. They need to measure LTSS domains, not merely adopt medical metrics that do not speak to LTSS performance.	LTSS funds should not be integrated into ACO plans until these non medical measures are adopted. We would never proceed with medical care wthout such outcome measures in place. If reports are not standardized, members and state reglators will be unable to evaluate performance among ACOs.

24	**Care Coordination: The** reporting criteria here needs to add "LTSS" to the use of providers list. Use of community providers is not just for medical services if it is an integrated services model.	The ACO design being recommended by MassHealth uses a "Health Homes" model for care coordinator of those with multiple chronic conditions, and "Community Partners" as direct providers. This model medicalizes LTSS, and abandons the state's commitment to CMS in 2014 to continue development work to ensure that HCBS employed a "conflict free" model for such services. All ACOs that have LTSS as part of their capitation should be required to provide all members with access at the care team level to independent, conflict free care coordination to conduct an initial LTSS baseline assessment, and ongoing LTSS care coordination, as specified in the BIP agreement between CMS and EOHHS. EOHHS should establish criteria for each department under its jurisdiction to develop designation criteria for entities which wish to be registered as Independent Conflict Free LTSS Care Coordination Entities. **ACOs should demonstrate that their members' benefit includes an initial assessment and ongoing LTSS care coordination by an independent conflict free care coordinator** from a list designated by the state. The line agencies, like DDS, DMH, MRC and EOEA would create designation regulations and procedures, and

		entities could apply to be an ILTSCs in one or more discipline areas. ACOs, as a matter of service delivery capacity, would be required to hold contracts with at least two conflict free entities who are certified as ILTSCs in each of its major geographic service areas.
25	**Review of Medication Reconciliation**: this service does not need to be medicalized. There are evidence-based MTM programs now available that use care managers in the home setting to perfrom medication reconciliation.	ACOs should be required to assure that all members have at least one annual medication therapy management visit, including models that use community care managers to review, in the home, the complete of prescription drugs and OTC meds being used, and to report "red flags" to a pharmacist reviewer.
28	**Use of Evidence-Based Guidelines:** To have a consistent benefit, ACOs should be given a list of EB interventions for LTSS that have been "approved" for use in ACO plans, and members should be able to easily find which programs are active at which ACOs.	It should be a state responsibility to provide ACOs with an initial and updated list of EB programs that ACOs are to select from as part of the LTSS benefit. For example, members should know that "Matter of Balance" is available at their ACO, or not.
30	Flow of payment to providers: This is an important fiscal transparency issue that has been lacking in the state's existing SCO and One Care managed care plans.	Members enrolled in ACOs should be able to determine easily how much of the capitated revenues from any given ACOs came from an LTSS funding source (e.g. Medicare or Medicaid) and of that revenue, how much was spent on community-based or institutional LTSS. Members should also be able to see each ACOS loss-ratio index for the preceeding fiscal year. ACO financial reports should be posted quarterly on a state MassHealth website for

		members and policymakers.
32	**EHRs Commitment**: ACOs need to operate from one standasrd EHR platform, or from software that be converted to one standard EHR reporting format.	EOHHS must mandate a single standard medical record reporting format that allows uniform reporting and analysis of patient activity across all ACOs. LTSS activities need to be place on that data reporting grid.

We would be happy to provide any further background information that the Commission may request.

Thank you for the opportunity to testify and submit these comments.

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