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Health Policy Commission
Attn: Catherine Harrison
50 Milk Street, 8th Floor
Boston, MA 02109

Re: Proposed Accountable Care Organization Certification Standards

Dear Ms. Harrison:

Thank you for the opportunity to comment on proposed Accountable Care Organization (ACO) certification standards. As you may know, the Association for Behavioral Healthcare (ABH) is a statewide association representing more than eighty community-based mental health and addiction treatment provider organizations. Our members are the primary providers of publicly-funded behavioral healthcare services in the Commonwealth, serving approximately 81,000 Massachusetts residents daily, 1.5 million residents annually, and employing over 46,500 people.

We applaud the Health Policy Commission for recognizing in the proposed ACO certification standards that the integration of behavioral and primary healthcare is one of the greatest opportunities for improved health status in recent years and that it needs to be supported through certification criteria.

I. Questions for Public Comment

Relative to the general questions for public comment, ABH offers the following responses and recommendations:

1. *Do the proposed HPC ACO certification criteria address the most important requirements and capabilities ACOs should have in order to operate successfully as ACOs? Do the certification criteria offer a comprehensive set of standards appropriate for all payers? If not, what other criteria should HPC add or substitute, and why?*

   <u>ABH Response</u>: Care coordination is a fundamental underpinning of the ACO model. ABH believes the care coordination requirements should be made mandatory for ACOs rather than "reporting only" and that the requirements themselves can be improved. Our specific recommendations follow under the appropriate criteria.

2. *Are the proposed criteria appropriately assigned to either the mandatory or reporting only category?*

   ABH Response: The following criteria should be moved from the reporting only to mandatory category:

   - All criteria within the Care Coordination domain (#23-#26) due to their centrality to the ACO model; and,
   - Transparent payment flow methodology (#30) due to the importance of transparency to instilling provider confidence in and developing support for care and payment transformation.

3. *To what degree would ACOs be able to submit existing documents and materials to the HPC, rather than create new documentation, to fulfill the proposed documentation requirements? Do the documentation requirements identifying existing, internal documents add to or reduce the administrative burden of applying for ACO certification?*

   ABH Response: With exceptions detailed for specific criteria, ABH believes that existing documentation should be utilized, where possible, because such documentation reflects practice as opposed to aspiration.

4. *Chapter 224 of the Acts of 2012 indicates a two-year period for ACO certification. Should the HPC re-certify ACOs more frequently during the first years of certification?*

   ABH Response: No, ACOs will need at least two years to begin operating at full-scale.

5. *Do you favor the HPC making public the application materials submitted for ACO certification?*

   ABH Response: ABH **strongly** supports the HPC making each ACO's certification application public. As Massachusetts seeks to transform its healthcare delivery system, a high degree of transparency is needed for patients/families and providers to decide whether to engage with each ACO, and for these stakeholders along with policymakers, regulators, and advocacy organizations to assess ACOs on their compliance and performance.

Our comments on the individual certification criteria are on the pages that follow.

II. Proposed ACO Certification Criteria

We offer comments on many of the HPC's proposed certification criteria and do so in order of their appearance in Table 1 of the public comment document:

A. Mandatory Criteria

Legal and Governance Structures

3. Patient or Consumer Representative
   To ensure meaningful participation by patients/consumers, ACOs should be required to have at least two patient/consumer representatives on the ACO Board. Alternatively, a percentage (perhaps 10-15% but no fewer than two individuals) of Board seats should be designated for patients/consumers. Participation as a designated patient/consumer representative can be intimidating in a group setting, particularly if most of the other participants have clinical backgrounds and the patient/consumer does not. Having another individual who can represent a patient/consumer perspective will help empower consumer and make him/her feel supported.

   In addition to the governing Board, ACOs should be required to have patient/consumer representatives on their Governing Committees. In all instances, patient/consumer representatives should have identical rights to any other Board or committee members including voting rights.

   In terms of documentation and demonstration of meaningful participation, the ACO should be required to provide relevant by-laws, committee charters, committee membership with individuals attributed to area represented, meeting minutes, etc. The ACO should be required to detail consumer/patient engagement activities (transportation vouchers or provision to meetings; child care assistance during meeting; translation/interpretation assistance, etc.); skills or education programs; meeting guidelines or rules of order that emphasize respectful listening and equal voices among clinical and non-clinical participants, etc.

4. Meaningful Participation of Primary Care, Addiction, Mental Health (including outpatient), and Specialist Providers
   Each ACO should be required to have at least two behavioral healthcare providers represented on its Governing Board, and at least one member of the ACO's executive team should be a behavioral health provider. Further, behavioral health providers must be represented on at least half of the ACO's Governing Committees, and inclusion on the committees must come with voting rights on the Board.

   In terms of defining the term "provider", ABH believes that at least one of the behavioral healthcare providers serving on the Governing Board be defined as a clinician or administrator from a community-based provider organization as opposed to an independent clinician or hospital-affiliated clinician. Representation from a community-based behavioral healthcare provider organization is more likely to reflect a system of care perspective and understanding of the various levels of care, including critical

diversionary services. These diversionary services are available in the community, and many are not currently available to commercially-insured individuals, or if they are, in a significantly limited way. As the Commonwealth seeks strategies to reduce avoidable utilization and to promote lower cost, effective services to drive systems change, a deeper knowledge of those services will be needed than that which is often found in care systems today. Community-based providers offer this knowledge and service expertise. The representative need not be part of the ACO organization.

Documentation of meaningful participation can include provision of organizational charts; membership of Executive Team, Governing Board, Governing Committees, showing individual attribution to designated provider types; by-laws; committee charters, etc.

6. Quality Committee to Improve on Clinical Quality/Health Outcomes (including behavioral health), patient/family experience measures, and disparities
   Representation on the quality committee must include representation from behavioral health providers, including outpatient providers, as well as patients and caregivers. ACOs should be required to provide the committee charter, committee membership and their representation area, and reporting relationship to ACO governance.

Risk Stratification and Population Specific Interventions

7. Approaches for Risk Stratification
   ABH endorses the HPC's inclusion of behavioral health conditions, high cost/high utilization, multiple chronic conditions and social determinants of health in the required risk stratification approach. ABH recommends that "medical conditions" be added to the minimum criteria to be used by ACOs.

8. Implementation of One or More Targeted Health Outcomes Programs, Including At Least One Addressing Mental Health, Addiction and/or Social Determinants of Health
   ABH strongly endorses the requirement that ACOs develop interventions for individuals with behavioral health needs. We believe that the requirement of a single program is insufficient. ACOs should be required to utilize their health assessment and risk stratification data to develop at least two programs, one of which focuses on mental health and/or addiction, to improve health outcomes for identified populations.

   For each program, ACOs should be required to document to the HPC on the use of data in program development, a description of the patient population targeted, the size of the patient population targeted, a description of the manner through which the intervention is anticipated to improve health outcomes, and the measurement metrics to be used. ACOs should be required to have a publicly-available summary of its annual program evaluation across patient experience, quality outcomes and financial performance.

Cross Continuum Network: Access to Behavioral Health and Long Term Services and Supports

9. Demonstrates and Assesses Effectiveness of Ongoing Collaborations
   As proposed, this criterion states "ACO demonstrates and assesses effectiveness of ongoing collaborations with and referrals to" a list of provider types. ABH recommends that this language be changed to "*ACO demonstrates and assesses effectiveness of contracts with and utilization of services provided by, or where not contracted, ongoing collaborations with and referrals to"* the provider types listed.

   Relative to documentation and assessment, in addition to the documents and data listed, ABH recommends adding "contracts" and "referral rates and patient utilization data" to establish whether the ACO utilizes services and providers appropriate to the populations served. Similar to the documentation requirements for less formal collaborations, the ACO should produce minutes from meetings with contracted providers to review the collaboration, referral pathways and utilization data and showing how these data will be used to make process, operational or clinical changes.

   Finally, the results of provider satisfaction surveys are a key success indicator, and ABH recommends that ACOs be required to undertake them annually and report on how the results will be incorporated into ongoing activities.

10. Capacity or Agreements with Mental Health Providers, Addiction Specialists, and LTSS Providers
    ABH recommends amending the language for this criterion to read "agreements should reflect a categorized approach for services by severity of patient need, including inpatient, intermediate/diversionary, and outpatient levels of care."

    In terms of documentation, ABH recommends adding "referral data and utilization data."

Analytic Capacity

13. Perform Cost, Utilization, and Quality Analyses and Disseminate Aggregate and Practice-Level Results
    Analytic capacity, whether vended or in-house, is an essential function of an ACO, and all ACOs regardless of size must be required to have these capabilities.

14. Patient/Family Survey and Experience Evaluation
    Relative to documentation, the ACO should be required to provide evidence of improvement efforts and results of those efforts.

B. Reporting Only Criteria

Care Coordination
Because care coordination is one of the defining attributes of the ACO model, ABH recommends moving this entire category (#23 through #26) to the Mandatory area.

23. Test and Referral Tracking
    ABH recommends that the ACO be required to provide "ACO policies and procedures describing how test results and referrals are communicated to participating providers of all types."

24. Preferred Providers
    ABH endorses the intention of this criteria to encourage connections to and utilization of providers, particularly specialists, within a patient's community. ABH recommends changing the language to read as follows (changes in italics):

    The ACO demonstrates a process for identifying preferred providers, with a specific *documented approach* to increase use of providers in the patient's community, as appropriate, specifically for:

    - oncology
    - orthopedics
    - pediatrics
    - obstetrics
    - *behavioral health (mental health and addictions)*

    In terms of documentation, ABH recommends changing the language as follows (changes in italicizes):

    - Written description of ACO's process for identifying preferred providers, including relevant quality, financial, *and risk or case mix adjustment analyses*
    - Documentation of provider *and patient* communication related to encouraging use of identified providers *in the patient's community*.

26. Care Coordination Process Improvement Plan
    ABH recommends that the real-time event notification language be made more explicit to read (changes in italics) "sending and receiving real-time notifications (admissions, discharges, transfers) *to and from* participating providers *of all types, including PCP and specialty providers*."

Peer Support

27. Peer Support Programs
    Peer support has been an important enhancement to a wide variety of Medicaid-funded behavioral healthcare services, including Emergency Services Programs (ESPs) and Program for Assertive Community Treatment (PACT) as well as state-funded programs such as Community-Based Flexible Supports (CBFS). However, the effective incorporation of the peer role into programming takes time, and clinical and nonclinical staff need to be trained on peer support. Relative to documentation, ABH recommends that the ACO be required to furnish evidence of training for ACO staff and care coordinators regarding peer support and related resources. Documentation could include curricula, the name and qualifications of the training staff and participant names.

Flow of Payment to Providers

30. Transparent Methodology of Funds Distribution to Providers
    ABH recommends moving this to the Mandatory criteria section. The HPC should take a role in evaluating documentation to ensure that the ACO fulfills this core transparency requirement.

EHR Interoperability Commitment

32. Meaningful Use-certified EHR Internal Adoption and Integration Rates
    ABH recommends that the ACO's improvement plan be required to detail the manner in which the adoption assessment results will inform any provider type-specific strategy.

33. Mass HIway Connection Rates
    ABH recommends that the ACO's improvement plan be required to detail any provider type-specific strategy.

ABH thanks the Health Policy Commission for its collaborative approach to the ACO certification process and for the opportunity to comment on the proposed certification criteria.

Sincerely,

Vicker V. DiGravio III
President/CEO