



January 29, 2016

Health Policy Commission
Attn: Catherine Harrison
50 Milk St., 8 th floor
Boston, MA 02109

Re: Comments on HPC's proposed ACO Certification standards

Dear Ms. Harrison:

Thank you for the opportunity to provide feedback on the Health Policy Commission's proposed ACO certification framework. We recognize the challenge of the task set forth by chapter 224 and appreciate being afforded the opportunity to participate in the policy-making process.

The Lowell General PHO is a non-profit subsidiary of Circle Health and an unincorporated department of the Hospital. The PHO was established in 1995 with the goal of developing a local integrated delivery system to partner with independent community providers and develop and support innovative approaches to providing industry-leading high- quality value-based care in the Greater Lowell area. The PHO is comprised of approximately 350 member physicians (95 PCPs and 255 Specialists) and the Lowell General Hospital. Although the PHO is a department of the hospital, it maintains its own budget, separate from the Hospital's and has its own Board of Directors comprised of five representatives from each: the hospital, PCPs, and specialists. This structure allows the PHO and Hospital to align their goals while allowing providers to maintain independent practices. The PHO Board sets the direction of the risk agreements and surplus distribution.

Attached is our specific feedback on questions raised by HPC in it request for public comment. I would also like to provide some global feedback about the general concept and scope of the criteria proposed in ACO framework and how it impacts provider organizations like ours as well as some consideration for amending the proposed framework.

Philosophically, Lowell General agrees with the principles of accountable, patient-centered care, as demonstrated by our commitment to APMs. A significant portion of our patients are under a risk agreements, including MSSP. As an organization of small, independent practices, often comprised of

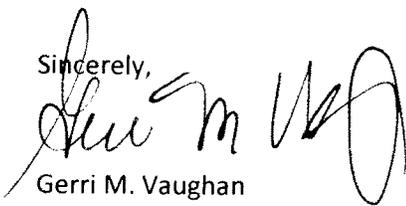
one or two physicians, the PHO aims to provide the infrastructure and support of a more traditional integrated system while allowing providers to maintain their independence as practitioners. This "virtual" integration allows us to engage with our providers on innovative approaches to improving

outcomes and patient satisfaction because they “buy-in” to the value-based care concepts and they enjoy the engagement in exploring innovative approaches to meeting the health care needs of their patients in a value-based environment. Simply put, they are part of the solution. Through our model, providers have a voice at the table and a stake in the outcomes. We believe this collaborative empowerment model is a key ingredient in our proven success as a leader in providing patient-centered, high-quality, high-value health care, the same goal as Accountable Care and Patient Centered Medical Homes. While the goal is clear, how we achieve that goal remains fluid with the changes in healthcare payment, policy and practice. We believe this flexibility allows us to be nimble and responsive to the ever-changing needs of and demands on the health care system. It is this philosophy that we strongly encourage HPC to consider adopting. *Objectives should be clear and meaningful*, but how each organization meets those objectives should be flexible to allow for the multitude of variances in the practices, needs, challenges, and drivers unique to each community and the every-changing face of healthcare. Flexibility not only allows for but encourages innovation, a key directive to HPC in Chapter 224.

By mandating *how* an organization provides care coordination and integration, access to services and accountability for quality outcomes, HPC is assuming a one-size-fits-all approach which specifically disadvantages the small independent practices by creating a significant administrative burden without any apparent return on investment. In addition, by dictating how to meet the objective, HPC inadvertently stifles innovation across the board. The healthcare landscape of 5-10 years ago has changed dramatically and given the current climate of change, will continue to do so for the foreseeable future. Require certain safeguards, hold ACOs accountable, but allow ACOs to determine how best to meet the aforementioned objectives.

Again, thank you for the opportunity to provide feedback. We at Lowell General are extremely committed to the philosophy of accountable care and would welcome the opportunity to discuss this in more detail with HPC.

Sincerely,



Gerri M. Vaughan
Executive Director

Lowell General Physician Hospital Organization

MHA MEMBERSHIP FEEDBACK ON HPC PROPOSED ACO CERTIFICATION CRITERIA

THIS DOCUMENT PROVIDES A SUMMARY OF COMMENTS RAISED IN MHA MEMBERSHIP MEETINGS AND SHOULD NOT BE CONSIDERED AS MHA'S FINAL COMMENTS ON THE HPC PROPOSAL

January 21, 2016

Mandatory Criteria					
Domain	#	Criterion	Documentation Requirements	Questions for Public Comment	LGH Comments
Legal and governance structures Note: "governance structure" refers to the ACO board and supporting committees.	1.	The ACO operates as a separate legal entity whose governing members have a fiduciary duty to the ACO, <i>except</i> if ACO participants are part of the same health care system.	- Evidence of legal status.		<i>Recommend HPC be less prescriptive in how an organization meets the intent of this requirement but rather demonstrate (either through participation in a CMS ACO program or participation in APMs with major payers with downside risk) how it meets the intent of this requirement.</i>
	2.	The ACO provides information about its participating providers to HPC, by Tax Identification Number (TIN) , for each of the three payer categories (Medicare, MassHealth, commercial).* <i>*To the extent possible, this will be done in coordination with RPO process.</i>	- List of ACO's participating providers (TINs). - Narrative of why an ACO's participating providers may differ by Medicaid, Medicare or commercial contracts.	At what organizational level would ACOs apply for ACO certification?	<i>ACOs should be allowed the flexibility to determine at what organizational level they apply as some organizations cover geographically and demographically diverse locations and providers. RPO data should be leveraged to avoid duplication of efforts.</i>
	3.	The ACO governance structure includes a patient or consumer representative . The ACO has a process for ensuring patient representative(s) can	- Written description of where/how the patient or consumer representative role	Describe and give examples of meaningful participation. What evidence should the HPC seek to assess meaningful	<i>HPC should define the objective not how an ACO meets it. For example, if HPC wants to ensure patients' perspectives considered in the governance of the organization, HPC could require ACOs to "demonstrate how the ACO engages patients in the decision-</i>

Comment [JH1]: Mirror request but leave flexibility in what organizational level it's filed

	<p>meaningfully participate in the ACO governance structure.</p>	<p>appears within the governance structure, and how an individual is identified or selected to serve.</p> <ul style="list-style-type: none"> - Written description of the specific strategies ACO deploys to ensure patient/consumer's meaningful participation. Such strategies may include providing: practical supports (e.g. transportation to meetings, translation of materials); formal or informal training or personal assistance in subject matter and/or skills; a code of conduct for meetings or other governance structure operations that emphasizes an inclusive, respectful approach; or other. 	<p>participation?</p>	<p><i>making process of the governing body.” Evidence could include patient panel feedback, meetings with advocates, and reporting and consideration of those result. While a position on the board could be an option, it should not be a requirement. The goal is to ensure the patients’ perspective is considered. With payers requiring patient satisfaction and participation as part of their quality measures tied to payment, it is in the organization’s best interest to engage patients in a meaningful way. Inclusion of a patient representative on the board does not ensure patients’ interests are being addressed</i></p>
<p>4.</p>	<p>The ACO governance structure provides for meaningful participation of primary care, addiction, mental health (including</p>	<ul style="list-style-type: none"> - Written description of official governance structure including 	<p>What evidence should the HPC seek to evaluate meaningful participation?</p>	<p><i>Due to the shortage of BH providers, HPC should not be prescriptive in its requirement of BH formal participation in governance. Many providers participate in multiple ACOs</i></p>

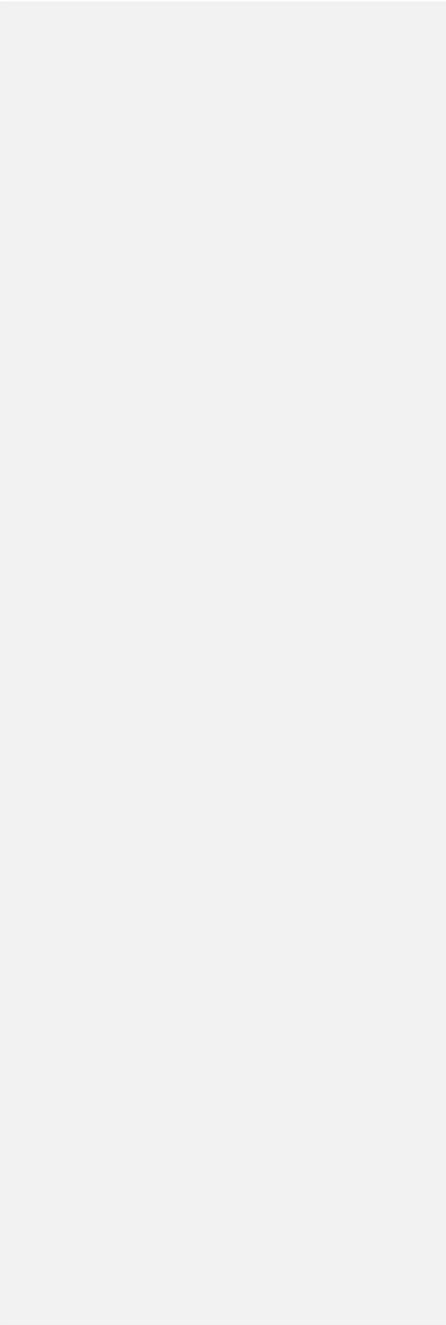
	<p>outpatient), and specialist providers.</p>	<p>the board and committees with members' names, professional degrees (e.g., MD, RN, LCSW, LMHC), titles, and organizations.</p> <ul style="list-style-type: none"> - Written description of how different provider types are represented in the governance structure of the ACO (i.e. in number, via voting rights, or other), and specific ways ACO ensures meaningful participation of different provider types. 		<p><i>and many ACOs don't dictate what BH providers their patients seek. With the increasing interest in evidence in integrating BH services into the medical realm, involvement of BH providers will be critical. But to overly burden already stretched resources by requiring formal participation in organizational structure, only adds to the shortage of provider availability. The organizational structure often relies on committees of specialists to make recommendation to the larger organization. If an organization can demonstrate how it involves providers across the care continuum to meet the needs of its patient population, regardless of specialty, inclusion in the governance structure should not be required as it is in the best interest of the ACO (or provider organization under risk arrangements) to meet the needs of its population.</i></p>
<p>5.</p>	<p>The ACO has a Patient & Family Advisory Council (PFAC) or similar committee(s) that gathers the perspectives of patients and families on operations of the ACO that regularly informs the ACO board.</p>	<ul style="list-style-type: none"> - Written description or charter for the PFAC, or similar group of patients, that provides input into ACO operations, or plans to establish such a council, including reporting relationship to ACO board. - Minutes from the most recent PFAC 		<p><i>HPC should define the objective not how an ACO meets it. For example, if HPC wants to ensure patients' perspectives are collected and considered in the operations of the organization, HPC could require ACOs to "demonstrate how the ACO gathers patient perspectives on operations and informs the board of their perspective." Evidence could include survey results, patient outreach initiatives, and patient experience reporting results to payers. This allows ACOs flexibility in how to effectively engage patients, and even allows for a more diverse representation of patient perspectives.</i></p>

			<p>meeting.</p> <p>Note: if an entity within the ACO (e.g. hospital) currently operates a PFAC, the same PFAC could be used to fulfill this criterion so long as the PFAC's scope will be expanded to address ACO-wide issues. ACOs would also need to demonstrate that the PFAC is representative of the whole patient population that the ACO serves.</p>		
	6.	<p>The ACO has a quality committee reporting directly to the ACO board, which regularly reviews and sets goals to improve on clinical quality/health outcomes (including behavioral health), patient/family experience measures, and disparities for different types of providers within the entity (PCPs, specialists, hospitals, post-acute care, etc.).</p>	<ul style="list-style-type: none"> - Charter or documentation of the quality committee's charge, members including titles and organizations, meeting frequency, and reporting relationship to ACO board. - Minutes from the most recent quality committee meeting. 		<p><i>HPC should define the objective and allow ACOs to determine how to meet that objective.</i></p>
Risk stratificatio	7.	<p>The ACO has approaches for risk stratification of its</p>	<ul style="list-style-type: none"> - Written description of the 		<p><i>Does HPC have any sources of SDH data it is suggestion ACOs use?</i></p>

<p>n and population specific interventions</p>	<p>patient population based on criteria including, at minimum:</p> <ul style="list-style-type: none"> - Behavioral health conditions - High cost/high utilization - Number and type of chronic conditions - Social determinants of health (SDH) <p>The approach also <i>may</i> include:</p> <ul style="list-style-type: none"> - Functional status, activities of daily living (ADLs), instrumental activities of daily living (IADLs) - Health literacy 	<p>risk stratification methodology(ies), including data types and sources, time of data, frequency of updating and criteria used.</p> <ul style="list-style-type: none"> - If the ACO uses socioeconomic or other demographic information to address social determinants of health outside of risk stratification, a written description of methodology and how data are collected. 		
	<p>8. Using data from health assessments and risk stratification or other patient information, the ACO implements one or more programs targeted at improving health outcomes for its patient population. At least one of these programs addresses mental health, addiction, and/or social determinants of health.</p>	<ul style="list-style-type: none"> - Written description of qualifying programs, including how participating patients are identified or selected, what the intervention is, the targets/performanc e metrics by which the ACO will monitor/assess the program, and how many patients the ACO projects to reach with each program. 	<p>Should the HPC be more prescriptive with this requirement (i.e., require more than one program)?</p>	<p><i>HPC should not be more prescriptive. If they have more guidance on what they expect to see, that would be helpful.</i></p>

			<p>Note: To qualify, a program must address a documented need for the ACO patient population; must have clear measures/outcome s-based approach; and must include/reflect community resources and partnerships as appropriate. A program of any size may fulfill this criterion.</p>		
<p>Cross continuum network: access to BH & LTSS providers</p>	<p>9.</p>	<p>ACO demonstrates and assesses effectiveness of ongoing collaborations with and referrals to:</p> <ul style="list-style-type: none"> - Hospitals - Specialists - Post-acute care providers (i.e., SNFs, LTACs) - Behavioral health providers (both mental health and substance use disorders) - Long-term services and supports (LTSS) providers (i.e., home health, adult day health, PCA, etc.) - Community/social service organizations (i.e., food pantry, transportation, shelters, schools, etc.) 	<ul style="list-style-type: none"> - Names of organizations and narrative or other evidence of how ACO collaborates with each provider type listed here. - Description of how ACO assesses and improves collaborative relationships with each provider type, including documents indicating processes used by the ACO to assess the effectiveness of ongoing 	<p>What evidence should the HPC seek to evaluate whether ACOs assess the effectiveness of the collaborations?</p> <p>This should be moved to the reporting only category.</p>	<p><i>This requirement is excessively burdensome (documentation required) and does not contemplate service gaps that exist in certain communities, specifically around BH and LTSS. HPC should allow for flexibility in how ACOs collaborate with community partners and how the effectiveness of those collaborations is evaluated. HPC should recognize the challenge of specific areas and offer additional support and leeway in the development of those collaborations. Due to the broad spectrum of innovations in healthcare currently underway, LGH encourages HPC to allow flexibility in how ACOs collaborate, as that may change over time.</i></p>

		<p>collaborations, such as:</p> <ul style="list-style-type: none">- Minutes from one Board or committee meeting documenting discussion of results of assessment with different provider types- Summary report on effectiveness of collaboration (e.g., % of providers that refer to collaborative partners) <p>Note: In evaluating the ACO's collaborations and assessments, the HPC will consider whether the ACO's submitted documents show that it sets targets or goals regarding such factors as:</p> <ul style="list-style-type: none">- Access- Appropriate breadth of services- Follow-up and reporting- Communication and/or data-exchange		
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		capabilities - Quality, cost, and patient experience scores - Extent to which collaborative partners are integrated into other areas of ACO, APMs, etc.		
	10.	As appropriate for its patient population, the ACO has capacity or agreements with mental health providers, addiction specialists, and LTSS providers. Agreements should reflect a categorized approach for services by severity of patient needs. These agreements should also include provisions for access and data sharing as permitted within current laws and regulations.	- Exemplar contract(s), memorandum(s) of understanding, or agreement(s) setting out terms of relationships between ACO and required provider types, including specific standards for access and requirements for clinical data sharing.	
Participation in MassHealth APMs	11.	The ACO participates in a budget-based contract for Medicaid patients by the end of Certification Year 2 (2017). * *Budget-based contracts are those that require a provider to accept a population-based contract centered on either a spending target (shared savings only) or a global budget (including down-side risk).	- Written commitment. Would a relative threshold be more meaningful? That is, measure ACOs' increase in rates of budget-based contracts year over year? Should a relative threshold be different for larger and smaller ACOs?	<i>It is beyond the scope of HPC to mandate payment structures with payers. Certification should not be tied to MassHealth participation, primarily because that program has yet to be designed.. Conversely, MassHealth can utilize HPC ACO certification as a requirement for participation. Regarding payment structure, LGH would strongly urge MassHealth to consider alternatives to the budget-based model as meeting the intent of APMs. Given the material movement between the Exchange and a Medicaid MCO and the significant</i>

					<p><i>volatility of that population, ACOs would face significant challenges in establishing a budget-based risk adjustment. ACOs that participate in value based risk arrangements however, can meet the objective of participation in APMs. ACO should not be locked into a budget-based model. GV you were going to provide more detail. Also, did you want to include something in relative threshold?</i></p>
<p>PCMH adoption rate</p>	<p>12.</p>	<p>The ACO reports to HPC on NCQA and HPC PCMH recognition rates and levels (e.g., II, III) of its participating primary care providers.</p> <p>The ACO describes its plan to increase these rates, particularly for assisting practices in fulfilling HPC's PCMH PRIME Criteria.</p>	<p>- Statement (or other documentation) outlining current PCMH recognition rates.</p> <p>- Narrative explaining plan for increasing rates, including HPC PCMH PRIME certification application/achievement.</p>	<p>How should the HPC best align its PCMH PRIME certification and ACO certification programs?</p>	<p><i>Given the high density of solo and small practices in the state, particularly in Greater Lowell, LGH strongly encourages HPC not to include expanding PCMH certification as requirement for ACO certification. Current requirements for PCMH certification are extremely prohibitive and burdensome for small community practices. Through our many innovations and initiatives currently underway, we are meeting the intent of PCMH by putting patients first in everything we do and developing cross-setting care coordination and collaboration, including BH services. Current PCMH structure is very burdensome for small practices. We are developing programs to meet the intent and goals of PCMH without the administrative burden on our providers. Evidence of these activities should be considered in lieu of certification rates.</i></p>
<p>Analytic capacity</p>	<p>13.</p>	<p>ACO regularly performs cost, utilization and quality analyses, including regular trending and forecasting of performance against budget and quality measure targets, and works with practices and</p>	<p>- Blinded sample cost, utilization, and quality report(s).</p> <p>- Written description or</p>	<p>Is this a feasible requirement for smaller ACOs?</p>	<p><i>We recommend HPC accept practice-level data for PCPs and aggregate data for specialists. Notwithstanding, payers have been unable to provide/develop credible specialty level benchmarks for performance. This requirement is feasible, but to date</i></p>

		<p>providers within the ACO to meet goals and targets. Analysis could be completed by a vendor or in-house.</p> <p>ACO disseminates reports to providers, in aggregate and at the practice level, and makes practice-level results on quality performance available to all participating providers within the ACO.</p>	<p>screenshot of how practice-level reports are made transparent and disseminated to providers/practices</p> <ul style="list-style-type: none"> - Documentation showing that the analysis is reviewed with providers, and how ACO uses reports to engage providers and practices in setting cost and quality improvement targets. <p>Note: Payer cost and utilization reports would fulfill this requirement, as long as they are disseminated down to the provider level.</p>		<p><i>practice-level cost/utilization reports have been determined not to be useful to practices. The comparison of practices to budget could be complicated to figure out how to put all payers at once into a report, if HPC expects that information to be shared with providers. Engaging providers on cost targets is not straightforward. If HPC has information about how ACOs have done this successfully that would be helpful.</i></p>
<p>Patient and family experience</p>	<p>14.</p>	<p>The ACO conducts an annual survey (using any evidence-based instrument) or uses the results from an accepted statewide survey to evaluate patient and family experiences on access, communication, coordination, whole person care/self-management support, and deploys plans to</p>	<ul style="list-style-type: none"> - Description of methods used to assess patient satisfaction/experience. - Description of how ACO identifies areas needing improvement and plans to address 		<p><i>HPC should not require ACO to conduct survey as those are done by payers, ACO can disseminate data once Payer provides.</i></p>

		improve on those results.	those areas.		
Community health	15.	ACO describes steps it is taking to advance or invest in the population health of one or more communities where it has at least 100 enrollees through a collaborative, integrative, multi-organization approach that acknowledges and accounts for the social determinants of health .	- Written description of plan to advance population health, along with identification of potential community partners.		

Market and Patient Protection

Domain		Criterion	Documentation Requirements	Provider Comments
Risk-bearing provider organizations (RBPO)	16.	If applicable, the ACO obtains a risk-based provider organization (RBPO) certificate or waiver from DOI.	- Attestation	
Material Change Notices (MCNs) filing attestation	17.	ACO attests to filing all relevant material change notices (MCNs) with HPC.	- Attestation	
Anti-trust laws	18.	ACO attests to compliance with all federal and state antitrust laws and regulations .	- Attestation	
Patient Protection	19.	ACO attests to compliance with HPC's Office of Patient Protection (OPP) guidance regarding a process to review and address patient grievances and provide notice to patients.	- Description of patient appeals process and sample notice to patients.	
Quality and financial performance reporting	20.	ACO will report ACO-level performance on a quality measure set associated with each contract and shared savings / losses for any commercial and public risk contracts for the previous contract year (2015).	- Plan-specific reports of ACO performance on contract-associated quality measures and overall financial shared savings or losses for calendar year 2015.	

Consumer Price Transparency	21.	ACO attests that it has taken steps to ensure that providers participating in the ACO have the ability to provide patients with relevant price information and are complying with consumer price transparency requirements pursuant to M.G.L. c. 111, § 228(a)-(b).	- Attestation		
Reporting Only Criteria					
Domain		Criterion	Documentation Requirements	Questions for Public Comment	Provider Comments
Palliative care	22.	The ACO provides palliative care and end-of-life planning , including: <ul style="list-style-type: none"> – integrated and coordinated care across network, especially with hospice providers; – training of providers to engage patients in conversations around palliative care to identify patient needs and preferences; and – EHR indication of such decisions 	<ul style="list-style-type: none"> - Written description of how ACO coordinates with and assesses appropriateness of hospice and end-of-life (EOL) planning programs/materials. - Examples of training programs. 		
Care coordination	23.	The ACO has a process to track tests and referrals across specialty and facility-based care both within and outside of the ACO .	<ul style="list-style-type: none"> - ACO policies and procedures or comparable documents describing protocols for tracking tests and referrals as described in the criterion. 		
	24.	The ACO demonstrates a process for identifying preferred providers , with specific emphasis to increase use of providers in the patient’s community, as appropriate, specifically for: <ul style="list-style-type: none"> – oncology – orthopedics – pediatrics – obstetrics 	<ul style="list-style-type: none"> - Written description of ACO’s process for identifying preferred providers, including relevant quality and financial analyses. - Documentation of provider communication related to encouraging use of identified providers 		
	25.	The ACO has a process for regular review of patient medication lists for reconciliation and optimization in partnership with patients’ PCPs.	<ul style="list-style-type: none"> - ACO policies and procedures or comparable documentation for medication reconciliation 		

			and optimization, including how ACO works with individual providers.		
	26.	The ACO assesses current capacity to, and develops and implements a plan of improvement for: – sending and receiving real-time event notifications (admissions, discharges, transfers); – utilizing decision support rules to help direct notifications to the right person in the ACO at the right time (i.e., prioritized based on urgency); and – setting up protocols to determine how event notifications should lead to changes in clinical interventions	- Written description of current system(s) for direct messaging, sharing of clinical summary documents and lab orders/results, e-prescribing, and other exchange of clinical information between ACO providers, including ability to securely exchange clinical information between providers with different EHRs or no EHR, and by care setting; and capabilities for sharing within and outside ACO.		
Peer support	27.	The ACO provides patients and family members access to peer support programs , particularly to assist patients with chronic conditions, complex care needs, and behavioral health needs. The ACO also provides training to peers as needed to support them in performing their role effectively.	- Written description of how the ACO provides peers or links patients and families to existing community-based peer support programs. - ACO training materials or plans to provide training as needed.		
Adherence to evidence-based guidelines	28.	The ACO monitors adherence to evidence-based guidelines and identifies areas where improved adherence is recommended or required. The ACO develops initiatives to support improvements in rates of adherence.	- Written description of methods and/or processes used by the ACO to monitor use of evidence-based guidelines, including: - Specific conditions and methodologies for assessing variation between ACO providers - How the ACO selects		

			<p>areas for improvement in variation if found</p> <ul style="list-style-type: none"> - Written description of initiatives or plans for initiatives to improve adherence rates. 		
<p>APM adoption for primary care</p>	<p>29.</p>	<p>The ACO reports the percentage of its primary care revenue or patients that are covered under budget-based contracts.*</p> <p><i>*Budget-based contracts are those that require a provider to accept a population-based contract centered on either a spending target (shared savings only) or a global budget (including down-side risk).</i></p>	<ul style="list-style-type: none"> - Report or statement providing percentage, including data, assumptions, methods, and calculations. - Percentage reported for commercial, Medicare and Medicaid separately and in aggregate. - Description of barriers faced in accepting higher volume of risk-based contracts. 	<p>Are there data collection or other challenges ACOs would face in reporting on this information? Are there other methods of assessing uptake of budget-based contracts that HPC should consider?</p>	
<p>Flow of payment to providers</p>	<p>30.</p>	<p>The ACO distributes funds among participating providers using a methodology and process that are transparent to all participating providers. Documentation must include both a description of the methodology and a demonstration of communication to all participating providers.</p>	<ul style="list-style-type: none"> - ACO participation agreements with providers describing how participating providers are compensated, highlighting if and how the method includes consideration of quality, cost, and patient satisfaction metrics. - Written description or example communication of how the ACO does or does not currently make funds flow methods transparent to all participating providers. 		
<p>ACO population demographic s and</p>	<p>31.</p>	<p>The ACO assesses the needs and preferences of its patient population with regard to race, ethnicity, gender identity, sexual preference, language, culture, literacy, social needs (food, transportation,</p>	<ul style="list-style-type: none"> - Description of how the ACO assesses its patient population characteristics. - Description of any 		

preferences		<p>housing, etc.) and other characteristics and develops plan(s) to meet those needs. This includes provision of interpretation/translation services and materials printed in languages representing the patient population (5% rule).</p>	<p>training or materials used to train practitioners and staff on meeting these needs.</p> <p>- Description of method for identifying gaps in need and capacity, including plans for addressing such gaps.</p>		
EHR inter operability commitment	32.	<p>ACO identifies Meaningful Use-certified electronic health record (EHR) adoption and integration rates within the ACO by provider type/geographic region; and develops and implements a plan to increase adoption and integration rates of certified EHRs.</p>	<p>- ACO operational plans for assessing EHR adoption status by provider type (e.g. primary care, behavioral health, and specialty providers) and implementing improvement plans, including timelines</p>		
	33.	<p>ACO identifies current connection rates to the Mass HIway and has a plan to improve rates over next year.</p>	<p>- ACO operational plans for assessing connectivity to Mass HIway and implementing improvement plans, including timelines.</p>	<p>What challenges would need to be overcome in order for ACOs to connect to and effectively use the HIway?</p>	