



January 28, 2016

Catherine Harrison, Senior Manager Care Delivery
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

re: Proposed Accountable Care Organization (ACO) Certification Standards

Dear Ms. Harrison:

On behalf of the Massachusetts Association of Health Plans (MAHP), which represents 17 health plans that provide coverage to more than 2.6 million Massachusetts residents, we are writing to offer comments regarding the Health Policy Commission's proposed Accountable Care Organization (ACO) Certification Standards. We appreciate the complexities involved in developing these criteria and commend the Commission for the comprehensive and balanced approach you have taken, as well as your inclusiveness in seeking feedback from stakeholders in your efforts to develop certification standards.

The requirements outlined in the HPC's ACO Certification Standards are an important roadmap for providers to follow in implementing new models of care delivery. These standards are intended to provide the HPC with detailed information about the capabilities of providers and provider organizations to deliver integrated care while containing costs and improving the quality of care for patients. A robust certification process will enable the Commission to review essential details about the proposed ACO's provider relationships, data-sharing and analytic capacity, and accountability for quality outcomes and costs.

It is paramount that the established criteria for ACO certification ensure that ACOs actually lead to lower health care costs for the state, employers, and consumers and provide better quality of care and outcomes for patients. Equally important is ensuring that ACOs are financially able to take on risk and that they meet important consumer protection standards. Failure to properly understand and guard against financial exposure for providers taking risk could be catastrophic to the Massachusetts marketplace and lead to bankruptcies and instability within the provider system as seen in California in the late 1990s.

At that time, the state of California saw rapid consolidation and transfer of risk without the appropriate safeguards which resulted in disaster for patients and providers. While the goal of the California model was for provider-sponsored organizations (PSOs) and physician-hospital organizations (PHOs) to take on greater degrees of financial risk for managing the health care of a defined population, many PSOs and PHOs failed to develop the necessary capacity in

information technology, actuarial risk, utilization management, administration, and management leadership to accommodate this growth. The organizations were ultimately unable to improve quality and efficiency, and 147 closed or went bankrupt between 1998 and 2002, disrupting over one million consumers' care. It is important that the certification process encourages care delivery transformation that is both sustainable and includes vital protections for consumers in Massachusetts.

MAHP believes that to the extent that an ACO takes substantial upside and downside risk, and restricts patients to a set of providers in a network, that entity is functioning as a Health Maintenance Organization (HMO) and should be licensed accordingly by the Division of Insurance under 176G. Any organization with HMO functions must be fully compliant with all statutory obligations necessary to ensure solvency standards and consumer protections. Entities taking on mostly upside risk, with open networks, could be determined to be functioning as ACOs and would be required to meet ACO certification standards. It is essential that the HPC, Division of Insurance, and the Baker Administration set out clear parameters for when HMO licensure or ACO certification is appropriate. Our comments focus on what we think the appropriate standards should be for entities acting as ACOs and taking on lower levels of risk, but whose activities still require state oversight to be fulfilled through ACO certification by the HPC. Having a strong mechanism in place to assess an ACO's ability to improve patient outcomes and quality of care while slowing cost growth is essential to safeguard against failed system reform.

The HPC's ACO certification process, while voluntary, will be the foundation for evaluating ACOs in the commercial market as well as other segments of the Massachusetts market. Already, MassHealth has indicated that its envisioned redesign will include a certification process for Medicaid ACOs that includes the HPC's standards with specialized additional standards for the MassHealth population. Accordingly, while we are supportive of the HPC's proposed certification standards, we recommend strengthening several areas to ensure that ACOs certified by the HPC are well-equipped to meet the goals of care transformation. Our specific comments are outlined below.

Mandatory Criteria

The Commission's mandatory criteria provide a strong foundation for assessing an ACO's ability to provide coordinated care for its patients. Given the weight of these criteria, we recommend the HPC be more prescriptive regarding the role of and relationships among participating providers, minimum panel size, and the ACOs financial arrangements.

Legal and Governance Structure

We are supportive of the requirements the HPC has outlined for ACOs, including that the ACO operate as a separate legal entity, provide information about its participating providers to the HPC, and that the governance structure provides for meaningful participation across provider types, including primary care, addiction, mental health, and specialist providers. These requirements provide necessary transparency and are vital to understanding the types of providers within the ACO, their relationships, and their ability to report on cost and quality to the ACO governance board.

We recommend several additional requirements in this area to increase transparency and protect against market consolidation and driving care to higher priced settings:

- ACOs should be required to provide information on all participating providers and this information should be transparent and available to consumers. The provider directories must be up-to-date, accurate, and complete, and should contain a list of participating providers in the ACO, organized by specialty, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any additional affiliations. Directories should be updated monthly and available electronically.
- ACOs should be led by physician groups, rather than hospital systems, with a majority of physicians including primary care physicians and behavioral health providers as a part of the governance board structure. Alternatively, if the HPC determines that ACOs can be hospital-led, the ACO should be required to provide detailed information on access to care outside of the hospital setting, including how the ACO will direct care to lower rather than higher cost settings, and how they will be held accountable for this measurement.
- ACOs should be required to operate as a separate legal entity, even where all participants are part of the same health system, as required in Section 15 of Chapter 224 of the Acts of 2012.

Empirical evidence has shown that provider consolidations lead to higher prices and provider mergers and acquisitions have the potential to increase prices for Massachusetts employers and consumers. By requiring ACOs to operate as a separate legal entity with physicians, rather than large hospital systems directing care, the HPC will help protect against consolidation that reduces access to lower-cost options for consumers.

Participation in MassHealth APMs

The requirement that the ACO participate in a budget-based contract for Medicaid populations by the end of Certification Year 2 should be removed. Commercial, Medicaid, and Medicare populations have different needs and not all providers have expertise with each population. If the goal is to reduce costs while coordinating care, the participation requirement should be for APM contracts, not participation in MassHealth. Changes in care delivery cannot occur when the reimbursement methodology remains based on fee-for-service. To meet the goals outlined in the HPC's proposed certification standards and to incentivize delivering value-based care, we recommend instead:

- ACOs should be required to increase its percentage of contracts in APMs by a percent certain by the end of Certification Year 2.

Panel Size

The Commission's standards closely mirror many important requirements contained in the Centers for Medicare and Medicaid (CMS) requirements for MSSP, Pioneer and Next Generation ACOs. However, the HPC is silent on the minimum number of patients required for an ACO to be certified. This is a vital piece of the CMS criteria for ACOs, ensuring the ACO's

population is sufficient to measure performance for quality and financial reporting measures, and that the ACO is able to identify and stratify its patient population by conditions, cost, utilization, and social determinants of health. As providers take on performance and financial risk, the HPC should establish a minimum panel size to ensure a sufficient population for the ACO seeking certification. We recommend:

- An ACO taking on upside-only, or shared savings risk should have a minimum patient panel of 5,000, in alignment with the CMS MSSP.
- An ACO taking on both upside and downside risk should have a minimum patient panel of 10,000, in alignment with the CMS Next Generation ACO model.
- If the number of number of patients drops below the mandated amount, the ACO should be required to submit a corrective action plan to the HPC for increasing patient numbers.

Total Cost of Care

The Commission's standards include important requirements regarding quality and financial reporting, care coordination, and funds flow; however, the standards do not provide detail on what services the ACO should be accountable for. In order for the HPC to determine whether an ACO is meaningfully bending the cost curve, the ACO should be accountable for its patients total cost of care, and should annually report on its health care spending. We recommend:

- ACOs should be accountable for patients' total cost of care, including medical, behavioral health, specialty care, and prescription drug costs.
- ACOs should be subject to ongoing reporting requirements on health care spending, including Total Medical Expenses (TME) at the individual patient level and at the ACO level.

External Monitoring

While the Commission's standards include requirements around quality and financial reporting, they do not include external review and oversight of the ACO. We recommend the regulations include a more formal process to monitor ACOs once they are certified in order to ensure satisfactory levels of performance regarding patient access protections, beneficiary due process, customer service levels, consistency of practice with policies and procedures, and accuracy and completeness of member information communications. These external accountability processes will be an important element in maintaining stakeholder confidence in the ACOs as they function over time and should be designed concurrently with the certification criteria.

Market and Patient Protections

The Commission's outlined market and patient protections are important requirements that will help ensure certified ACOs are financially solvent, comply with all appropriate patient protections, and are truly delivering on the promise of providing coordinated care at lower costs. We are supportive of each of the outlined requirements, and would recommend the following additional requirements:

Risk-bearing Provider Organizations

The requirement that an ACO obtain an RBPO certificate or waiver from the Division of Insurance is an important requirement, but alone it is not sufficient to provide necessary ongoing monitoring of ACOs. As these new models of care delivery are certified and begin providing care for patients, we recommend the following ongoing review requirements:

- The Division of Insurance has the responsibility to license and monitor entities taking on the functions of Health Maintenance Organizations under M.G.L. c. 176G. The Commission should work with the Division of Insurance to ensure the ACOs viability through ongoing reporting requirements, assessment of financial solvency and levels of risk, including establishing reserves requirements for ACOs taking on financial risk, and monitoring of the number of patients attributed to an ACO.
- Ongoing reporting requirements established jointly by the Commission and the Division of Insurance should assess ACOs on a quarterly basis to prevent any failing ACO from having a detrimental impact on the market.
- In the absence of a robust monitoring process, the HPC should re-certify ACOs annually during the first two years of certification.

Patient Protection

Consumers of the Commonwealth are guaranteed a number of protections through relevant insurance statutes, notably M.G.L. c.176O, or regulations, notably 211 CMR 52.00. The HPC should carefully consider how these protections will be preserved for consumers participating in ACOs. A robust patient appeals process is crucial to any care delivery system. We support the requirement that the ACO attests to compliance with the HPC's Office of Patient Protection guidance regarding review of patient grievances, and would recommend:

- The grievance and appeals process be robust, provide strong due process to members, and be transparent and easily accessible to members.
- The ACO grievance and appeals process distinguishes between clinical appeals and coverage appeals to avoid duplication of health plan and ACO functions, and to avoid consumer confusion.

Quality and Financial Performance Reporting

We are supportive of the requirement that ACOs report ACO-level performance on a set quality measure set associated with each of its contracts, as well as shared savings or losses for any commercial and public risk contracts for the previous year. These reporting requirements are crucial to understanding an ACO's ability to deliver on its goals, particularly when the ACO is responsible for the total cost of care including medical, behavioral health, and pharmacy spend. We would recommend the following additional reporting requirements for quality and financial performance:

- An ACO must have the ability to accept, compile, and report data to payers and providers in a manner sufficient to demonstrate the ACO's ability to meet performance standards for quality measures.

- An ACO should be required to report on its ability to meet the cost benchmark, improve the quality of care, and meet policy goals outlined by the HPC in any given year. This reporting should be transparent and be made publically available.
- An ACO should be required to report utilization data, and demonstrate that it has the ability to measure utilization to evaluate whether care is at the appropriate levels among its component providers, and to evaluate the appropriateness of utilization against relevant benchmarks.

Reporting Only Criteria

Many of the Commission's reporting only criteria are crucial to assessing the capabilities of an ACO, particularly those around care coordination, adherence to evidence-based guidelines, and electronic health records adoption and interoperability. We suggest that the following criteria are considered mandatory, rather than reporting only, and that the HPC assess the ACO's responses in these areas.

Care Coordination

An ACO's ability to coordinate care, including having a process to track tests and referrals, identify preferred providers, review patient medication lists, and support interoperable electronic health records, is vital. If the goal of an ACO is to provide coordinated care at lower costs, demonstrating the capability to coordinate that care should be a mandatory requirement. We would further recommend:

- ACOs should be accountable for care across the entire continuum of services, but should not be required to provide those services. Rather, the services may be arranged through referral contracts between the ACO and outside providers or through the health plan. A requirement for ACOs to provide an expansive array of services will incentivize the formation of, or consolidation into, large provider institutions rather than array of diverse provider organizations based on primary care.
- Primary care should be the center of care coordination. We believe that physicians rather than hospital systems are best equipped to coordinate care. The current composition of ACOs in the marketplace are predominantly hospital led; we have concerns that encouraging hospital-led ACOs could lead to further consolidation, increased market power, and higher health care costs.

Adherence to Evidence-Based Guidelines

ACOs should be required to attest to following evidence-based medicine. This important patient protection will help ensure patients are receiving appropriate, medically necessary care. In order to meet the attestation requirement, we recommend:

- To ensure transparency, ACOs should be required to publish their evidence-based medicine / medical necessity criteria and protocols which are not licensed or proprietary on a publicly accessible website easily accessible to the general public.
- ACOs should be required to provide a written description as to how the ACO practices evidence-based medicine and adheres to such guidelines in providing care for its members.

EHR Adoption and Connection to MassHIway

Interoperable electronic health records are necessary for an ACO to support care coordination. All providers in an ACO should have access to electronic health records in order to securely transmit patient data. For many ACOs currently in the marketplace, a lack of interoperability among their health information technology systems is the number one challenge they face. We recommend that ACOs be required to attest that the ACO has a system for electronic health records in place, that all providers and systems within the ACO have connectivity to the MassHIway, and provide a written description of how electronic records can be accessed by both patients and providers.

We appreciate the opportunity to provide comments on the certification standards and look forward to continued conversations with you and your staff as the Commission works towards launching the ACO Certification process. If you have any questions or require any additional information, please do not hesitate to contact me at 617-338-2244.

Sincerely,



Lora Pellegrini
President & CEO

cc: Stuart Altman, Ph.D., Chairman, Health Policy Commission
Wendy Everett, Sc.D., President of NEHI, Vice Chair, Health Policy Commission
Kristen Lepore, Secretary, Executive Office for Administration and Finance
Marylou Sudders, M.S.W., Secretary, Executive Office of Health and Human Services
Carole Allen, M.D.
Don Berwick, MD, MPP, President Emeritus and Senior Fellow, Institute for Healthcare Improvement
Martin Cohen, President and CEO of the MetroWest Health Foundation
David Cutler, Ph.D., Otto Eckstein Professor of Applied Economics, Department of Economics, Harvard University
Richard C. Lord, President & CEO, Associated Industries of Massachusetts
Veronica Turner, Executive Vice President, 1199SEIU
Ron Mastrogiovanni, President & CEO, HealthView Services
David Seltz, Executive Director, Health Policy Commission
Daniel Tsai, Assistant Secretary for MassHealth and Medicaid Director, Commonwealth of Massachusetts
Dan Judson, Commissioner, Division of Insurance