

February 29, 2016

Dear members of the Massachusetts Health Policy Commission,

Thank you for the opportunity to respond to the proposed ACO certification standards. New England Quality Care Alliance (NEQCA) is a network of over 1,700 community physicians based throughout Eastern Massachusetts, and affiliated with Tufts Medical Center. NEQCA is wholly committed to the quadruple aim of better care, better patient experience, lower cost and professional satisfaction. As of January 1, 2015, NEQCA providers launched their Medicare Shared Savings Program (MSSP) ACO which now, in its second year, serves over 23,000 Medicare beneficiaries. We believe the MSSP ACO will improve care for our patients, will better prepare us for value based contracts and will ultimately help transform our healthcare delivery system for the better.

According to the Request for Public Comment document, the purpose of the ACO certification program is to:

- Complement existing local and national care transformation and payment reforms
- Validate value-based care
- Promote investments by all payers in efficient, high quality, and cost effective care across the continuum

Further, the document states that the certification is meant to:

- Complement, not replace, requirements and activities of other state agencies by evaluating core competencies for ACOs
- And will not address the financial solvency of an ACO or its sustainability to operate as a risk-bearing organization.

Our overall comment about the proposed criteria is that certification of ACOs should be made general enough to allow ACOs to govern themselves and develop processes and clinical coordination strategies to meet the unique needs of their assigned populations.

We also are in favor of criteria which align as much as possible with existing ACO programs, i.e., the Medicare Shared Savings and Pioneer ACO models. To do otherwise would only create added administrative burden and complexity to the healthcare system and would be at odds with the efficiency goal of accountable care.

Having just completed the first of three years in the MSSP, we are well aware of the requirements, restrictions and drawbacks of the Medicare ACO model. NEQCA therefore provides its responses to the proposed ACO certification criteria from the point of view of what we have learned in terms of

what works, what is reasonable to expect from an ACO, and what will take more time to develop for an ACO. We believe that the ACO certification criteria should align with the Medicare models but be no more restrictive than, and in some cases less restrictive than, those ACO models.

We are in agreement that the certification of ACOs by the Health Policy Commission should not address the financial solvency of an ACO or its sustainability as a risk-bearing organization, and that this might be the purview of another agency, much further down the road, when the ACO model is further developed as a sustainable cost-effective payment method.

As you may know, most of the current Track 1 MSSP ACOs would not be solvent if they were at risk for losses today. ACOs represent just the beginning of the sea change that will need to occur in order to be truly patient-centered and coordinated across the care continuum. Achieving savings can be difficult in this model especially for provider-only ACOs. ACOs require infrastructure investments. Many simply lack the resources and infrastructure necessary to identify and manage the chronically ill patients, to effectively analyze the data in order to track performance and inform clinical strategies to meet the particular needs of the population, to successfully implement and report on the quality measures, to document risk and to manage the participants, providing the necessary communications and trainings. ACOs that manage to earn savings must first cover their operating costs, and this often leaves less for the providers to reinvest in better care coordination efforts at the practice level.

NEQCA's responses to the proposed criteria also reflect our knowledge of the costs and time required to become a successful ACO. Transforming the health care system will not be done overnight and will evolve over time. NEQCA remains committed to this long term vision which puts the patient/primary care physician relationship at the center of the system.

We respectfully submit our comments and are grateful for the efforts of the Commission on behalf of the Commonwealth of Massachusetts.

Sincerely,



Jeffrey Lasker, MD, MMM, FAAP, President & CEO
New England Quality Care Alliance

Mandatory Criteria

Domain	#	Criterion	Documentation Requirements	Questions for Public Comment	Provider 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.		NEQCA agrees with the ACO operating as a separate legal entity. However, this legal entity should be able to participate as an ACO for Medicare, Medicaid and commercial contracts; it should NOT have to create separate legal entities to contract with each of these payers.
	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?	NEQCA agrees with providing a list of participant TINs. But, providing a narrative of why participating providers may differ by payer is overly prescriptive.
	3.	The ACO governance structure includes a patient or consumer representative . The ACO has a process for ensuring patient representative(s) can meaningfully participate in the ACO governance structure.	- Written description of where/how the patient or consumer representative role appears within the governance structure, and how an individual is identified or selected to serve. - 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	Describe and give examples of meaningful participation. What evidence should the HPC seek to assess meaningful participation?	NEQCA agrees with the criteria of including a patient or consumer representative. But, providing a written description of specific strategies used to ensure this member’s participation is overly prescriptive.

			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.		
	4.	The ACO governance structure provides for meaningful participation of primary care, addiction, mental health (including outpatient), and specialist providers.	<ul style="list-style-type: none"> - Written description of official governance structure including the board and committees with members' names, professional degrees (e.g., MD, RN, LCSW, LMHC), titles, and organizations. - 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. 	What evidence should the HPC seek to evaluate meaningful participation?	<p>NEQCA agrees with providing a description of the governing body and names, titles and degrees and types of providers.</p> <p>But, requiring that certain types of providers be represented on the Board is overly prescriptive and does not align with Medicare ACO requirements.</p>
	5.	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.	<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 meeting. <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</p>		<p>Requiring a patient and family advisory council would be overly prescriptive and does not align with the Medicare ACO models. This is not required in the current MSSP ACO regulations and would add additional administrative burden and costs to the ACO.</p>

			ACO serves.		
	6.	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.).	<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>NEQCA is in agreement with having a quality committee for the ACO.</p> <p>But, requiring minutes is overly prescriptive and does not align with Medicare ACO requirements.</p>
Risk stratification and population specific interventions	7.	<p>The ACO has approaches for risk stratification of its 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 	<ul style="list-style-type: none"> - Written description of the risk stratification methodology(ies), including data types and sources, time of data, frequency of updating and criteria used. - 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>NEQCA finds that this criteria, including the two written descriptions, are overly prescriptive and do not align with the Medicare models.</p> <p>Clearly, ACOs have an incentive to stratify their populations but most ACOs are not equipped to do this from the start and would need to learn from their specific population’s health status data as to the best way to stratify risk.</p> <p>Collecting social determinants of health is an ideal that many ACOs are grappling with, much less analyze and project need. This is still a long way off in terms of being able to document methodologies.</p>

	8.	<p>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>	<p>- Written description of qualifying programs, including how participating patients are identified or selected, what the intervention is, the targets/performance metrics by which the ACO will monitor/assess the program, and how many patients the ACO projects to reach with each program.</p> <p>Note: To qualify, a program must address a documented need for the ACO patient population; must have clear measures/outcomes-based approach; and must include/reflect community resources and partnerships as appropriate. A program of any size may fulfill this criterion.</p>	Should the HPC be more prescriptive with this requirement (i.e., require more than one program)?	This criteria is overly prescriptive. ACOs need allowance to study and analyze their own populations' needs without being required to offer specific programs that may not be as needed as others.
Cross continuum network: access to BH & LTSS providers	9.	<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 collaborations, such as: <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) 	What evidence should the HPC seek to evaluate whether ACOs assess the effectiveness of the collaborations?	<p>NEQCA finds this criteria particularly unreasonable and overly prescriptive.</p> <p>Collaboration with the facilities and organizations across the health care delivery spectrum is certainly the goal of any ACO.</p> <p>Achieving that collaboration is a very long term process. Most ACOs would be nowhere near able to provide narratives about how they are collaborating.</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: <ul style="list-style-type: none"> - Access - Appropriate breadth of services - Follow-up and reporting - Communication and/or data-exchange 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.		This criteria is overly prescriptive.
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?	NEQCA finds this criteria overly prescriptive. An ACO should not be required now to participate in a future risk-based contract by a certain time with no knowledge of the contract specifics.

<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. The ACO describes its plan to increase these rates, particularly for assisting practices in fulfilling HPC's PCMH PRIME Criteria.</p>	<ul style="list-style-type: none"> - Statement (or other documentation) outlining current PCMH recognition rates. - Narrative explaining plan for increasing rates, including HPC PCMH PRIME certification application/achievement. 	<p>How should the HPC best align its PCMH PRIME certification and ACO certification programs?</p>	<p>NEQCA is not opposed to providing a statement about current NCQA PCMH recognition rates.</p> <p>NCQA PCMH goals should align with ACO goals. There should not be a second PCMH recognition program (PRIME).</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 providers within the ACO to meet goals and targets. Analysis could be completed by a vendor or in-house. 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>	<ul style="list-style-type: none"> - Blinded sample cost, utilization, and quality report(s). - Written description or screenshot of how practice-level reports are made transparent and disseminated to providers/practices. - 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>Is this a feasible requirement for smaller ACOs?</p>	<p>This is an overly prescriptive criteria. The ACO can decide how best to communicate and effect change amongst its providers.</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 improve on those results.</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 those areas. 		<p>NEQCA agrees with the criteria of providing methods used to assess patient and family satisfaction/experience.</p> <p>However, it is overly prescriptive to request a</p>

					description of how the ACO identifies areas for improvement and action plans.
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.		This is an overly prescriptive criteria. Most ACOs are not mature enough to have a multi-organization collaborative effort put into place that accounts for social determinants of health. This would take a long time to develop.

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	This is overly prescriptive and would only apply to commercial contracts.
Material Change Notices (MCNs) filing attestation	17.	ACO attests to filing all relevant material change notices (MCNs) with HPC.	- Attestation	This is overly prescriptive and is more relevant to individual payer-ACO contract requirements.
Anti-trust laws	18.	ACO attests to compliance with all federal and state antitrust laws and regulations .	- Attestation	Agreed.
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.	This criteria should apply to payer-based ACOs only, and not to provider-only ACOs.
Quality and financial performance	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	- Plan-specific reports of ACO performance on contract-associated	Agreed. This aligns with Medicare models.

reporting		risk contracts for the previous contract year (2015).	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	This should not apply to provider-only ACOs.

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. 		<p>NEQCA finds this to be an overly prescriptive criteria.</p> <p>ACOs should be able to decide which organizations they will coordinate with and would likely include palliative care and end-of-life planning strategies but this should not have to be reported on in detail to the HPC.</p>
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. 		<p>NEQCA finds this to be an overly prescriptive criteria and does not align with Medicare models.</p> <p>Again, this may be an ideal best practice but not all ACOs are mature enough to have the ability</p>

					to track referrals and should decide for themselves when and which strategies to put into place.
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: – oncology – orthopedics – pediatrics – obstetrics	- 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			NECA finds this to be an overly prescriptive criteria. ACOs should be given leeway to decide whether or not they want specific preferred providers or not, and should not have to report this to the HPC.
25.	The ACO has a process for regular review of patient medication lists for reconciliation and optimization in partnership with patients’ PCPs.	- ACO policies and procedures or comparable documentation for medication reconciliation and optimization, including how ACO works with individual providers.			NECA finds this to be an overly prescriptive criteria. This would be better aligned with Medicare models if left as part of the quality measures reporting.
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			NECQA finds this to be an overly prescriptive criteria. This is an ideal ACOs hope to achieve but takes a lot of technology and time to develop. ACOs should be allowed to develop this capability

			capabilities for sharing within and outside ACO.		when and how they see fit and should not be required to report on this to the HPC.
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.	<ul style="list-style-type: none"> - 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. 		NEQCA finds this to be an overly prescriptive criteria. ACOs should be free to develop materials and training program most aligned with the needs of their populations as they see fit.
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.	<ul style="list-style-type: none"> - 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 areas for improvement in variation if found - Written description of initiatives or plans for initiatives to improve adherence rates. 		This is an overly prescriptive criteria. This would be more appropriate as part of individual contracts.
APM adoption for primary care	29.	The ACO reports the percentage of its primary care revenue or patients that are covered under budget-based contracts. *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).	<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. 	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?	
Flow of	30.	The ACO distributes funds among	- ACO participation agreements		NEQCA agrees with the

payment to providers		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.	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.		criteria for having transparency around funds flow methodology but that it should only be required to report at the highest level what the distribution would be. The ACO should not have to provide written details further than that nor should it have to report on how it communicates with participating providers.
ACO population demographics and preferences	31.	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, 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).	- Description of how the ACO assesses its patient population characteristics. - Description of any training or materials used to train practitioners and staff on meeting these needs. - Description of method for identifying gaps in need and capacity, including plans for addressing such gaps.		NEQCA finds this to be an overly prescriptive criteria. Merely collecting and documenting these statistics would be an overly burdensome task. ACOs should be left to decide how best to understand the needs of its population.
EHR inter operability commitment	32.	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.	- 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		NEQCA has no issue with documenting E.H.R. adoption among participating providers and this aligns with one of the requirements of the Medicare ACO models.
	33.	ACO identifies current connection rates to the Mass HIway and has a plan to improve rates over next year.	- ACO operational plans for assessing connectivity to Mass HIway and implementing	What challenges would need to be overcome in order for	This is an overly prescriptive criteria given that the Mass HIway is

			improvement plans, including timelines.	ACOs to connect to and effectively use the HIway?	still in development and somewhat unproven in terms of its effectiveness.
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