PARTNERS HEALTHCARE | FOUNDED BY BRIGHAM AND WOMEN'S HOSPITAL AND MASSACHUSETTS GENERAL HOSPITAL

January 29, 2016

Ms. Catherine Harrison
Commonwealth of Massachusetts Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109
Sent via US Mail and via email to: HPC-Certification@state.ma.us

RE: Proposed Accountable Care Organization (ACO) Certification Standards – Request for Public Comment

Dear Ms. Harrison,

We appreciate the opportunity to respond to the request for public comment regarding the Accountable Care Organization (ACO) Certification Standards proposed by the Health Policy Commission (HPC). We have found the process transparent, with ample opportunity to provide feedback. This memo outlines our responses to the specific questions for providers, as well as feedback on the various domains proposed by the HPC. Our responses are included below in italics:

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?
    - *The criteria are comprehensive. In general, we would encourage the HPC to leverage other processes already in place for contractual, regulatory and/or certification requirements (e.g. the Risk Bearing Provider Organization certification process).*

2.) Are the proposed criteria appropriately assigned to either the mandatory or reporting only category?
    - *In general the criteria appear to be appropriately assigned as mandatory or reporting only. If criteria will be converted to specific targets, we would request sufficient notification with opportunity to comment on target setting methodologies.*

3.) What is the operational and financial feasibility of implementation for these standards? Specifically, are these criteria feasible for ACOs of varying size, experience, resources, and other salient factors?
    - *We think that the requirements would be burdensome for all types of ACOs.*

4.) 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?

- *While our ACO would be able to leverage some existing documents and materials, the majority would require the development of new documents and agreements. To the extent possible, we would strongly suggest that HPC leverage existing documentation for other state or federal government submissions.*

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

- *Given the extensive documentation requirements, a two-year period for ACO certification seems reasonable. We would not endorse a more frequent certification process. Several regulatory bodies will extend the interval in cases where a provider significantly exceeds standards. HPC should consider for high performing ACOs that they might recertify at an intervals greater than two years.*

6.) The HPC intends to develop a technical assistance program to support ACO transformation. This may include HPC's analysis of information collected through the certification process in aggregate, and the identification of best practices among ACOs. What are the best modes by which to share this information with the market? What other types of technical assistance would be most useful to ACOs?

- *Online information sharing would be most useful (e.g. availability via HPC website, etc). In addition to the document distribution, we would welcome technical calls to walk through methodologies and insights of any analytics conducted by HPC.*

7.) Do you favor the HPC making public the application materials submitted for ACO certification?

- *We are not in general support of making the application materials public. While some elements could be shared publicly (e.g. programmatic information), much of the information is proprietary and confidential.*

8.) What policies, if any, should the HPC adopt in its certification program to prevent negative impacts on competition?

- *We think that existing anti-trust and consumer protection laws are sufficient to protect competition in the market.*

In addition to our responses to the questions above, we would like to provide specific feedback on the domains under consideration for ACO Certification. We have overarching concerns that the criteria are both prescriptive and numerous. HPC should take the opportunity over the upcoming months to reduce overall administrative burden and pursue simplification of the overall criteria. HPC should also work on behalf of providers to collate existing information in advance of the certification process. As we will mention below, HPC has the opportunity to utilize existing public submissions such as the Risk Bearing Provider Organization submission to

the Department of Insurance, the submission to the Health Policy Commission for the Registration of Provider Organizations, the submissions for the Annual Cost Hearings, and documents submitted to credit agencies for annual bond financing.

Legal and Governance Structures. We find the proposed legal and governance structure requirements in this area to be too prescriptive. HPC should not require the ACO to operate as a separate legal entity. We recommend that ACOs not be required to create new legal structures when an ACO consists of entities that already have existing legal relationships.

Risk Stratification and Population-Specific Interventions. Overall, we believe that the measures within this section are consistent with the approaches we believe are necessary for successful population health management. We believe that providing evidence of these risk stratification processes are reasonable. Letting providers demonstrate their capabilities per their discretion without prescriptive requirements (e.g. meeting minutes) may prevent undue administrative burden while still achieving the HPC's goals.

Cross Continuum Network: Access to Behavioral Health and Long-Term Support Services (LTSS) Providers. Community collaborations are an essential component of any successful ACO. Given the breadth of our integrated network, we have significant access to hospitals, specialists, post-acute providers (including home care) and behavioral health providers (including adult day programs). Through our Partners Community Health division, we also have strong relationships with community and social service organizations. The proposed HPC requirement would mandate the reporting of ACOs' evaluation of the efficacy of these types of collaborations. This could prove challenging given the sheer number of providers with whom ACOs collaborate. We would suggest modifying these requirements such that assessments of specific providers or provider types (e.g. home care providers) could be completed over time, allowing for the development of processes to track the areas noted in HPC's proposed documentation requirements (access, breadth of services quality, cost and patient experience scores). We see little value, and significant administrative burden associated with this criteria. We would suggest removal of this standard. Measurement of outcomes with these provider types would be a better demonstration of effectiveness.

Participation in MassHealth APMs. We look forward to receiving more information about the proposed budget-based contract for Medicaid patients. Until such time it is difficult for us to further comment on this proposed requirement for ACO certification. The criteria should clarify if an ACO does not participate in such a contract by 2017, if it is forever precluded from being certified.

PCMH Adoption Rate. This proposed criterion might require further clarification. We noted that the HPC PCMH recognition appears to be a requirement for ACO certification, however, a secondary criterion asks the ACO to describe its plan for assisting practices in fulfilling HPC's PCMH PRIME Criteria.

Analytic Capacity. Providers will have varying analytical capabilities. Large provider systems would be able to meet this requirement, however flexibility should be considered for smaller and/or new ACOs. Payer reports (in addition to vendor or provider produced) may help smaller providers meet their obligations.

Patient and Family Experience. We support using an evidence based, nationally recognized assessment of patient and family experience.

Community Health. As ACOs mature, we believe they will need to address social determinants of health and develop community partnerships. Given the heterogeneity of populations and geographies, there will need to be a reasonable amount of flexibility for providers to determine what relationships are necessary and how they will forge these relationships.

Market and Patient Protection (Risk-Bearing Provider Organizations, Material Change Notices filing attestation, anti-trust laws, patient protection, quality and financial performance reporting, consumer price transparency). We are currently certified as a Risk-Bearing Provider Organization (RBPO) and file relevant Material Change Notices (MCNs). We have no concerns with the proposed attestation requirements in this area.

Palliative Care. We have a number of efforts underway regarding palliative care and planning for the end-of-life, including "Goals of Care Conversations". We could certainly provide a written description of how we coordinate with and assess the appropriateness of hospice and end-of life (EOL) planning programs/materials.

Care Coordination. We agree that care coordination requires test and referral tracking, a network of trusted high quality providers across specialties, information sharing across institutions and care settings, and the regular review of clinical information. Given its growing evidence base and adoption, HPC may want to consider specifically encouraging ACOs to adopt primary-care based high risk care management as a method of care coordination. In addition, we believe there is greater opportunity with the Mass HIWay (see answer below on EHR interoperability), and lack of participation by providers not participating in the ACO may impair the ability of ACO providers to meet the HPC's certification criteria in this domain. In addition, PCMH certification encompasses all of the criteria in this domain. We would encourage HPC to consider PCMH certification as evidence of meeting the care coordination domain measures, as they are currently articulated.

Peer Support. Given the relative heterogeneity in the data regarding the impact of various peer support models on health, HPC should provide flexibility in how and when providers implement these models.

Adherence to Evidence-Based Guidelines. Given the sheer number of conditions that providers manage, HPC may want to suggest that ACOs focus on a small set of key chronic conditions (e.g. CHF, COPD, Depression) that are relevant to the population that the ACO manages.

APM Adoption for Primary Care. We again suggest that HPC leverage available information. HPC also asks for a description of barriers faced in accepting higher volume of risk-based contracts. An ACO's comfort level with taking on additional risk may be a significant barrier here. Another barrier might be overall capacity of an ACO's population health management programs and the need for further investments in order to manage an expanded number of patients under risk contracts. For some providers, current data structures will have to be adapted or modified to break out primary care revenue, requiring significant work. We support the options to report either revenue or patients.

Flow of Payment to Providers. Our distribution methodology for the shared savings and shared losses associated with our internal performance framework and external budget based risk arrangements is transparent to all of our providers.

ACO Population Demographics and Preferences. There is potential overlap between this domain and the domain regarding community partnerships. HPC may have an opportunity to combine these domains into a single measure for ACO certification.

EHR Inter-Operability Commitment. Many ACOs reached full adoption of EHRs several years ago and therefore are no longer monitoring EHR use, as it is implied. If that proposed requirement is upheld then many ACOs will need to re-establish those types of monitoring processes, and such processes would need to be introduced to include other providers across the continuum (e.g. post-acute, behavioral health, etc). The Meaningful Use program appears ready to end and therefore we are not certain that the concept of a Meaningful Use-certified EHR will continue past the next year or two. We are eager to see use of the MA HIway increase. The concept of measuring its adoption can be considered in two ways: How many providers are connected to the HIway? And, how many transactions are sent over the HIway? It is easier to measure the former (number of providers registered with the HIway), and it seems reasonable to expect ACOs to develop a plan to on-board more providers. The growth of the MA HIway has been hindered by a number of issues:

- Not enough providers are registered
- Vendors have built the minimum clinical document standard (defined by regulators) to send over the HIway which is generally insufficient to convey health information to another provider caring for your patient. So while some clinical information can be sent, it is often not very useful to the recipient.
- The MA HIway requirement that each patient expressly consent to his/her information being sent via the HIway. Express consent to the mode of transmission is not required for other types of transmissions (e.g., transmission by fax) and obtaining these consents is challenging from an operational and a patient education standpoint.
- If some of these issues could be solved, more meaningful transactions could be sent for more patients, and then more providers would see the value in registering.

Thank you for the opportunity to provide feedback. Should you have any questions or concerns, please feel free to contact Dr. Sree Chaguturu at 617-278-1055 or via email at schaguturu@partners.org.

Sincerely,

Tim Ferris, MD
Senior Vice President for Population Health Management
Partners HealthCare

Sree Chaguturu, MD
Vice President for Population Health Management
Partners HealthCare