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January 29, 2016

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

RE: Southcoast Health System's response to HPC Accountable Care Organization Certification Standards

Dear Ms. Harrison:

Thank you for this opportunity to provide comment on the Commission's thirty-three Accountable Care Organization standards. Attached are Southcoast Health System's comments to that request.

The enclosed document describes five overarching comments, four of which were presented to the Health Policy Commission during provider testimony on January 6, 2016. Additionally, each of these five issues includes specific operating examples.

I hope the Health Policy Commission finds these comments informative and helpful. Please do not hesitate to contact me directly should there be any questions or a need for additional information. I can be reached by email at RoseM@southcoast.org or by phone at 508-973-2950.

Thank you again for this opportunity to provide feedback on this most important issue. We look forward to continuing our collaborative work with the Commission.

Sincerely,

A handwritten signature in black ink that reads "Melissa Rose". The signature is written in a cursive, flowing style.

Melissa Rose
Vice President of Revenue
Southcoast Health System

Attachments

Executive Summary

Thank you for the opportunity to provide comment on the Health Policy Commission's (HPC) proposed Accountable Care Organization Certification Standards.

The following five points are submitted by Southcoast Health to the HPC relative to the Commission's request for comments and critical concerns related to the Commission's proposed thirty-three ACO Certification standards. Southcoast's comments are not fully aligned with the eight questions asked by the Commission as we wanted to most accurately convey our thoughts on this most important issue.

Southcoast Health is concerned with several aspects of the overall breadth and depth of the proposed criteria, specifically:

- Southcoast has been in alternative payment method contracts with payers for over seven years, and many of the HPC criteria are already handled in those arrangements;
- In reviewing the proposed criteria, the burden of submitting all of the data would overwhelm any perceived marketing benefit from organizations seeking ACO certification;
- If the proposed criteria are mainly for the MassHealth ACO initiative, these standards should be incorporated into the Request for Proposal from MassHealth. Most commercial contracts already address many of the criteria listed;
- There are areas of opportunity where the HPC could provide assistance, but are not currently addressed in the proposed standards, such as: uniform reporting structures for patient data files from payers, standardized and timely time frames to deliver data to ACO organizations, and comprehensive claims files including behavioral-health associated claims;
- The format for submission of responses for ACO certification should take into consideration time and resources. For example, answers in Yes/No format could be completed on-line, with minimal need to submit narratives or additional documentation, unless a No answer requires a detail response.
- There are areas to modify the questions to better reflect the information and/or documentation sought. For example, instead of requesting detailed provider lists, an alternative question could be asked regarding whether we check to ensure that all of our participating providers are not on the Exclusion List produced by CMS.

Southcoast Health would be receptive to further engagement with the HPC to identify additional areas of redundant, inapplicable and/or conflicting data requests. This would align nicely with Governor Baker's current initiative to minimize redundancy and overly burdensome state regulation.

1. Conflicts with Medicare:

As much as possible, the Health Policy Commission ACO standards should avoid conflicts with the Medicare ACO model (MSSP, Pioneer or Next Generation) standards. Alignment with existing federal Medicare standards would be extremely helpful in the highly sensitive area of governance. To avoid conflicting standards, Medicare standard(s) should be adopted by the HPC, and included as state standards by default, in situations where the HPC fails to propose or address a Medicare standard.

Example: The Medicare *Conflict of Interest* standard mandates that the ACO governing body:

1. Requires each member of the ACO governing body to disclose relevant financial interests;
2. Provide a procedure to determine whether a conflict of interest exists and set forth a process to address any conflicts that arise;
3. Address remedial action for members of the governing body that fail to comply with the policy.

The HPC does not directly address the Medicare ACO *Conflict of Interests* rules enumerated above. In situations such as this, where the HPC has not proposed or addressed a standard required by Medicare, the Medicare standard would become the HPC standard by default.

2. Payer Information:

Unfortunately, billing forms and payment remittances vary significantly for both public and commercial payers. In any review of population health, obtaining a record of health services rendered to members is a significant challenge, not simply due to different billing conventions, but also the different administrative software needs to price, process and forward data for integration.

The HPC has a unique opportunity to help promote standardized claims information by requiring payers to conform to accepted informational disclosures, and to require payers and claims-processors to adjudicate and make available information at the earliest possible opportunity following claims submissions by providers.

Several of the Massachusetts departments and agencies tasked with monitoring and minimizing the rise of health expenditures require hospitals to comply with standard forms of data submission and disclosure. The success of population management will require a degree of data uniformity that is not currently available. The HPC is well-positioned to capture this unique opportunity to address population health by mandating standard reporting formats that would increase efficiencies while decreasing administrative costs.

For example, Southcoast Health currently has seven payers feeding data into an internal software system in order to control expenses, improve quality and data mine for projects. Each of these payers has their own specific data fields that may or may not correspond or comply with the data needed. If the HPC was to develop uniform data tables, it could significantly minimize the operational expenses for each ACO. The hospitals currently submit uniform data to the State, and it is now time to align the data sharing between all payers and providers into a uniformed approach.

3. Duplication:

The HPC ACO standards have been written independently of Medicare's ACO standards and may have overlooked the reality that many of the health care providers in the Commonwealth already possess several years of ACO experience. Therefore, it is important not to mandate avoidable duplication.

For example, Medicare ACO quality standards require a process to achieve quality improvements, taking into account the circumstances of individual enrollees and the infrastructure to enable the ACO to monitor, provide feedback and internal reporting, and evaluate its providers and suppliers to determine how care may be improved. HPC standard #6 proposes a quality committee to accomplish these goals, which is duplicative. An alternative to this approach would be for the HPC to mandate that the ACO "should have access to" rather than "create a new" infrastructure for quality management.

A further redundant circumstance would exist when Southcoast submits to the Department of Insurance, for the Risk Bearing Provider Organization application, detailed provider listings of providers in our network by tax identification number. This would be duplicative if also required by the Health Policy Commission. In addition, there is concern about how frequently various data elements would need to be reported. Provider updates are currently provided to payers on a monthly basis, and it would be redundant to do so for the HPC as well.

Additionally, Southcoast and its payers have existing initiatives on population management and risk stratification, which are included in our Alternative Payment Methodology contracts. The HPC mandatory submission requirement is not necessary and is duplicative of existing relationships. If the criteria were for MassHealth only, it should be included as part of the request for proposals (RFP).

4. Grandfathered Status:

As the comments in #1 and #3 above describe, the unnecessary duplication of already established services, and the avoidance of conflicts with Medicare, are critically important points. An additional opportunity to avoid this overlap is to certify ACO's that have already met the Medicare standards. Since Medicare and Medicaid are programs administered at the federal level by the same *Centers for Medicare and Medicaid Services*, the standards should be consistent, except in instances where the patient population differences between Medicare and Medicaid involve some small degree of variation.

For example, early intervention infrastructure and reporting standards are not addressed by Medicare, but may be addressed by MassHealth. The differences due to population health management may require limited specific variations in standards.

5. Physical and Mental Health:

The health care community has longed struggled to obtain access and delivery parity between physical and mental health. One reason for this differential is the payers' employment of "carve-out" companies to approve, limit, and administer the substance abuse and mental health components of most managed care contracts—completely independent of the payer administering physical health programs. Not only is behavioral care not coordinated with physical care, concern exists that many of these companies are being used to ration behavioral services and reduce costs.

Instead of providers reporting on ongoing collaborations and referrals, the HPC has the ability to enhance collaboration among providers by collecting data on various provider services that could be accessed by ACOs.