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David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th floor
Boston, MA 02108

Via Electronic Mail to HPC-Certification@state.ma.us

Dear Director Seltz:

Thank you for the opportunity to provide comments and recommendations regarding the Health Policy Commission's (HPC) proposed Accountable Care Organization (ACO) Certification Standards.

As you know, Steward Health Care System LLC (Steward) is New England's largest community-based accountable care organization, encompassing ten hospital campuses and over 2,700 physicians and specialists, as well as nurses, home health, behavioral health and allied services professionals. All of Steward's acute care hospitals are classified as Medicaid disproportionate share hospitals (DSH). Steward serves a critical role providing care to low-income and vulnerable populations in the communities where our patients live and work. Steward was among the first in the nation to participate in Medicare's Pioneer ACO program beginning in 2012, and we are proud to be among 21 ACOs in the nation – just one of two in Massachusetts – now participating in Medicare's Next Generation ACO program.

Nationally, Medicare has led the way to establish, develop and evolve its ACO program over time, and to account for different levels of provider capability and readiness in establishing standards for accountable care organizations. In just 4 years, Medicare has transitioned more than 180,000 providers into accountable care models serving more than 8.9 million Medicare beneficiaries. One of the fundamental keys to Medicare's success in widespread adoption of ACOs has been Medicare's continued ability to support innovation, as well as efforts to break down regulatory barriers that would otherwise impede ACO adoption or innovation.

We strongly urge the HPC to closely review the Centers for Medicare and Medicaid Services' (CMS) ACO regulations and consider mirroring CMS' innovative regulatory approach to ACO development. In that spirit, we respectfully request that the Health Policy Commission consider the following recommendations:

- A. Design standards with sufficient flexibility to enable ACO innovation.

- B. Do not require disclosure of nonpublic, proprietary and confidential information by applicants to meet certification standards.
- C. For criteria driven largely by Medicaid-specific ACOs, allow ACOs to phase in compliance as MassHealth rolls out its program requirements.

A. Design standards with sufficient flexibility to enable ACO innovation.

Introducing criteria for ACOs that are more restrictive than existing requirements on health plans, or that conflict with existing Medicare ACO requirements may create unintended barriers to ACO adoption or unnecessary costs in the Massachusetts' healthcare market. A parallel structure to these proposed certification standards with similar specificity does not exist for health insurers who coincidentally also aim to improve quality and care coordination for their members.

In general, allowing flexibility in how each ACO fulfills HPC's certification will foster innovation among ACOs. Overall, we are concerned that the breadth and depth of requirements, many of which are not necessarily evidence-based or applicable across all provider networks, will introduce substantial administrative and financial burden that will divert resources away from care coordination and patient care, limit investment in required infrastructure, and inhibit further evolution of accountable care models in the marketplace.

For example, Massachusetts' ACOs have existing and accepted governance structures to care for Medicare ACO patients and/or commercial patients under risk. The level of governance specificity proposed by the HPC (criteria #1-4) would require substantial reconstitution of existing governance boards. Further, they could require ACOs to create a new, parallel Medicaid ACO governance body separate and distinct from governance for Medicare and commercial patients. HPC should adopt governance requirements that mirror Medicare's payer-agnostic governance requirements.

The level of specificity proposed for risk stratification (criterion #7) is another example where the level of specificity proposed may create unintended market consequences. Risk stratification methodologies are population specific, and differ across Medicare, Medicaid, and commercial members. In addition, the minimum risk stratification methodology proposed (incorporating behavioral health, high cost, number and type of chronic conditions, and social determinants of health) may or may not correlate with actual risk. An ACO's risk stratification methodology is proprietary, just like a commercial insurer's risk stratification approach may be proprietary to that health plan.

In addition, ACOs should not be required to embrace the PCMH model in the absence of compelling evidence that such model improves care (criterion #12). Grounded in our experience, we believe that prospective, pre-capitated global payments to entities equipped to care for a patient's total health needs are the best means to create appropriate economic and clinical incentives for all providers, including primary care practitioners, to deliver high-quality, coordinated care.

A fundamental disconnect also exists between the criteria and funding mechanisms in place within alternative payment models, which are not yet robust enough to support required infrastructure, ongoing program costs, distributions to providers, and ancillary programs as proposed in the HPC's criteria; in this environment, providers cannot create programs simply to fulfill certification requirements without clear proof that such requirements will yield sustainable value to ACOs and ACO members.

B. Do not require disclosure of nonpublic, proprietary and confidential information by applicants to meet certification standards.

Several criteria request non-public, proprietary and confidential information to comply. For these criteria, we recommend modifying documentation requirements to submit attestations of compliance, instead of source documentation. In cases where the HPC determines a need for source documentation, we urge the HPC to maintain confidentiality of the submission by excluding confidential documents from public disclosure and ensuring exemption for these materials from any public disclosure requests. We also strongly discourage any plan to summarize source documentation or excerpt for public disclosure given its proprietary nature.

The following proposed requirements provide examples of documentation Steward considers proprietary and confidential; these proposed requirements include, but are not limited to:

- #7: "Written description of risk stratification methodologies, including data types and sources, time of data, frequency of updating, and criteria used."
- #8: Detailed description of ACO-specific 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."
- #10: Agreements with providers within the ACO's network, including "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 clinical data sharing."
- #20: ACO-level performance on each contract's quality and financial measures, including "plan-specific reports of ACO performance on contract-associated quality measures and overall financial shared savings or losses."
- #28: Monitoring adherence to evidence-based guidelines, by requiring "written description of methods 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, and written description of initiatives or plans to improve adherence rates."
- #30: Disclosure of flow of payments to providers, including "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."

C. For criteria driven largely by Medicaid-specific ACOs, allow ACOs to phase in compliance as MassHealth rolls out its program requirements.

No national standards currently exist for Medicaid ACOs, and MassHealth has not yet released their final proposal for Medicaid ACO models in Massachusetts. As noted earlier, we recommend that the HPC follow Medicare's lead to break down regulatory barriers that would otherwise impede Medicaid ACO adoption or innovation.

In addition, several proposed criteria appear driven by MassHealth's planned ACO program. In these instances, we recommend the HPC's role as establishing a baseline in a payer-agnostic manner, since MassHealth may choose to implement additional requirements specific to Medicaid populations. If HPC plans to move forward with MassHealth-centric criteria, we recommend allowing ACOs to phase in compliance with these aspects of certification in accordance with MassHealth's ACO timeline. Specific examples where this applies include:

- #1-5, to the extent the governance criteria differ with Medicare expectations;
- #8, as the ACO needs to analyze data to determine the attributed Medicaid population's needs prior to proposing interventions; and
- #9-10, #15, and #27, as MassHealth has indicated that relationships with organizations that provide long term support services and social determinants of health may be phased in over time.

We also recommend the following modifications to specific criteria:

Refine "budget-based contract" definition for criteria #11 and 29: If the HPC advances requirements related to "budget-based contracts", we recommend clarifying the language to explicitly advance prospective forms of payment; the proposed definition of "budget-based" implies retrospective-only models.

Seek data from payers when providers do not have access to data required for reporting purposes: ACOs do not necessarily have access to all billing and claims data for all providers in their network. Proposed criteria #29 requires ACOs to report alternative payment model adoption; we recommend collecting this information at the payer level, not from the ACOs, as payers have full access to claims and enrollment data. Similarly, patient population characteristics required in proposed criteria #31 should be collected by the payers at the time of enrollment and shared with the ACO.

Thank you for considering these comments. We welcome the opportunity to discuss these recommendations with you in more detail.

Sincerely,



Angela Sherwin, MPH

Vice President, Public Policy and Strategic Analysis