COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Care Delivery and Payment System Transformation Committee

April 1, 2015

Agenda

- Approval of Minutes from the March 4, 2015 Meeting **(VOTE)**
- Discussion of Registration of Provider Organizations Data Submission Manual for Initial Registration: Part 2
- Discussion of HPC Certification Programs
- Schedule of Next Committee Meeting (May 5, 2015)

Agenda

- **Approval of Minutes from the March 4, 2015 Meeting (VOTE)**
- Discussion of Registration of Provider Organizations Data Submission Manual for Initial Registration: Part 2
- Discussion of HPC Certification Programs
- Schedule of Next Committee Meeting (May 5, 2015)

Vote: Approving Minutes

Motion: That the Care Delivery and Payment System Transformation Committee hereby approves the minutes of the Committee meeting held on March 4, 2015, as presented.

Agenda

- Approval of Minutes from the March 4, 2015 Meeting (VOTE)
- **Discussion of Registration of Provider Organizations Data Submission Manual for Initial Registration: Part 2**
- Discussion of HPC Certification Programs
- Schedule of Next Committee Meeting (May 5, 2015)

Structure of Program

Purpose of the Program

RPO contributes to a foundation of information needed to support health care system monitoring and improvement. Regularly reported information on the healthcare delivery system is necessary to support:

1. Care delivery innovation
2. Evaluation of market changes
3. Health resource planning: assessing capacity, need, utilization
4. Tracking and analyzing system-wide and provider-specific trends

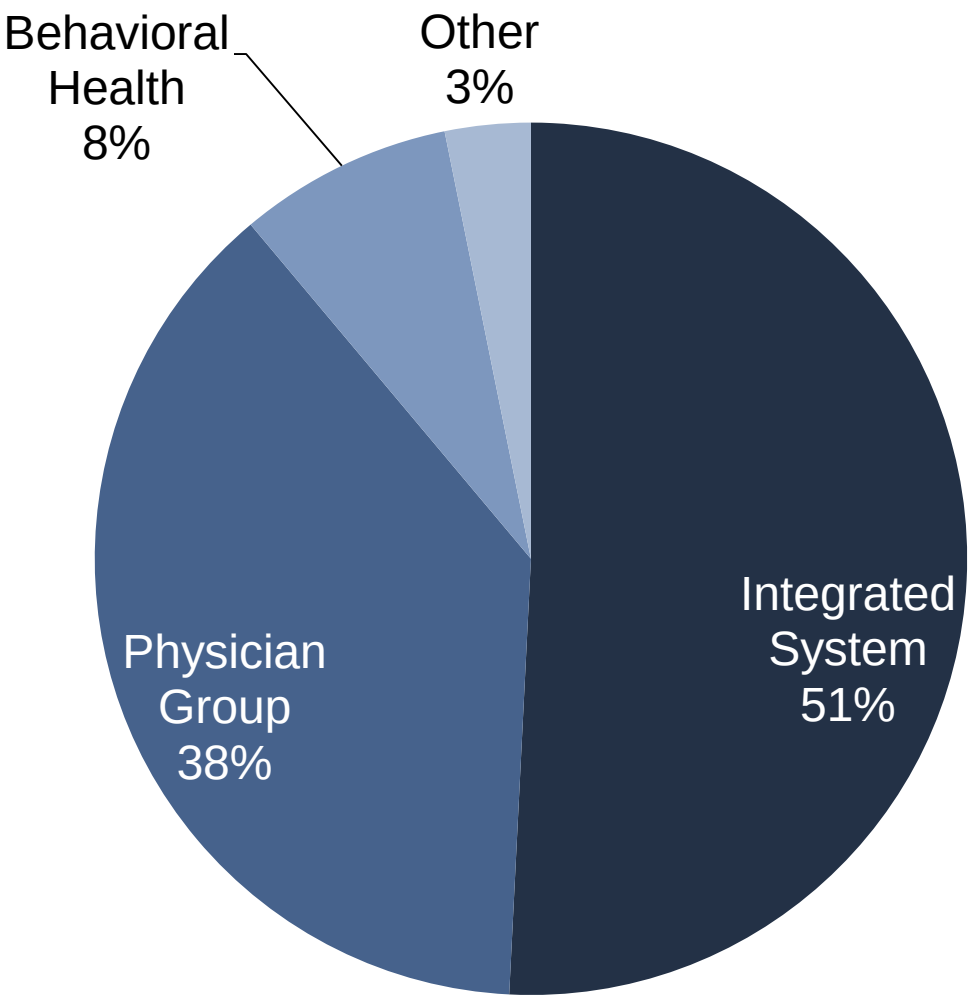
Summary of Applicants

Submitted Applications	
Applications received on or before the 11/14 deadline	62
Applications received after the 11/14 deadline	16
Outstanding applications expected	4
Total applications received or expected as of 3/30	**82**

Applications Deemed Not Active or Otherwise Complete	
Corporate Affiliates of Registrants	15
RBPO Applicants Deemed Complete	4
Total applications deemed complete or not active	**19**

Total Anticipated Applications Moving to Part 2	
Total Anticipated Applications Moving to Part 2	**63**

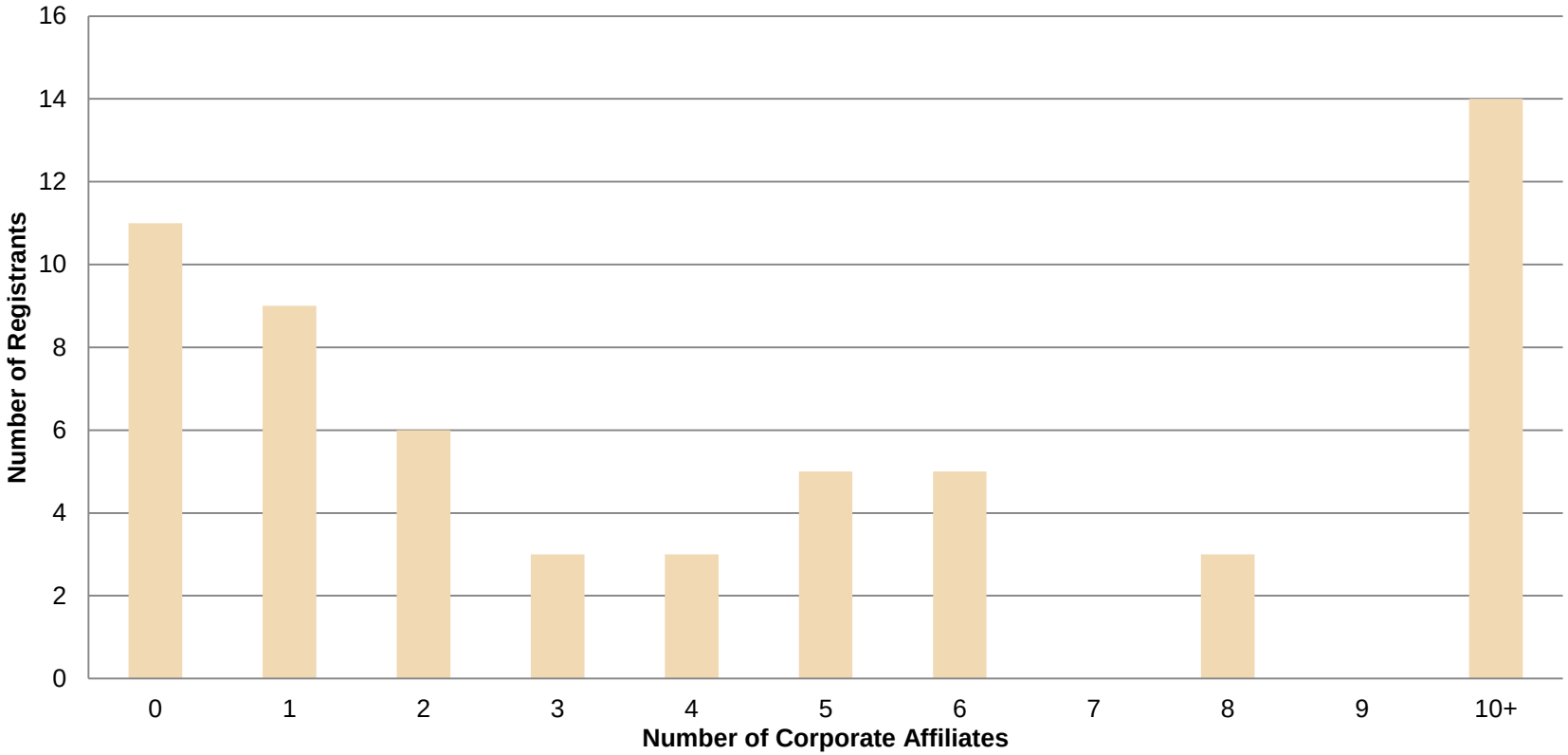
Summary of Applicants: Organization Types



Disclaimer: The HPC has not completed its review of Part 1 materials. The information above is not considered final, is subject to change, and is not intended for use beyond discussion purposes.

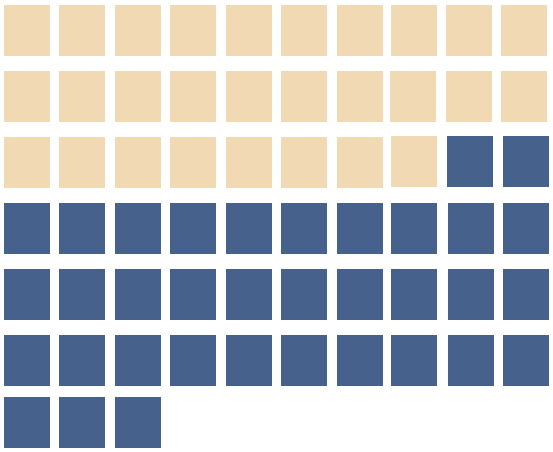
Summary of Applicants: Corporate Affiliates

Approximately Half of Provider Organizations Reported Having Either Zero or Ten or More Corporate Affiliates



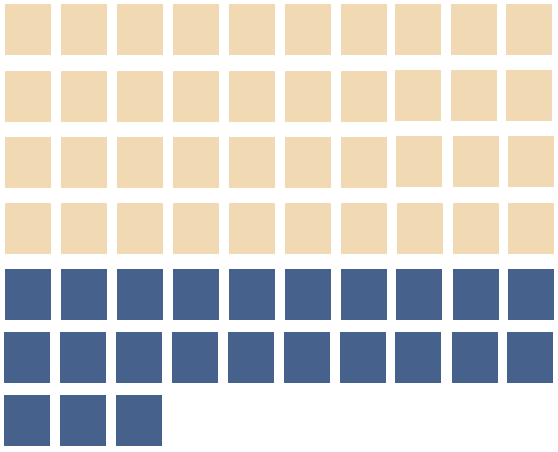
Disclaimer: This graph includes 59 of 63 final applicants. The HPC has not completed its review of Part 1 materials. The information above is not considered final, is subject to change, and is not intended for use beyond discussion purposes.

Summary of Applicants: Risk-Bearing Provider Organizations and Abbreviated Applications



56%

Of registrants applied for a Risk Certificate or a Risk Certificate Waiver

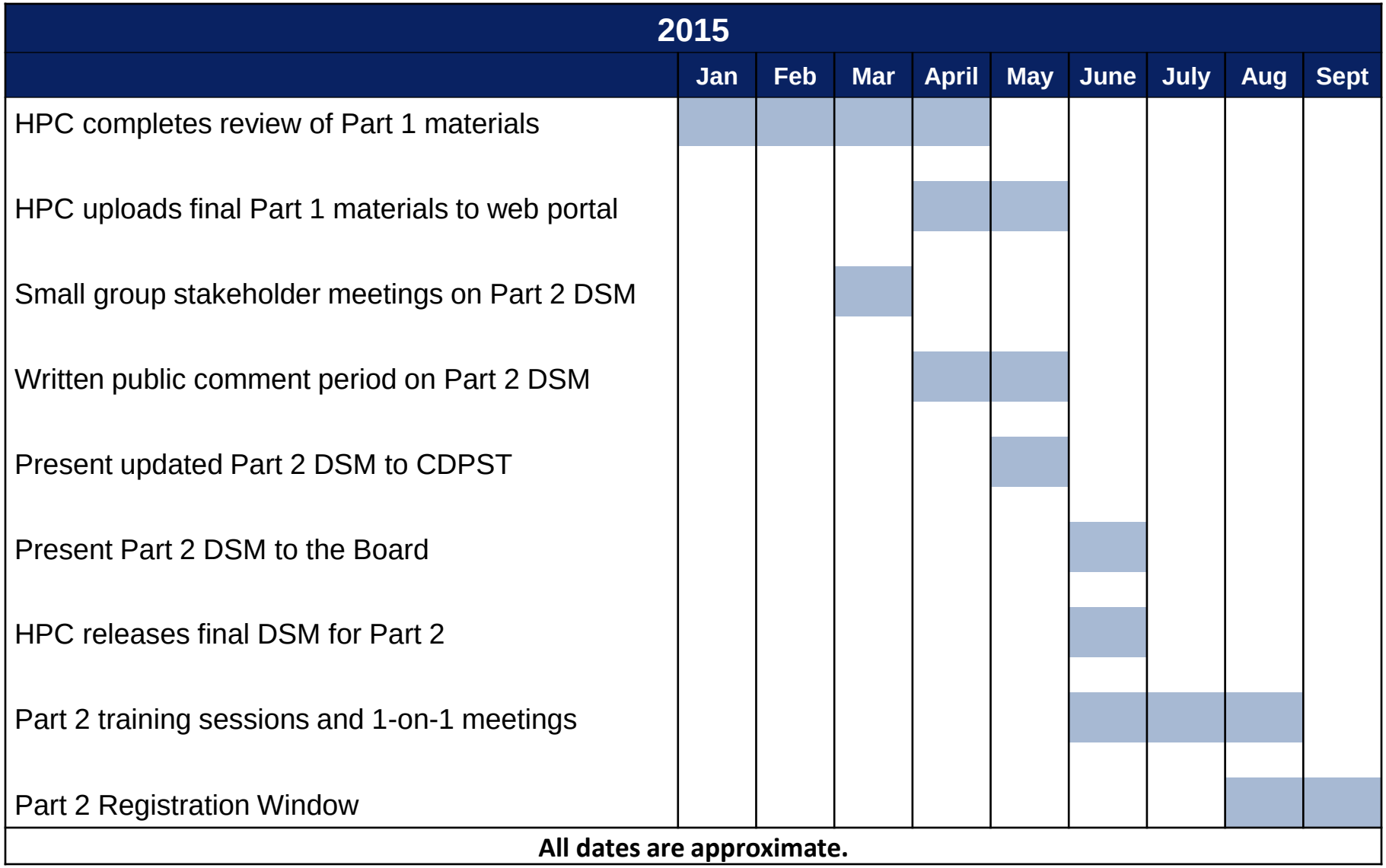


37%

Of registrants applied to file an abbreviated application in Part 2

Disclaimer: The HPC has not completed its review of Part 1 materials. The information above is not considered final, is subject to change, and is not intended for use beyond discussion purposes.

Part 2 Anticipated Process



Information about Corporate Affiliations

Description	Any Updates from 2014 Proposal	Value

• The Provider Organization completes questions in the Corporate Affiliations file for each entity that it owns or controls, whether fully or partially.
 	
• The Provider Organization provides identifying information about each entity, such as tax status, organization type and level of ownership.
	• No significant changes were made to this file.	• The file will provide insight into:
		
		  • The types of services that Provider Organizations create internally rather than purchase externally
		
		  • Relationships between organizations (e.g., joint ventures between otherwise independent corporate entities)
		
		  • Non-healthcare service offerings

Information about Contracting Relationships

Description	Any Updates from 2014 Proposal	Value
• The Contracting Affiliations file asks for identifying information about each entity that the Provider Organization does not own or control, but on whose behalf it establishes contracts. • The Contracting Entity file asks for identifying information about each entity owned or controlled by the Provider Organization that establishes contracts with payers.	• Staff have removed a number of questions and shifted several questions from the Contracting Affiliations file to the Contracting Entity file due to Provider Organization concerns about burden and availability of information.	• These files provide insight into which medical groups, hospitals, and other providers are aligning their contracting to achieve efficiencies, care delivery improvements, and other goals. • These files will track changes to the contracting landscape over time, including which entities have adopted global budgets.

Information about Facilities and Physicians

Description	Any Updates from 2014 Proposal	Value
• The Facilities File asks for information about the location, type and available services at the Provider Organization's licensed facilities. • The Physician Roster asks for identifying information for each physician, whether employed or affiliated, who gets his or her contracts through the Provider Organization.	• Requests for FTE calculations by facility and/or site have been replaced with a physician roster requirement, based on public comment from Provider Organizations.	• The Facilities file and Physician Roster will support health planning efforts by providing key information about the location of physicians, facilities and services across the Commonwealth.

Information about Clinical Affiliations

Description	Any Updates from 2014 Proposal	Value

• The Clinical Affiliations file asks for identifying information about the clinical relationships that acute care hospitals have with other Providers.	• The Clinical Affiliations file has been significantly pared down based on Provider insight and feedback. The following topic areas have been removed from the current draft DSM:
	  • Compensation
	  • Service lines
	  • End date
		• This information provides insight into how care is being delivered and coordinated between providers.

Agenda

- Approval of Minutes from the March 4, 2015 Meeting (VOTE)
- Discussion of Registration of Provider Organizations Data Submission Manual for Initial Registration: Part 2
- **Discussion of HPC Certification Programs**
  - ACO Program: Overall program design framework
  - PCMH Program: Model payment approach
- Schedule of Next Committee Meeting (May 5, 2015)

Agenda

- Approval of Minutes from the March 4, 2015 Meeting (VOTE)
- Discussion of Registration of Provider Organizations Data Submission Manual for Initial Registration: Part 2
- Discussion of HPC Certification Programs
  - **ACO Program: Overall program design framework**
  - PCMH Program: Model payment approach
- Schedule of Next Committee Meeting (May 5, 2015)

Principles for developing the ACO program

ACO certification standards will:

- **Be compatible with existing Medicare ACO programs and MA commercial global budget contracts**
- **Be aligned with MassHealth ACO** program development timeline and requirements
- **Maintain flexibility** for market innovation while ensuring minimum standards for an efficient and high quality care delivery system
- Be **evidence-based**
- **Minimize unnecessary administrative burden** on providers

Fundamental Construct of ACO Certification

ACO certification design depends on the fundamental goals of this program:

Option 1: Wait and See (No tiers)	Option 2: Broad participation with some differentiation (single tier)	Option 3: Narrower participation, more differentiation (multiple tiers with scoring)
▪ Align requirements with CMS such that all existing ACOs are expected to meet standards	▪ Build in enhancements to CMS requirements while maintaining broad participation	▪ Build in enhancements to CMS requirements
▪ Do not differentiate amongst certified ACOs – everyone is either in or out	▪ Create a "pass or fail" assessment process in which ACOs are evaluated based on presence or absence of capabilities	▪ Create a scoring system that encourages broad participation at entry level, however, creates clear differentiation even amongst Pioneer and MSSPs (e.g., multiple tiers)
▪ Allows HPC to collect data, with the intent to define 'what works' later (through model ACO designation or re-certification)	▪ ACOs that also demonstrate historical success with lower TME and good quality metrics may be granted "gold star" status	
	Current hypothesis	

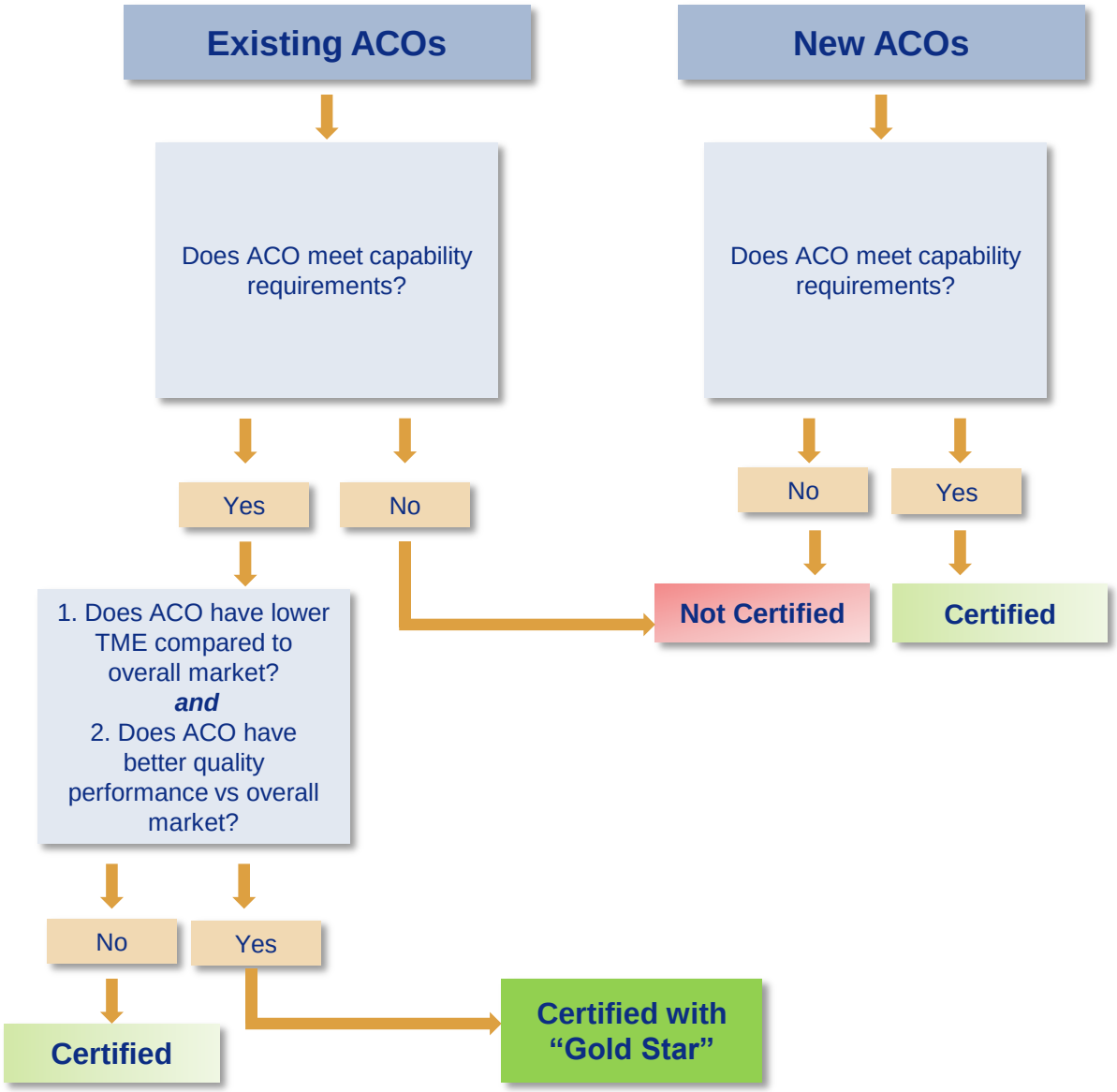
Overall program structure

I ACO Certification Program	II Model ACO designation	III Improving market efficiency

Mandatory requirements around legal structure, governance, patient protection and market protection
 	
Proposed assessment:
✓ Capability based framework across 5 domains (descriptive, not prescriptive)
✓ ACO must meet 50%+ of capabilities in each domain
 	
Existing ACOs with better TME & Quality performance vs. peers will earn "gold star" recognition
✓ Intended to support payers, employers and consumers in value based decision making
	▪ More heavily weighted towards outcome measures, e.g.,
	  ▪ Relative TME and TME growth (HMO and PPO)
	  ▪ Quality / Health Outcomes
	  ▪ Potentially preventable events (readmissions, avoidable ED visits, etc.)
	
	▪ HPC to signal to the market key principles for model ACO designation
	
	▪ However, standards will be refined over the course of 2-3 years
		▪ Model ACO payment
		▪ Model ACO contract
		▪ Model 'risk adjustment' methodology
		▪ Model performance reports (cost, utilization, quality)

Over time, the vision is:
- **To weigh certification standards more heavily towards outcome based metrics**
- **To incorporate 'Model ACO' criteria into the base certification standards**

Pathways to Certification



Overview of requirements for initial certification

Mandatory Requirements

A — Statutory Mandates

▪ Legal structure	▪ Separate legal entity (consistent with CMS requirements) except if ACO participants are part of the same legal entity ▪ If applicable, ACO must obtain an RBPO risk certification from DOI
▪ Governance	▪ Structure must include administrative officer, medical officer, and patient or consumer representative
▪ Coverage of Services	▪ ACO demonstrates collaboration across the care continuum
▪ APM Adoption for Primary Care	▪ By the EOY 2, ACO must have 40% of its revenue attributed to aligned PCPs coming from contracts with incentives based on total cost of care

B — Patient / Market Protection

▪ Patient Protection	▪ ACO must file an appeals plan with OPP for approval ▪ HPC will publicly report ACO performance on quality, including patient experience
▪ Market protections	▪ Application of state and federal antitrust laws to protect against anticompetitive behavior

Assessment

C — Capabilities

▪ Care Delivery Model	▪ Identification of patient health needs and targeted care delivery interventions based on population needs
▪ Analytics & Performance Improvement	▪ Ability to analyze and report on quality, utilization and physician practice patterns
▪ Clinical Data Systems	▪ EHR and HIE capabilities, care decision support
▪ Financial Incentives	▪ APM adoption (beyond primary care), incentives within ACO
▪ Patient/Family Engagement	▪ Patient self-management resources, measure and improve on patient/family engagement and involvement

D — Transparency/ Reporting

- TME
- Quality / Health Outcomes
- Patient/Family Experience

Overview of requirements over time for purposes of re-certification and Model ACO designation

		Initial Certification	Re-certification	Reporting/ Data collection	Model ACO
Mandatory Requirements	A Statutory Mandates				
	▪ Legal structure	X			
	▪ Governance	X			
	▪ Coverage of Services	X			
	▪ APM Adoption for Primary Care	X	X	X	
	B Patient / Market Protection				
	▪ Patient protection	X		X	
	▪ Market protections	X			
Assessment	C Capabilities				
	▪ (See previous page)	X		X	
	D Transparency/ Reporting				
	▪ TME (HMO only)	X		X	
	▪ TME (HMO and PPO)		X	X	X
	▪ Quality / Health Outcomes	X	X	X	X
	▪ Patient/Family Experience		X	X	X

***"X" in green** indicates that the criteria is assessed at initial certification for purpose of "Gold Star" status only*

Proposed Capability Domains for Certification

Care Delivery Model	Analytics & Performance Improvement	Clinical Data Systems	Financial Incentives	Patient/Family Engagement
Risk Stratification & Empanelment	Quality & Cost Analytics	EHR & Care Decision Support	APM Adoption	Patient /Family Engagement, & Self-Mgmt
Population Specific Interventions	Goals & Process for QI, PE, and Cost Containment	Real-time Information Exchange	Incentives within ACO	
Cross Continuum Network				
Care Coordination				

Behavioral Health is strongly integrated within entire structure

ACO must have at <u>least 50%</u> of the capabilities <u>within each of the 5 domains</u>

Number of capabilities	15	4	4	3	4

Proposed capability domains and requirements are going to be largely aligned with CMS, with potential enhancements (1/3)

Example: **Cross Continuum Network**

	CMS	HPC
Primary Care Infrastructure	▪ ACO should describe strength of its **primary care infrastructure**, including number and type of providers and degree to which the providers have demonstrated advanced patient centered primary care capabilities	▪ The ACO demonstrates capabilities for assessing and ensuring **patient access for primary care services** both during and outside regular office hours, including provision of same-day appointments and telephonic/e-message clinical advice
Cross Continuum Care	▪ ACO should demonstrate ability to **coordinate care across full continuum of care** ▪ ACO should describe how it plans to provide care that is **integrated with community resources** beneficiaries require	▪ The ACO **demonstrates & assesses effectiveness of ongoing collaboration** between the ACO and: ▪ **hospitals** ▪ **specialists** ▪ **post-acute care providers** ▪ **behavioral health specialists**
Evidence-Based Medicine	▪ ACO should describe its ability to **promote evidence-based medicine**, such as through establishment and implementation of EBGs at the organizational or institutional level, which includes regular assessments and updates.	▪ The ACO develops and commits to **evidence-based guidelines** for the following: ▪ Chronic conditions ▪ High-risk or complex conditions ▪ Conditions related to unhealthy behaviors or mental health or substance abuse.
Decision Support	▪ ACO should describe **decisions support** (such as knowledge sources, drug alerts, reminders, and clinical guidelines and pathways)	▪ The ACO has **point-of-care reminders** (provider-initiated or embedded in EHR) and **decision support tools** (e.g., training, written materials, best practices) built on the developed evidence-based guidelines

Proposed capability domains and requirements are going to be largely aligned with CMS, with potential enhancements (2/3)

Example: **APM Adoption**

	CMS Pioneer	HPC
Affiliated PCPs	▪ ACOs are expected to enter into **outcomes-based contracts with other payers**, such that at least **50% of the ACO's total revenue** (including from Medicare) will be derived from such arrangements, by the end of the second performance period	The ACO demonstrates that : ▪ 30% of its revenue attributed to its affiliated PCPs will come from contracts with incentives based on total cost of care by the end of Certification Year 1 ▪ 40% of its revenue attributed to its affiliated PCPs will come from contracts with incentives based on total cost of care by the end of Certification Year 2
Affiliated Specialists	▪ *Not specified*	The ACO demonstrates that: ▪ 20% of its revenue attributed to aligned specialists will come from contracts based on global budgets or bundled payments by the end of Certification Year 1 ▪ 30% of its revenue attributed to aligned specialists will come from contracts based on global budgets or bundled payments by the end of Certification Year 2
BH Providers	▪ *Not specified*	The ACO develops a plan that includes behavioral health payments within its global budget contract

Proposed capability domains and requirements are going to be largely aligned with CMS, with potential enhancements (3/3)

Example: **Patient/Family Engagement**

	CMS	HPC
Self-Management	▪ Demonstrate the ability to **engage and activate patients** at home to improve self-management ▪ ACO should have established mechanisms to **conduct patient outreach and education** on the necessity and benefits of **care coordination**	▪ The ACO has a process for the care team and patient/family to collaborate (at relevant visits) to develop and update an **individual care plan that includes a self-management plan**
Evaluating Patient Satisfaction	▪ Have mechanism to **evaluate patient satisfaction** with the access and quality of their care	▪ The ACO conducts a survey (using any instrument) to **evaluate patient/family experiences** on access, communication, coordination, whole person care/self-management support ▪ The ACO conducts a survey (using any instrument) that **measures patient/family engagement** in his healthcare and appropriately acts to increase patient engagement
CLAS	▪ The ACO should describe its ability to ensure patient/caregiver engagement and shared decision making processes that take into account the **beneficiaries' unique needs, preferences, values, and priorities**, while including methods for **fostering health literacy**	▪ The ACO assesses **linguistic, cultural, racial, ethnic, and literacy** needs of patient population 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)

Next Steps

Today

- **Stakeholder engagement** (providers, payers, other state agencies) around ACO structure, domains, and assessment
- **Expert learning** around key characteristics of ACOs, national and state trends
- **Research** on MA-specific programs and out-of-state programs to determine common themes, measures, and key characteristics of ACOs

- Present **draft** ACO program design to **CDPST (4/1)**
- Continue to **refine ACO structure, criteria, documentation requirements**
- Finalize approach for **quality measurement and reporting**
- Finalize methodology for **TME assessment** for certification and recertification

- **Committee and Board input on proposed design**
- **Stakeholder engagement** to receive feedback on structure and criteria (focus groups, individual meetings)

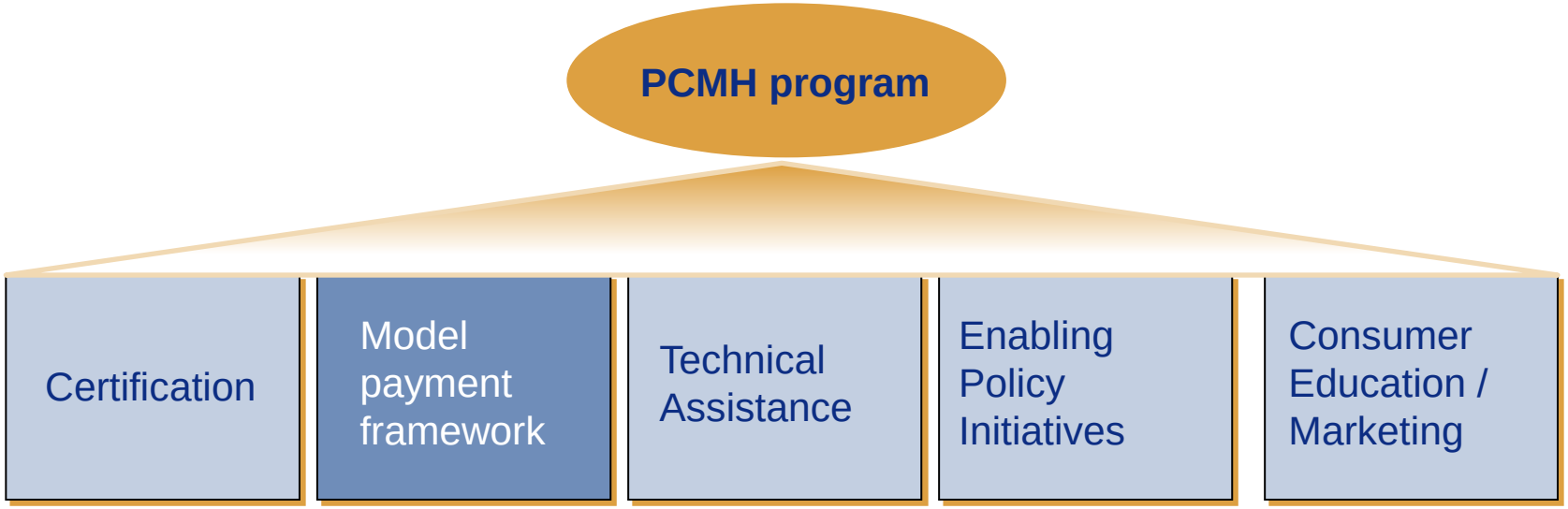
- Publish ACO certification program design for **public comment**

Agenda

- Approval of Minutes from the March 4, 2015 Meeting (VOTE)
- Discussion of Registration of Provider Organizations Data Submission Manual for Initial Registration: Part 2
- Discussion of HPC Certification Programs
  - ACO Program: Overall program design framework
  - **PCMH Program: Model payment approach**
- Schedule of Next Committee Meeting (May 5, 2015)

HPC's PCMH program will involve 5 key initiatives

Focus for today's discussion



Goals for today's discussion

- Recap on statutory requirements
- Discuss evidence from national and other state PCMH payment initiatives
- Agree on principles and approach for model payment design
- Discuss HPC's plans for advancing the conversation on addressing potential policy barriers to support model PCMH payment adoption

Background

- Chapter 224 requires HPC "to develop a multi-payer model payment system for certified patient centered medical homes"
- Recognizing the variety of models already in existence as well as provider readiness to accept alternative models of payment, HPC intends to develop a PCMH model payment framework, as opposed to a single specific payment model, to help support payment reform at the primary care level
- The model payment framework is intended to be implemented either as a stand-alone payment system or nested into global payment arrangements
- Adoption of the PCMH model payment framework proposed by the HPC will be voluntary, however, HPC is working in close collaboration with payers to design a model payment framework that they will embrace

Evidence on existing PCMH payment models is mixed; successful models typically include PMPM investment for specific PCMH interventions and ensure timely utilization and cost data access for PCMHs

	Initiative	Payment model	Data sharing	Results
Stand-alone PCMHs	**RI**	FFS + PMPM *All payer: $5.0-6.0 PMPM*[1]	✓ Provider web portal and state HIE	Reduced TME by 14% over 4 years
	VT	FFS + PMPM *All payer: $1.2-2.4 PMPM*[2]	✓ Provider web portal and state HIE	Reduced TME by 11% over 1 year for commercial
	MN	FFS + PMPM (risk-adjusted) *Medicaid: $10.0-60.0 PMPM* *Medicare: $10.0-45.0 PMPM* *Commercial: Negotiated**	✓ Separate Medicaid and commercial payer quality reports	Reduced TME by 9.2% for Medicaid over 3 years
	CMS (CPCi)[3]	FFS + PMPM + SS *Medicare: $8.0-40.0 PMPM* *Commercial: $2.0-8.0 PMPM* *Medicaid: $2.5-15.0 PMPM*	✓ Payer quality reports[5]	Cost neutral; covered PMPM costs for Medicare in the 1st year
PCMHs within ACOs	**OR**	Global budget[4] *Medicaid, Commercial: $10.0-24.0 PMPM*	✓ State web portal	ED visits reduced by 9 % over 1 year

Key Findings:

- PMPM payments vary across states, ranging from $1.20 to $60, depending on payer type
- Most initiatives stratified PMPM payments by NCQA or state certification levels
- More states are shifting focus away from PMPM and towards TME-based arrangements

1. RI payers use a common contract and pay practices a uniform monthly per capita care management fee to support nurse care managers.
2. VT PMPM payments vary by NCQA PCMH recognition year and score. Higher scores result in higher payments. All payers (including Medicare, beginning in 2011) equally share in funding the $350,000 cost associated with funding Community Health Teams and use same method for calculating PMPM.
3. Stands for "Comprehensive Primary Care Initiative". Medicare PMPM is risk-adjusted. Most other payers are not risk-adjusting PMPM payments and payers who risk-adjust use variety of methodologies
4. OR PCMHs receive PMPM via (1) Coordinated Care Organizations or large networks which distribute payment (2) Direct contracts with Aetna. PMPM based on PCMH tier
5. CMS and two-thirds of other payers provided quality reports to participating practices

* MN Private payers must pay in manner "consistent" with Medicaid

In light of findings, HPC proposes the following principles for the model payment framework:

Proposed HPC principles

Proposed model payment framework should:

- Be cost neutral or cost saving for the overall health care system
- Promote progressively increased levels of incentives for managing total medical expenditure (TME) while taking into consideration different levels of provider readiness
- Incorporate patient health risk status, ideally including social determinants of health, and enable/support consistent risk adjustment methodology across payers

Potential principles (for discussion)

Proposed model payment framework could:

- Differentiate risk tracks and payment levels based on HPC/NCQA qualification tier
- Align PCMH related quality measures across payers

The appropriate payment structure will depend on providers' current payment arrangements

	Independent PCMH practice	PCMH practice under ACO network
How PCMH contracts with payers	Direct contracting	Via ACO contracts
Proposed payment structure	Comprehensive payment for primary care* ✚ Shared-savings based on TME **OR** Capitation based on total TME	Capitation based on total TME ✚ Transparent mechanism for PCMH incentives to trickle down within the ACO

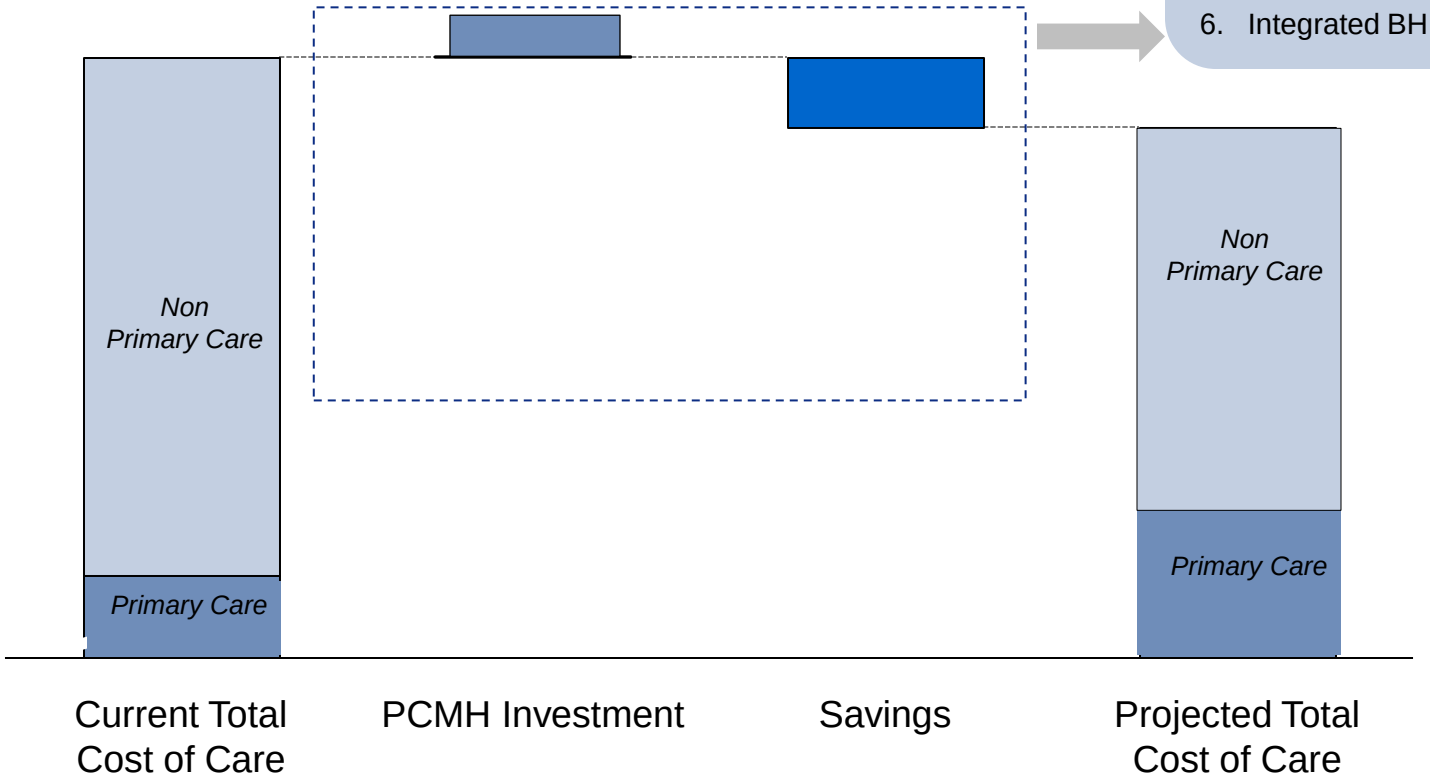
* Defined as: Payment that includes support for team-based care (e.g. nurse practitioner, social worker, care coordinator) and support for essential infrastructures and systems, most importantly, an interoperable electronic health record with decision support, essential to the delivery of comprehensive, coordinated care

The model PCMH payment will be determined based on a comprehensive financial model that quantifies the investment required for the 6 PCMH interventions and estimated savings across various populations

ILLUSTRATIVE ONLY

Investment in 6 interventions

1. Care Management
2. Population health management and prevention
3. Care transitions
4. Enhanced Access
5. Referral management
6. Integrated BH services



The proposed approach is to build a financial model for PMCH payment across various patient populations

Model Objectives:

1. Estimate investments/costs required for each PCMH intervention (multi-year)
2. Estimate corresponding savings for each PCMH intervention (multi-year)

PCMH Interventions

1. Care Management
2. Population health management and prevention
3. Care transitions
4. Enhanced Access
5. Referral management
6. Integrated BH services

Patient Populations

- Pediatric Medicaid
- Adult Medicaid
- Pediatric Commercial
- Adult Commercial
- Medicare

Alongside business case modeling, HPC will work towards policy alignment to more easily facilitate communication and sharing of health information between providers

	Recommendations:	Next steps for the HPC:
Data Sharing	SQAC should develop standard PCMH quality and outcome measures	Present to SQAC recommendations on standard quality measures
	Payers should provide timely and standardized reports to providers on quality and cost/utilization	Continue engagement with payers; potential legislative action
Health information privacy	Collaborate with the HIT council and other state agencies to inform the HPC on key barriers limiting health information sharing	HPC to assess whether existing state laws could/should be amended to facilitate appropriate information sharing across providers

HPC PCMH Model Payment Framework Timeline

Stage 1: Research
January –March 2015

- Perform **assessment of MA market landscape** with regards to PCMH payment activity and identify current gaps
- Examine strengths and weaknesses of payment models in **other states** to identify learnings for MA (interviews, literature search, ongoing evaluation studies)
- Develop **conceptual framework**, including critical design options

Stage 2: Design
March – July 2015

- Engage with stakeholder community to obtain input on the conceptual framework
- **Perform financial modeling** to estimate cost impact for the overall system
- Discuss findings with the stakeholder community and refine financial modeling
- Release draft policy recommendations for PCMH model payment framework **for public comment**
- **Engage with payers** to form strategies to incorporate model payment framework into current arrangements

Stage 3: Implementation
July 2015 - onwards

- **Finalize** policy recommendations for PCMH model payment framework
- **Promote** incorporation of proposed model payment framework as contracts come up for renewal

Agenda

- Approval of Minutes from the March 4, 2015 Meeting (VOTE)
- Discussion of Registration of Provider Organizations Data Submission Manual for Initial Registration: Part 2
- Discussion of HPC Certification Programs
- **Schedule of Next Committee Meeting (May 5, 2015)**

Contact Information

For more information about the Health Policy Commission:

Visit us: http://www.mass.gov/hpc

Follow us: @Mass_HPC

E-mail us: HPC-Info@state.ma.us

Appendix – Preliminary Capability Framework

Note:

For assessment purposes, "ACO" includes both the corporate structure of an ACO as well as any entities that exist within that structure

Under Development

A Statutory Mandates: Legal Structure & Governance

Legal Structure

- **Separate legal entity** (consistent with CMS requirements) *except* if ACO participants are part of the same legal entity
- If applicable, ACO must obtain an **RBPO risk certification** from DOI

Governance

- Per statute, the ACO governance structure must include an **administrative officer, medical officer, and patient or consumer representative**

A Statutory Mandates: Coverage of Services & APMs

Coverage of Services

- The ACO must have capabilities to arrange for **coverage of services, internally or through referrals, including, but not limited to:**
  - Primary care
  - Specialty care
  - Behavioral health
  - Urgent and emergency care
  - Inpatient care
  - Post-acute care
  - Community-based and home-based services

APM Adoption for Primary Care

- The ACO demonstrates that :
  - **30% of its revenue attributed to its affiliated PCPs** will come from contracts with **incentives based on total cost of care by the end of Certification Year 1***
  - **40% of its revenue attributed to its affiliated PCPs** will come from contracts with **incentives based on total cost of care by the end of Certification Year 2***

* Definition consistent with CHIA definition

B Patient & Market Protections

Patient Protection

- An ACO must establish, and submit for **review and approval by** HPC's **Office of Patient Protection (OPP)**, a **process to review and address patient grievances** and provide patients the **right to seek external review of grievances** in a process to be developed by OPP
- **HPC will publicly report ACO performance or quality, including patient experience**
- An ACO must implement systems that allow ACO participants to report on the **pricing of services** such that participants have the ability to provide patients with relevant price information when contemplating their care and potential referrals

Market Protection

- Application of state and federal antitrust laws to protect against anticompetitive behavior

C Risk Stratification & Empanelment

Capability
Absent | Present

- The ACO has a mechanism for **empaneling each patient to a particular provider**

- To understand the health risks and information needs of patients/families, the ACO **collects and regularly updates a comprehensive health assessment** that includes assessment of medical, behavioral (depression, anxiety, and SUD screening), and socioeconomic needs as well as communication preferences

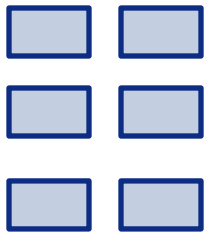
- The ACO has an approach for **risk stratification of its patient population** based on criteria identified by the ACO, which may include:
  - Behavioral health conditions
  - High cost/high utilization
  - Poorly controlled or complex conditions
  - Social determinants of health
  - Other factors the ACO deems important

Total
Absent | Present

C Population Specific Interventions

Capability
Absent | Present

- Using data from comprehensive health assessments and risk stratification, the ACO designs programs targeted at improving health outcomes for specific populations of patients, including but not limited to:
  - **Wellness and health promotion programs**
  - **Chronic disease management programs**
  - **Complex case management.**



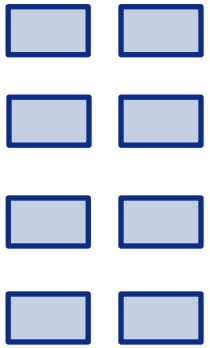
Total
Absent | Present

C Cross Continuum Network (1 of 2)

Capability
Absent | Present

- ACO should describe strength of its **primary care infrastructure**, including number and type of providers and degree to which the providers have demonstrated advanced patient centered primary care capabilities

- The ACO **demonstrates & assesses effectiveness of ongoing collaboration** between the ACO and:
  - **Hospitals**
  - **specialists**
  - **post-acute care providers**
  - **behavioral health specialists**



C Cross Continuum Network (2 of 2)

Capability
Absent | Present

- The ACO develops and commits to **evidence-based guidelines** for the following:
  - Chronic conditions
  - High-risk or complex conditions
  - Conditions related to unhealthy behaviors or mental health or substance abuse.

- The ACO has **point-of-care reminders** (provider-initiated or embedded in EHR) and **decision support tools** (e.g., training, written materials, best practices) built on the developed evidence-based guidelines

Total
Absent | Present

C Care Coordination

Capability
Absent | Present

- The ACO has a process to **track tests and referrals, and coordinate care across specialty care, facility-based care, and community organizations**. Specifically, ACO has capabilities to:
  - Proactively identify patients with unplanned hospital admissions and emergency department visits
  - Share and receive timely clinical information with and from other providers, especially admitting hospitals and emergency departments

- The ACO demonstrates its process for **identifying preferred providers**, with specific emphasis to increase use of providers in the patient's community, as appropriate

Total
Absent | Present

C Quality & Cost Analytics

Capability
Absent | Present

- The ACO monitors **practice pattern variation and identifies** areas where improved adherence to best practices is recommended and develops initiatives to support reducing unexplained or unnecessary variation

- ACO regularly performs **cost and utilization analysis**, including regular trending and forecasting of volume, revenue, and cost by driver (e.g., payer, service line, MD, cost center, episode), and model effects of changes

- The ACO regularly **disseminates reports to providers** on standardized and customized clinical quality and financial metrics, in aggregate and at the physician level

Total
Absent | Present

C Goals & Process for QI, PE, and Cost Containment

Capability
Absent | Present

- At least annually, the ACO **sets goals and acts to improve on clinical quality/health outcomes, total cost of care, patient/family experience** measures for different types of providers within the entity (PCPs, specialists, hospitals, post acute care, etc.)

Total
Absent | Present

C EHR & Care Decision Support

Capability
Absent | Present

- ACO identifies network **EHR adoption rates** by provider type/geographic region; and develops and implements a plan to **increase adoption rates of certified EHR**s, ideally with **searchable data capabilities**

- A majority (51%) of the **PCPs** within an ACO should meet **Meaningful Use** requirements

- The ACO uses EHR for **point-of-care reminders** (provider-initiated or embedded) and **decision support** built on evidence-based guidelines for patient population-specific conditions

Total
Absent | Present

C Real-time Information Exchange

Capability
Absent | Present

- ACO should assess current capacity, and **develop and implement a plan for 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)
  - Setting up **protocols** to determine how event notifications should lead to changes in **clinical interventions**

Total
Absent | Present

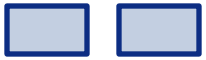
C APM Adoption

Capability
Absent | Present

- The ACO demonstrates that:
  - **20% of its revenue attributed to aligned specialists** will come from contracts **based on global budgets or bundled payments by the end of Certification Year 1***
  - **30% of its revenue attributed to aligned specialists** will come from contracts **based on global budgets or bundled payments by the end of Certification Year 2***

- The ACO develops a plan to include behavioral health services within its global budget contracts

Total
Absent | Present



* Definition consistent with CHIA definition

C Incentives within the ACO

Capability
Absent | Present

- The ACO has a process to **delineate the flow of financial payments among participating providers** down to the individual provider
  - Flow of payments should partially be based on provider performance on clinical quality/health outcomes, patient experience, and TME
  - If applicable, the ACO should highlight the direct inclusion of community organizations in the payment model structure

Total
Absent | Present

C Patient/Family Education, Engagement, & Self-Management

Capability
Absent | Present

- The ACO has a process for the care team and patient/family to collaborate (at relevant visits) to develop and update an **individual care plan that includes a self-management plan**

- The ACO conducts a survey (using any instrument) to **evaluate patient/family experiences** on access, communication, coordination, whole person care/self-management support

- The ACO conducts a survey (using any instrument) that **measures patient/family engagement** in his healthcare and appropriately acts to increase patient engagement

- The ACO assesses **linguistic, cultural, racial, ethnic, and literacy** needs of patient population 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)

Total
Absent | Present

D Transparency & Reporting

- ACO should monitor and report on a **standardized set of quality metrics periodically**
  - Since MA lacks a standardized quality set, HPC intends to align program measures with measures used by CMS, MassHealth and commercial plans
  - HPC also intends to leverage the ACO program to work towards convergence to the proposed standardized quality metric set over time

- ACO reports on **HSA TME (PMPM level and trend)**

- ACO reports on **patient/family experience** for at least three of four categories (access, communication, coordination, whole person care/self-management support)

Summary of behavioral health criteria integrated within ACO structure

- **Care Delivery**
  - Comprehensive Health Assessment must include BH factors
  - Coverage of services must include BH
  - Ongoing collaboration between ACO and BH providers
  - Decision support tools include BH conditions
- **Data & Analytics**
  - ACOs must stratify its population according to risk, incl. BH conditions
- **Clinical Data Systems**
  - Point-of-Care reminders and decision support tools should include BH conditions
- **APM Adoption**
  - ACO includes behavioral health payments within its global budget contracts