APPLICATION REQUIREMENTS AND PLATFORM USER GUIDE (PUG)

Accountable Care Organization Certification Program: Learning, Equity, and Patient-Centeredness (LEAP) 2022-2023

MASSACHUSETTS
HEALTH POLICY COMMISSION

ABOUT THE HEALTH POLICY COMMISSION

The Massachusetts Health Policy Commission (HPC) is an independent state agency that develops policy to reduce health care cost growth and improve the quality of patient care. The HPC's mission is to advance a more transparent, accountable, and equitable health care system through its independent policy leadership and innovative investment programs. The HPC's goal is better health and better care – at a lower cost – for all residents across the Commonwealth.

The agency's main responsibilities are led by HPC staff and overseen by an 11-member Board of Commissioners. HPC staff and commissioners work collaboratively to monitor and improve the performance of the health care system. Key activities include setting the health care cost growth benchmark; setting and monitoring provider and payer performance relative to the health care cost growth benchmark; creating standards for care delivery systems that are accountable to better meet patients' medical, behavioral, and social needs; analyzing the impact of health care market transactions on cost, quality, and access; investing in community health care delivery and innovations; and safeguarding the rights of health insurance consumers and patients regarding coverage and care decisions by health plans and certain provider organizations.

EXECUTIVE DIRECTOR LETTER

Dear Stakeholders,

I am pleased to announce the release of the 2022-23 Application Requirements and Platform User Guide (PUG) for the Accountable Care Organization (ACO) Certification program. The Health Policy Commission (HPC) is committed to learning from and improving on the ACO Certification program over time. This release marks the next step in the evolution of the program, which we are calling ACO Learning, Equity, and Patient-Centeredness (LEAP) 2022-23.

Since its inception in 2017, the ACO Certification program has served to provide all-payer standards for ACO care delivery and transparent information for the public on ACO structures and operations. As of 2021, the HPC has certified sixteen ACOs that collectively represent 2.9 million attributed commercial, Medicare, and MassHealth patients in the Commonwealth. We look forward to building on that success with you through our third round of certifications.

This new certification cycle comes at a time of immense challenge for health care providers and organizations. The remarkable response of the Massachusetts health care system to the COVID-19 pandemic owes much to the adaptability and collaborative approach to care delivery displayed by the Commonwealth's health care providers. Now as we look toward a new post-pandemic normal, the HPC is making changes to the ACO Certification program's standards that we believe suit this moment, both in their content and their form.

Inspired by the National Academy of Medicine's "Learning Health System" framework, the ACO LEAP standards emphasize the sorts of adaptations, learning, and innovation that health care organizations displayed during the pandemic. A pronounced theme of patient-centeredness runs throughout the standards, and this year we introduce an emphasis on addressing long-standing health inequities that have been laid bare by the pandemic. Acknowledging that there are multiple paths to delivery system transformation, the ACO LEAP application itself will offer flexibility in how ACOs meet the standards while still requiring all ACOs to follow evidence-based and data-driven strategies to improve care delivery. We hope to find ways to couple certification with opportunities for continued learning, via both voluntary peer-to-peer engagement and investment or technical assistance opportunities for the Certified ACOs.

Thank you for your continued participation in this collaborative process. If you have any questions or concerns, please feel free to reach out to the HPC's ACO program staff at HPC-Certification@mass.gov at any time.

Thank you,

David Seltz
Executive Director

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GLOSSARY OF TERMS

ACO Participant	A health care provider or an entity identified by a tax identification number (TIN) through which one or more health care providers bill, that alone or together with one or more other ACO Participants comprise an ACO.
Applicant	The health care provider or provider organization applying for HPC ACO Certification, which must have common ownership or control of any and all of the corporately affiliated contracting entities that enter into risk contracts on behalf of one or more health care providers.
Component ACO	A contracting entity, with a unique Governing Body, over which the Applicant has partial or complete common ownership or control and that enters into one or more risk contracts on behalf of one or more health care providers.
Governance Structure	The Governing Body, the committees that report to that Governing Body, and executive management/leadership team(s) that support the work of that Governing Body. Applicants with multiple Component ACOs may have multiple Governance Structures.
Governing Body	A group of ACO Participant representatives, patients/consumer advocates, and others that formulates policy and directs the affairs of an ACO, e.g., a board of directors or similar body that routinely meets to conduct ACO business and has a fiduciary duty to an ACO. An Applicant may have one Governing Body for all ACO business or multiple Governing Bodies that each conducts the business of a Component ACO.
Health Inequity(ies)	Differences in health status and mortality rates across population groups that are systemic, avoidable, unfair, and unjust. These differences are rooted in social and economic injustice, and are attributable to social, economic and environmental conditions in which people are born, grow, live, work and age.
Health-Related Social Needs	The immediate daily necessities that arise from the inequities caused by the social determinants of health. These needs are often defined by a lack of access to basic resources like stable housing, public safety, healthy food, physical and mental healthcare, income support,

	transportation, emergency services, and environments free of life-threatening toxins.
Learning Health System	As defined by the National Academy of Medicine (formerly the Institute of Medicine), a health care system in which science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the care process, patients and families active participants in all elements, and new knowledge captured as an integral by-product of the care experience.
Risk-Bearing Provider Organization	A provider organization that manages the treatment of a group of patients and bears downside risk according to the terms of an alternative payment contract and has received a certificate or waiver from the Division of Insurance (DOI) in accordance with 211 CMR 155.00.
Risk Contract	Contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged, including contracts that subject the ACO to very limited or minimal "downside" risk or "upside" risk/shared savings only. Risk contracts should include incentives (e.g., required thresholds on quality measures in order to receive a portion of shared savings) based on an ACO's performance on a set of valid, nationally-endorsed, well-accepted measures of health care quality.

ABBREVIATIONS

ACO	Accountable Care Organization
BHI	Behavioral Health Integration
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare and Medicaid Services
DOI	Division of Insurance
ED	Emergency Department
EHR	Electronic Health Record
EOTSS	Executive Office of Technology and Security Services
HEDIS	Healthcare Effectiveness Data and Information Set
HIT	Health Information Technology
HMO	Health Maintenance Organization
HPC	Health Policy Commission
HRSN	Health-Related Social Needs
LEAP	Learning, Equity, and Patient-Centeredness
LTSS	Long-term Services and Supports
MCN	Material Change Notice
NPI	National Provider Identifier
OPP	Office of Patient Protection
PCMH	Patient-centered Medical Home
PFAC	Patient and Family Advisory Council
PPO	Preferred Provider Organization
PUG	Platform User Guide
RBPO	Risk-Bearing Provider Organization
RPO	Registration of Provider Organizations
SAMHSA	Substance Abuse and Mental Health Services Administration
TIN	Tax Identification Number
TME	Total Medical Expense

INTRODUCTION

HPC Accountable Care Organization Certification Program: ACO LEAP 2022-23

The HPC is charged with developing and implementing all-payer standards of certification for accountable care organizations (ACOs) in the Commonwealth. Through these standards, the HPC seeks to promote continued transformation in care delivery while ensuring that certification is within reach of provider organizations of varying sizes, experience, organizational models (e.g., community-hospital anchored, physician-organization anchored), infrastructure and technical capabilities, populations served, and locations.

The purpose of the HPC ACO Certification program is to complement existing local and national care transformation and payment reform efforts, encourage value-based care delivery, and promote investments by all payers in high-quality and cost-effective care across the continuum. HPC certification of ACOs complements, but does not replace, requirements and activities of other state agencies. ACO Certification does not assess the ACO's suitability to operate as a Risk-Bearing Provider Organization (RBPO), which is under the purview of the Division of Insurance (DOI).

The HPC is updating its ACO Certification standards for certifications effective beginning in 2022. This third cycle for the ACO Certification program provides an opportunity to recognize the heterogeneity among ACOs in the Commonwealth and to evolve the certification requirements to focus on the ACO model as a catalyst for learning and improvement. This first significant update to the certification standards is known as ACO LEAP 2022-23 reflecting its emphasis on learning, equity, and patient-centeredness.

Learning. HPC-certified ACOs are exploring multiple pathways to delivery system transformation, and national evidence suggests that factors like experience and longevity in risk contracts and ACO programs are associated with better performance on cost and quality.[1,2,3] The ACO LEAP standards encourage ACO success by recognizing structures, processes, and approaches conducive to effectively learning from their experiences over time. The standards are designed to allow for a variety of ACO approaches to meeting core principles consistent with the "Learning Health System" framework developed by the National Academy of Medicine (formerly the Institute of Medicine).[4]

Equity. Health care delivery organizations have an important role to play as partners in ensuring that everyone in the Commonwealth has the opportunity to attain their full health potential. As

[1] Marietou Ouayogode, Carrie H. Colla, and Valerie A. Lewis. "Determinants of Success in Shared Savings Programs: An Analysis of ACO and Market Characteristics," *Healthcare* 5.1-2(2017): 53-61. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5368036/

[2] John Schulz, Matthew DeCamp, and Scott A. Berkowitz. "Regional cost and experience, not size or hospital inclusion, helps predict ACO success,' *Medicine* 96.24 (2017): https://www.ncbi.nlm.nih.gov/pubmed/28614267

[3] William K. Bleser, Robert S. Saunders, David B. Muhlestein, Spencer Q. Morrison, Hongmai Pham, and Mark B. McClellan. "ACO Quality Over Time: The MSSP Experience and Opportunities for System-Wide Improvement," *American Journal of Accountable Care* (February 2018) https://www.ajmc.com/journals/ajac/2018/2018-vol6-n1/aco-quality-over-time-the-mssp-experience-and-opportunities-for-systemwide-improvement

[4] Institute of Medicine. 2013. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Washington, DC: The National Academies Press. https://doi.org/10.17226/13444.

ACOs learn from their experiences over time, it is critical that this process includes exploring ways to improve health equity to ensure that no one is disadvantaged from achieving his or her health potential because of his or her social position (e.g., class, socioeconomic status) or socially assigned circumstance (e.g., race, gender, ethnicity, religion, sexual orientation, geography, etc.) The ACO LEAP standards elevate this important issue through a required Health Equity Response (see page 15).

Patient-centeredness. The ACO LEAP 2022-23 framework builds on the 2017 and 2019 certification standards in addressing ACOs' commitments and approaches to hearing patient voices and understanding their needs. It continues the program's focus on patient engagement and population health management programs tailored to the ACO's patient population, while adding criteria pertaining to whole-person care delivery. Understanding patients' preferences and needs and implementing interventions to meet both continues to be a core function of ACOs.

Alignment with MassHealth

In 2018, MassHealth substantially shifted towards accountable and integrated models of care through a set of investments under a restructured federal 1115 Demonstration Waiver. MassHealth has implemented three ACO models (Accountable Care Partnership Plan, Primary Care ACO, and MCO-Administered ACO), each with its own set of contractual requirements.[5] While the HPC ACO Certification is designed to be an all-payer, all-patient program, the HPC has collaborated extensively with MassHealth to align ACO Certification with its requirements and minimize administrative burden wherever possible. ACOs under all three MassHealth models are required to achieve HPC ACO Certification by the start of the first performance year, and maintain certification throughout the contract period.

[5] For more information on the Massachusetts Delivery System Reform Incentive Program, see https://www.mass.gov/info-details/massachusetts-delivery-system-reform-incentive-payment-program.

APPLICANT FOR CERTIFICATION

Definition of Applicant

A health care provider or provider organization may own or control other entities that establish risk-based contracts with one or more other payers (contracting entities). In keeping with the all-payer nature of the ACO Certification program, the health care provider or provider organization applying for certification (the Applicant) must have **partial or complete common ownership or control of any and all corporately affiliated[6] contracting entities** that enter into risk contracts on behalf of one or more health care providers (Component ACOs)**.** All entities meeting the definition of Component ACOs must be included in the Applicant's application for Certification.

If all criteria are met, the HPC will certify the Applicant, inclusive of its Component ACOs.

Example 1: A provider organization holds a risk-based contract with a commercial payer. It also fully controls two additional contracting entities that hold risk-based contracts with Medicare and MassHealth, respectively. The provider organization with the commercial risk-based contract must serve as the Applicant for Certification, and the two additional entities are Component ACOs.

Example 2: A provider organization holds a risk-based contract with a commercial payer. It also has (1) complete control of a contracting entity that holds a risk-based contract with MassHealth, and (2) 33% ownership of a contracting entity that holds a risk-based contract with Medicare. The provider organization with the commercial risk-based contract is the Applicant for Certification, and the two additional entities are Component ACOs.

Example 3: A provider organization holds a risk-based contract with MassHealth. It is controlled by a parent organization that (1) controls another contracting entity that holds a commercial risk-based contract, and (2) owns 50% of a contracting entity that holds a risk-based contract with Medicare. The parent organization is the Applicant for Certification, and all three organizations holding risk-based contracts must be included as Component ACOs in the Application.

Please contact the HPC at HPC-Certification@mass.gov for assistance in identifying the proper Applicant for Certification.

Applicant Responsibilities

While ACO structures can vary considerably, the certification is intended to be accessible to a wide range of ACOs. Within some Applicant organizations, strategic and operational direction may rest with Component ACOs. The level of influence Applicants and/or Component ACOs have over day-to-day operations and finances of participating practices also may vary.

The ACO LEAP standards are designed not with the expectation that ACOs directly manage practices' activities, but to focus on ACOs' contributions to transforming care delivery. The

[6] A corporate affiliation is any relationship between two entities that reflects, directly or indirectly, a partial or complete controlling interest or partial or complete common control.

standards contemplate that these contributions may derive from centralized infrastructure or administration, strategic and clinical guidance to practices, and ACO-wide decision-making, but all are compatible with organizations coupling centralized programming with local flexibility for implementation.

Applicants must show that they meet the Assessment Criteria inclusive of any Component ACOs, or they must show that each Component ACO meets the standards individually. Additional guidance is provided below regarding how this requirement applies to the Assessment Criteria and Supplemental Information questions. The HPC also recognizes that some Applicants are part of a larger health system that may address the topics covered in the certification requirements through system-wide strategies or approaches. The Applicant may rely on the approach of the larger system to meet the requirements for certification, provided that the Applicant (and its Component ACOs, if applicable) can show that it adopts and consistently implements the given system-level approach.

TERM OF CERTIFICATION

Deadline to Apply and Duration of Certification

The HPC is cognizant that the COVID-19 pandemic significantly influenced the operations of health care provider organizations in 2020 and early 2021 and may have lingering effects for some time. To provide flexibility to ACOs as they navigate competing demands, the HPC will relax the application deadline for applications for certifications effective in 2022 and offer a **rolling deadline for ACO certification applications throughout the fourth quarter of calendar year 2021 (October 1 to December 31, 2021).**

For all Applicants that are certified in the fall of 2021, the term of Certification will end on December 31, 2023. For Applicants seeking certification that are certified in the fall of 2022, the application deadline will be October 1, 2022 and the term of Certification will end on December 31, 2024.

Significant Changes to an Applicant During the Term of Certification

The HPC requires Applicants that have received ACO Certification to notify the HPC of any significant changes to the information in the application during the Certification term. Significant changes are changes to the Applicant's organization or operations that make it and/or its Component ACOs no longer able to meet the HPC's Certification criteria.

To notify the HPC of a significant change, please email HPC-Certification@mass.gov.

In addition, the HPC may request other updates from Applicants during the Certification term, so the HPC has accurate information about certified ACOs for public reporting purposes. Applicants may contact the HPC at HPC-Certification@mass.gov to provide updates at any time.

CERTIFICATION REQUIREMENTS AND APPLICATION

The HPC ACO Certification application is completed and submitted using a web-based application hosted by the Executive Office of Technology and Security Services (EOTSS). Applicants must first gain access to the application portal, then complete an Intent to Apply form prior to accessing the full application.

Part 0: Application Portal Access

An Applicant for certification must designate a Primary Application Contact person to request login credentials for the application portal and complete the Intent to Apply form. The link to the application portal will be available on the HPC website. To request login credentials, the Primary Application Contact must provide the following information:

Field	Format
Prefix	Text box
First name	Text box
Last name	Text box
Title	Text box
Email address	Text box
Applicant organization name	Text box

The HPC will review and approve the Primary Application Contact's request for credentials, or contact the individual with any questions regarding the request. **Please note**: the HPC will provide detailed guidance on accessing and using the application portal in separate training materials.

The Primary Application Contact must complete and submit the Intent to Apply form. After the Intent to Apply form has been approved by the HPC, additional individuals from the Applicant organization may request login credentials for the application portal.

Part 1: Intent to Apply

After receiving login credentials, the Primary Application Contact must log into the application portal and complete and submit an Intent to Apply form. The form requests certain preliminary information about the Applicant as follows:

Field	Format
Applicant name (legal and d/b/a)	Text box
Applicant Tax Identification Number (TIN)	Digits (usually up to 9)
Applicant street address	Text box
Applicant city	Text box
Applicant state	Drop-down box
Applicant zip code	5 digits
Component ACO name(s) (legal and d/b/a)	Text box(es)

Applicant information will be pre-populated in the ITA but should be reviewed by the Primary Application Contact.

Component ACO TIN(s)	Digits
Applicant Public Contact first name	Text box
Applicant Public Contact last name	Text box
Applicant Public Contact prefix	Drop-down box
Applicant Public Contact title	Text box
Applicant Public Contact phone number	Text box
Applicant Public Contact email	Text box
Primary Application Contact first name	Text box
Primary Application Contact last name	Text box
Primary Application Contact prefix	Drop-down box
Primary Application Contact title	Text box
Primary Application Contact phone number	Text box
Primary Application Contact email address	Text box

Applicant Public Contact will be publicly listed on the HPC's website as the primary public contact for ACO-related matters.

Primary Application Contact is an application portal user and the person designated to be the HPC's primary contact for purposes of ACO certification.

In addition, each Applicant must attest, **via a check-box**, to the following seven Pre-Requisite statements on the Intent to Apply form:

1. Applicant has obtained, if applicable, one or more **Risk-Bearing Provider Organization (RBPO)** certificate(s) or waiver(s) from the **DOI.**[7]
2. Applicant has filed all required **Material Change Notices (MCNs)** with the **HPC**, if applicable.[8]
3. Applicant is in compliance with all **federal and state antitrust laws and regulations**.
4. Applicant is in compliance with the HPC's **Office of Patient Protection (OPP)** guidance, if applicable,[9] regarding establishing a **patient appeals process**.
5. Applicant has at least one **risk contract** with a public or private payer in the Commonwealth.
6. Applicant has an identifiable and unique **Governing Body** with authority to execute the functions of the ACO.

An Applicant must attest to all six of the above statements to be considered eligible to seek ACO Certification.

The HPC will review an Applicant's submitted ITA and contact the Primary Application Contact with any questions or requests for revisions. If the ITA is approved by the HPC, the HPC will

[7]An entity is required to obtain an RBPO certificate or waiver if it is a provider organization that both manages treatment of a group of patients and bears downside risk for those patients according to the terms of an alternative payment contract. *See* DOI's Bulletin 2014-05 for more information. *See also* 211 CMR 155.00. Provider organizations are certified from March 1st of a particular year to February 28th of the next year.

[8]As outlined in the MCN FAQs published by the HPC on July 27, 2016, the formation of an ACO for the purpose of solely establishing Medicaid or Medicare contracts does not require an MCN filing at this time. The full set of FAQs can be found at http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/material-change-notices-cost-and-market-impact-reviews/forms.html.

[9] Pursuant to OPP guidance, Bulletin HPC-OPP-2016-01, this appeals process does not apply to any MassHealth (Medicaid), Medicare, or Medicare Advantage patients. *See* http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/regulations/20160506-bulletin-rbpo-appeals-final.pdf.

review and approve, as appropriate, requests for login credentials submitted by any other ACO staff. All ACO users will then have access to and may begin completing the application for Certification.

Part 2: Application for Certification

The ACO Certification requirements are organized into three categories: **Pre-Requisite Uploads**, **Assessment Criteria**, and **Supplemental Information**. An Applicant must meet all of the Pre-Requisites and demonstrate that it meets all of the Assessment Criteria in order to receive HPC ACO Certification. In addition, an Applicant must provide complete responses to the Supplemental Information questions.

Pre-Requisite Uploads

Applicants are required to provide additional documentation within the application to support two of the Pre-Requisite check boxes as indicated below.

For Pre-Requisite Upload #1:

- ☐ Provide an organizational chart(s) of the Governance Structure(s), including Governing Body, executive committees, and executive management. If the Applicant has Component ACOs with unique Governance Structures, the Applicant must provide a separate organizational chart for each Governing Body. UPLOAD

- ☐ Identify the name of the Governing Body and briefly describe the key responsibilities of any executive committees in the Governance Structure LONG TEXT BOX and UPLOAD

For Pre-Requisite Upload #2:

1. For each of the risk-based contracts established by the Applicant and/or its Component ACOs,[10] complete an Excel template (see Appendix) to report:
    a. Name of payer, risk contracts, and product type (e.g., PPO, HMO, fully-insured, self-insured)
    b. Number of years risk experience with payer, and year when current contract began and year of expiration
    c. Number of attributed patients
    d. Payment methodology (e.g., fully capitated, sub-capitated)
    e. Quality incentives in the risk contract
    f. Financial risk terms for each contract:
        i. Upside only or upside and downside risk
        ii. Maximum shared savings and shared loss rates
        iii. Any cap on shared savings or losses

    UPLOAD using template provided

[10] The Applicant should report only on current contracts directly held by the Applicant and/or its Component ACOs (not risk contracts in which you may participate but that are held by other organizations).

Risk Contract Performance

1. Report ACO-level final quality performance on the measures associated with each up- or downside risk contract for the last performance year for which this data are available (if applicable).[11] UPLOAD

Assessment Criteria

The HPC will evaluate Applicants for certification using the Assessment Criteria and associated documentation requirements detailed in this guide. The Applicant and/or all of its Component ACOs must meet each of the Assessment Criteria to receive HPC ACO Certification. **Where applicable, an Applicant with multiple Component ACOs that use different approaches or initiatives must submit separate documentation for each Component ACO**. (Note: If an Applicant does not itself hold risk contracts, then only its Component ACOs must meet the criteria.) The HPC may request clarifying or additional information if a submission is incomplete.

For several of the Assessment Criteria, the application offers flexibility by providing options for the documentation requirements. For Assessment Criteria AC-1, AC-2, and AC-3, Applicants may select an approach from a menu of options. Where appropriate, Applicants are encouraged to submit Primary Source Documents (i.e., existing internal materials such as guidelines, memoranda, presentations, reports, tools, etc.) to show that the criteria are met. In cases where no suitable Primary Source Documents exist, the Applicant may provide an original narrative.

All Primary Source Documents submitted must be reasonably timely (i.e., produced within the past two years) and broadly representative of the Applicant's and/or Component ACOs' current approach to meeting the standard set forth in each Assessment Criterion.

Health Equity Response

In recognition of the important role that health care providers, and ACOs in particular, have in promoting health equity, Applicants are required to provide a Health Equity Response in at least one of the Assessment Criterion domains. The Applicant must show within its response an intentional activity or initiative to address a Health Inequity affecting its patient population.

In addition to meeting the requirements of the selected Assessment Criterion, the Health Equity Response must include the following three elements:

1. The Health Inequity that the activity or initiative is intended to address, including the specific populations impacted by the inequity
2. How the ACO identified the Health Inequity, including any formal or informal data sources used; and

[11] If Applicant is unable to submit performance information because it has yet to receive final performance information from payer(s), the Applicant should submit the list of quality measures upon which the Applicant and any Component ACO(s) will be measured under current contract(s) and any interim performance information it has received.

3. What the ACO activity or initiative is and how it aims to address the Health Inequity, including specific goals or targets for improvement

The Health Equity Response may be focused on the activities of just one Component ACO; any Component ACOs not included in the Health Equity Response must demonstrate that they otherwise meet the requirements of the selected Assessment Criterion. Additional guidance is provided in the documentation requirements below.

Applicants specify which of the Assessment Criteria contains the Health Equity Response by selecting: CHECK BOXES, check one

- ☐ AC-1: Patient-Centeredness
- ☐ AC-2: Culture of Performance Improvement
- ☐ AC-3: Data-Driven Decision-Making and Care Delivery
- ☐ AC-4: Population Health Management Programs
- ☐ AC-5: Whole-Person Care

AC-1: Patient Centered Care

The ACO collects and uses information from patients to deliver and improve patient-centered care.

This Assessment Criterion is divided into two requirements: AC-1.1 and AC-1.2.

AC-1.1: The ACO **systematically monitors and assesses** the experience, perspectives, and/or preferences of the patient population served.

Documentation Requirements

The Applicant and/or its Component ACOs satisfy(ies) this requirement through one or more of the following **approaches**: CHECK BOXES, check all that apply across Applicant and/or Component ACOs

- ☐ Regular monitoring of patient experiences or preferences (e.g., online communities, patient focus groups, patient experience survey collection)
- ☐ Systematic data collection on patients' cultural, linguistic, literacy, and similar care-related needs and preferences
- ☐ Robust mechanisms for engaging consumers in governance and/or advisory bodies informing leadership (e.g., active consumer representation on each Governing Body, use of Patient and Family Advisory Councils)

For itself and/or each Component ACO, the Applicant may submit a Primary Source Document as documentation of this approach. If no appropriate Primary Source Document is available, the Applicant may submit an original narrative description.

Primary Source Document

A Primary Source Document must include the following elements, or the Applicant must provide them in Box AC-1.1

- ✓ Short description of the Primary Source Document (including the Component ACO to which it corresponds, if applicable)
- ✓ The frequency of the activity

Examples of possible Primary Source Documents may include, but are not limited to:

- Survey instruments or response summaries of periodic patient experience surveys or data collection instruments
- Summaries of feedback received through focus groups or from online communities, or other documentation of these sources (e.g., screenshots or meeting schedules)
- Patient and Family Advisory Council meeting minutes or feedback summaries showing active feedback solicitation, or Governing Body agendas or meeting minutes showing attention to lived experience of consumer representative

Box AC-1.1: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Original Narrative
If submitting an original narrative description in lieu of a Primary Source Document, the narrative must include the following (limit 500 words total): UPLOAD

- ✓ A description of the approach used by ACO leadership for AC-1.1, including scope and scale
- ✓ The frequency with which the ACO conducts the activity

AC-1.2: The information/data gathered via AC-1.1 **informs the ACO's strategy and/or organization-level initiatives** for improving patient experience.

Documentation Requirements

For itself and/or each Component ACO, the Applicant may submit a Primary Source Document **describing one ACO- or system-level initiative** to improve an aspect of patient experience in the past two years. If no appropriate Primary Source Document is available, the Applicant may submit an original narrative description.

Primary Source Document
A Primary Source Document must include the following elements, or the Applicant must provide them in Box AC-1.2:

- ✓ Short description of the Primary Source Document
- ✓ How the need or opportunity was identified from information collected in AC-1.1
- ✓ How the initiative is being measured to gauge impact and/or make improvements

Examples of possible Primary Source Documents may include but are not limited to:

- Overview presentations or written summaries describing the initiative
- Memos or internal communications detailing the initiative

Box AC-1.2: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Original Narrative
If submitting an original narrative description in lieu of a Primary Source Document, the narrative must include the following (limit 500 words total): UPLOAD

- ✓ A description of the ACO- or system-level initiative and its goals
- ✓ A description of how the need or opportunity was identified from information collected in AC-1.1
- ✓ How the initiative is being measured to gauge impact and/or make improvements.
- ✓ An estimate of the number of providers, patients, and/or practices engaged in the initiative.

Health Equity Response

Applicants may fulfill the Health Equity Response requirement through the response to AC-1.2. To do so, the narrative or Primary Source Document(s) for AC-1.2 must include a description of an intentional activity or initiative to address a Health Inequity identified through formal or informal assessments of the patient experience. The original narrative or Primary Source Document provided in response to AC-1.2 must include the three elements described on page 16.

AC-2: Culture of Performance Improvement

The ACO fosters a culture of continuous improvement, innovation, and learning to improve the patient experience and value of care delivery.

This Assessment Criterion has one requirement.

AC-2: The ACO's culture of performance improvement is demonstrated by at least two different **approaches**.

Documentation Requirements

The Applicant and/or its Component ACOs satisfy(ies) this requirement through **at least two of the following approaches**: CHECK BOXES, check all that apply across Applicant and/or Component ACOs

- ☐ Periodically convening clinical and/or business leaders from around the ACO to discuss performance improvement goals, opportunities, strategies, and/or activities
- ☐ Leadership commitment to tracking and reviewing performance
- ☐ Internal financial incentives
- ☐ Internal systems or processes to facilitate or encourage innovation and improvement
- ☐ Selection or evaluation of clinical or non-clinical affiliates or partners based on alignment with ACO performance improvement priorities
- ☐ Support for an ACO- or system-wide primary care transformation strategy

For itself and/or each Component ACO, the Applicant may submit a Primary Source Document as documentation for each of the two approaches selected. If no appropriate Primary Source Document is available for one or both approaches selected, the Applicant may submit an original narrative description.

Primary Source Document

A Primary Source Document must include the following elements, or the Applicant must provide them in Box AC-2:

- ✓ Short description of the Primary Source Document
- ✓ Brief explanation of how the approach described contributes to a culture of improvement in the ACO

Examples of possible Primary Source Documents may include but are not limited to:

- Agendas, minutes, or written summaries of internal ACO meetings, organizational management activities, or recruitment strategies aimed at advancing a culture of improvement
- Dashboards or other tools for tracking system or ACO-level quality and financial metrics against ACO goals by leadership, or a narrative describing how the Governing Body(ies) sets strategic performance improvement goals
- Memos, overview presentations, or summaries demonstrating implementation of systems

learning (e.g., Lean) and/or process improvement approaches, or an example of an initiative where frontline staff identified waste, inefficiency, or quality improvement opportunities and were empowered by leadership to test and/or scale proposed solutions

- Scoresheets or written criteria for evaluating potential clinical or non-clinical affiliates or partners (e.g., on factors like use of team-based care, communication and/or data exchange, coordination with community-based services, care transition protocols, cost, quality, or access, etc.)
- Plans or summary documents describing an ACO- or system-wide strategy for primary care transformation based on advanced primary care principles[12], including continuous quality improvement

Box AC-2: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Original Narrative

If submitting an original narrative description in lieu of a Primary Source Document for one or both approaches selected, the narrative(s) must include the following (limit 500 words total): UPLOAD

- ✓ A description of the approach(es) used by ACO leadership
- ✓ Brief explanation of how the approach(es) described contributes to a culture of improvement in the ACO

Health Equity Response

Applicants choosing to provide a Health Equity Response to AC-2 must include in the narrative or Primary Source Document(s) for AC-2 a description of an intentional activity or initiative to address a Health Inequity via one of the approaches to continuous improvement identified above. The original narrative or Primary Source Document provided in response to AC-2 must include the three elements described on page 16.

[12] *Advanced primary care* refers to functions and attributes like comprehensive care, patient-centeredness, coordinated care, accessible services, and a commitment to quality and safety. See: AHRQ. "Defining the PCMH." https://pcmh.ahrq.gov/page/defining-pcmh.

AC-3: Data-Driven Decision-Making and Care Delivery

The ACO is committed to using the best available data and evidence to guide and support improved clinical decision-making.

This Assessment Criterion is divided into two requirements: AC-3.1 and AC-3.2.

AC-3.1: To facilitate learning among providers, decrease provider practice variation, and support provider adherence to evidence-based guidelines, the **ACO adopts processes or tools that make available reliable, current clinical knowledge at the point of care**.

Documentation Requirements

The Applicant and/or its Component ACOs satisfy(ies) this requirement through **at least one of the following approaches**: CHECK BOXES, check all that apply across Applicant and/or Component ACOs

- ☐ Launching an initiative to reduce inefficiency or low-value care, or decrease provider practice variation in the past two years[13]
- ☐ Facilitating or encouraging use of a clinical decision support tool[14]
- ☐ Developing or making available to providers an evidence-based protocol or structured learning opportunity

For itself and/or each Component ACO, the Applicant may submit a Primary Source Document as documentation of this approach. If no appropriate Primary Source Document is available, the Applicant may submit an original narrative description.

Primary Source Document

A Primary Source Document must include the following elements, or the Applicant must provide them in Box AC-3.1:

- ✓ Short description of the Primary Source Document
- ✓ Estimate of the scale of the approach (e.g., prevalence of use or uptake among providers)

Examples of possible Primary Source Documents may include but are not limited to:

- Internal summary materials or presentations describing an initiative to reduce low value care
- Strategy document, memorandum, or internal communication encouraging use of a particular

[13] Examples of low-value care include: screenings that are not clinically indicated, certain pre-operative services, potentially unnecessary procedures, imaging services for conditions for which they have little diagnostic value, and inappropriate prescribing. See: Health Policy Commission. "2018 Annual Health Care Cost Trends Report." February 2019. Available at: https://www.mass.gov/files/documents/2019/02/20/2018%20Cost%20Trends%20Report.pdf

[14] Some commercially available electronic health records include embedded clinical decision support tools. The existence of decision support within electronic health records used by ACO-participating providers is not sufficient to meet the AC-3.1 requirement. To meet the requirement, the ACO must provide strategic guidance or direction to increase provider awareness of decision support tools that align with ACO priorities and/or decrease variations in care delivery among ACO-participating providers.

decision support tool or evidence-based protocol among clinicians, event agenda or summary of a structured learning opportunity, or internal summary or dashboard tracking use of a clinical decision support tool

Box AC-3.1: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Original Narrative

If submitting an original narrative description in lieu of a Primary Source Document, the narrative must include the following (limit 500 words total): UPLOAD

- ✓ A description of the initiative, tool, protocol, or learning opportunity and the ACO's role in supporting or encouraging its use
- ✓ A description of the scale of the process or reach of the tool (e.g., estimated prevalence of use or uptake among clinicians)
- ✓ Any known quantitative or qualitative outcomes associated with implementation of the process or tool

AC-3.2: The ACO also collects and offers providers **actionable data** (e.g., on quality, safety, cost, and/or health outcomes) to guide clinical decision-making, identify and eliminate waste, and enable high-value care delivery.

Documentation Requirements

The Applicant and/or its Component ACOs satisfy(ies) this requirement through **at least one of the following approaches**: CHECK BOXES, check all that apply across Applicant and/or Component ACOs

- ☐ Periodically providing data and/or feedback on cost or quality performance at the individual provider or group level, benchmarked to peers or external standard
- ☐ Offering providers understandable, actionable information on their patients via data analytics (e.g., identifying patients due for mammograms, or diabetic patients in need of HbA1c tests)

For itself and/or each Component ACO, the Applicant may submit a Primary Source Document as documentation of this approach. If no appropriate Primary Source Document is available, the Applicant may submit an original narrative description.

Primary Source Document

A Primary Source Document must include the following elements, or the Applicant must provide them in Box AC-3.2:

- ✓ Short description of the Primary Source Document
- ✓ Estimate of the scale of the approach (e.g., number or percentage of clinicians offered data)

Examples of possible Primary Source Documents may include but are not limited to:

- Template for or de-identified example of a cost or quality performance report in use
- De-identified screenshots, memos, or internal communications detailing data analytics available to providers

Box AC-3.2: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Original Narrative

If submitting an original narrative description in lieu of a Primary Source Document, the narrative must include the following (limit 500 words total): UPLOAD

- ✓ A description of the ACO's approach, including the type of data provided
- ✓ How often the data are provided
- ✓ How these activities fit into the ACO's overall performance improvement strategy(ies)

Health Equity Response

Applicants may fulfill the Health Equity Response requirement through the response to AC-3.1 or AC-3.2. To do so, the narrative or Primary Source Document(s) for AC-3.1 or AC-3.2 must include a description of an intentional activity or initiative to address a Health Inequity via processes or tools, or via actionable data, made available to providers. The original narrative or Primary Source Document provided in response to AC-3.1 or AC-3.2 must include the three elements described on page 16.

AC-4: Population Health Management Programs

The ACO develops, implements, and refines programs and care delivery innovations to coordinate care, manage health conditions, and improve the health of its patient population.

This Assessment Criterion is divided into two requirements: AC-4.1 and AC-4.2.

AC-4.1: The ACO **collects data** to understand the health needs of its patient population and performs appropriate **risk stratification**.

Documentation Requirements

The Applicant and/or its Component ACOs satisfy(ies) this requirement by providing a written narrative describing its approach to collecting and using data to stratify its patient population for inclusion in population health management programs (see AC-4.2). Responses must include: UPLOAD

a. Description of the approach to analyzing data, including source of information (e.g., payer-provided reports, proprietary software from a vendor, internal stratification methodology)
b. Factors on which stratification is based (e.g., emergency department use, functional status, chronic conditions, social factors)
c. Frequency of stratification
d. Any methodological variation by sub-population (e.g., Medicare, Medicaid, commercial)

AC-4.2: The ACO uses the data analysis or risk stratification described in AC-4.1 to design and implement **one or more patient-facing population health management programs** that address areas of need for a defined patient population. The ACO **sets targets for and measures the impact of these programs** to support continuous performance improvement over time.

Documentation Requirements

The Applicant and/or its Component ACOs satisfy(ies) this requirement by completing the Population Health Management Programs and Targets template (see Appendix) to report the following data elements: UPLOAD, using template provided

a. Priority area or program
b. Specific interventions
c. Populations targeted
d. Number of patients served
e. Metrics and targets
f. Progress on metrics, and/or
g. Program change(s) made in past two years based on data gathered or targets missed over the course of implementation

h. Notes or clarifications (optional)

Health Equity Response

Applicants may fulfill the Health Equity Response requirement through the response to AC-4.1 or AC-4.2. To do so, a narrative or Primary Source Document(s) must be included that provides a description of an intentional activity or initiative to address a Health Inequity via the ACO's stratification approach or via the ACO's population health management programs. The original narrative or Primary Source Document provided in response to AC-4.1 or AC-4.2 must include the three elements described on page 16.

AC-5: Whole-Person Care

The ACO recognizes the importance of non-medical factors to overall health outcomes and cost of care and seeks to integrate behavioral health and health-related social supports into its care delivery models.

This Assessment Criterion is divided into two requirements: AC-5.1 and AC-5.2.

AC-5.1: The ACO is **advancing the integration of behavioral health care** into primary care settings, with respect to workforce, administration, clinical operations, and/or funding. The ACO also **sets and measures progress on discrete goals** for further increasing integration over time.

Documentation Requirements

The Applicant satisfies this requirement by completing the Behavioral Health Integration Progress (BHI) and Targets template (see Appendix) to report : UPLOAD, using template provided

a. BHI Priority Area[15]
b. Goal(s) for the Priority Area
c. Actual Performance in Previous Measurement Period, if applicable
d. Current Target
e. Time Period for Previous Measurement and Current Target
f. Type of ACO Support Provided

AC-5.2: The ACO is also advancing efforts to **understand and address its patients' health-related social needs** through screening and referral relationships with community-based and/or social service organizations. The ACO also sets and **measures progress on discrete goals** for improving the effectiveness of these processes.

Documentation Requirements

The Applicant may submit a Primary Source Document as documentation of these processes. If no appropriate Primary Source Document is available, the Applicant may submit an original narrative description.

Note: if the Applicant's HRSN screening process is embedded in the Applicant's Population Health Management Program(s) described in AC-4.1, the Applicant may provide the information required for AC-5.2 in the Population Health Management Programs and Targets template

[15] Behavioral health integration priorities may include, but are not limited to, activities like supporting co-location of providers, incorporating behavioral health providers onto care teams, facilitating information-sharing, implementing of behavioral health screening and referral processes, or supporting evidence-based behavioral health care. Include any area that the ACO is investing in or otherwise supporting. The scale of these efforts and investments may vary and need not apply to every practice participating in the ACO.

submitted in AC-4.1. In that case, the Applicant must: note in Box AC-5.2 that it has exercised this option; and provide additional information on progress toward or plans for use of bi-directional methods or platforms to refer patients to community services and facilitate communication between the ACO, primary care provider, and community-based service provider.

Primary Source Document

A Primary Source Document must include the following elements, or the Applicant must provide them in Box AC-5.2:

- ✓ Short description of the Primary Source Document
- ✓ Estimate of the scale of the screening processes

Examples of possible Primary Source Documents may include but are not limited to:

- Copies of screening tools in use or response summaries or results dashboards
- Memos, overview presentations, or summaries detailing the ACO's approach to HRSN screening

Box AC-5.2 (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Original Narrative

If submitting an original narrative description in lieu of a Primary Source Document, the narrative must include the following (limit 500 words total): UPLOAD

- ✓ Description of ACO's approach to HRSN screening, including tools used
- ✓ Progress on or plans for use of bi-directional methods or platforms to refer patients to community services and facilitate communication between the ACO, primary care provider, and community-based service provider
- ✓ Metrics tracked
- ✓ Current performance
- ✓ Performance targets

Health Equity Response

Applicants may fulfill the Health Equity Response requirement through the response to AC-5.1 or AC-5.2. To do so, the narrative or Primary Source Document(s) for AC-1.2 must include a description of an intentional activity or initiative to address a Health Inequity via the ACO's behavioral health integration strategy or via the deployment of health-related social needs screening resources. The original narrative or Primary Source Document provided in response to AC-5.2 must include the three elements described on page 16.

Supplemental Information

Applicants must provide complete responses to all of the Supplemental Information questions in order to receive HPC ACO Certification. If the Applicant has multiple Component ACOs, unless otherwise noted, please provide a response that best describes the overall characteristics or approach across the Applicant and all of its Component ACOs.

For each set of Supplemental Information questions, Applicants will have the option to upload one or more additional documents to further explain or supplement a response.

SI-1: Activities to Promote Health Equity

Questions:

1. For each of the patient populations served by the ACO, indicate whether the Applicant or a Component ACO has reliable, patient-level data on race, ethnicity, language, and/or disability (either directly collected by the ACO, or collected by participating providers and shared with the ACO):
    a. Commercial CHECK BOXES, check all that apply
        - ☐ Race
        - ☐ Ethnicity
        - ☐ Language
        - ☐ Disability
        - ☐ None of the above
    b. Medicare CHECK BOXES, check all that apply
        - ☐ Race
        - ☐ Ethnicity
        - ☐ Language
        - ☐ Disability
        - ☐ None of the above
    c. MassHealth CHECK BOXES, check all that apply
        - ☐ Race
        - ☐ Ethnicity
        - ☐ Language
        - ☐ Disability
        - ☐ None of the above

2. Does the Applicant or a Component ACO receive individual patient-level data on race, ethnicity, language, and/or disability from a source external to the ACO, such as a payer? If yes, briefly indicate the type(s) of RELD data received and the data source. RADIO BUTTON
    - ☐ Yes TEXT BOX
    - ☐ No

3. In which of the following areas, if any, has the ACO taken explicit and intentional steps to promote equity in the ACO's care delivery models or within the ACO? For any

response, please provide 3-5 sentences summarizing the ACO's actions. CHECK BOXES, check all that apply

- ☐ Representation on the Governing Body SHORT TEXT BOX
- ☐ Provider/staff training SHORT TEXT BOX
- ☐ Provider/staff recruitment SHORT TEXT BOX
- ☐ Use or development of patient-facing resources or materials SHORT TEXT BOX
- ☐ Quality improvement strategies SHORT TEXT BOX
- ☐ Telehealth access and/or usability SHORT TEXT BOX
- ☐ Other SHORT TEXT BOX

SI-2: Use of Innovative Care Models

Questions:

1. Which of the following are components of the digital health strategy being pursued by the ACO or the health system of which the ACO is a part? CHECK BOXES, check all that apply
   - ☐ Patient portals
   - ☐ Virtual visits
   - ☐ Remote patient monitoring (e.g., wearable devices)
   - ☐ E-consults between medical specialists and primary care providers
   - ☐ E-consults between behavioral health specialists and primary care providers
   - ☐ Apps supporting care management, wellness, and/or diet and exercise
   - ☐ Apps supporting diagnostics, telehealth, and/or linking of patients and providers
   - ☐ Other (please specify) TEXT BOX
   - ☐ None of the above

2. If the ACO or health system of which the ACO is a part has a strategy to support integration of telehealth into clinical practice, select which of the types of support below are included: CHECK BOXES, check all that apply
   - ☐ A common technology platform for providers
   - ☐ Financial support for providers to purchase and implement a platform
   - ☐ Dedicated telehealth support staff
   - ☐ Coordination with third party telehealth providers
   - ☐ Technical assistance for providers
   - ☐ Technology support for patients
   - ☐ Patient outreach to raise awareness of telehealth options
   - ☐ Interpreter services
   - ☐ Other (please specify) TEXT BOX
   - ☐ No strategy or supports in place

3. Which of the following non-clinical supports has the ACO incorporated into care or population health management models?
   - ☐ Community Health Workers
   - ☐ Recovery coaches
   - ☐ Peer supporters (e.g. certified peer specialists)
   - ☐ Doulas
   - ☐ Other (please specify) TEXT BOX

SI-3: Strategies to Control Total Medical Expense Growth

Questions:

1. Which of the following have been the **top three** most successful strategies for the ACO in controlling Total Medical Expense growth? For any response, please provide 3-5 sentences summarizing the ACO's actions. CHECK BOXES, check THREE
   - ☐ Investments in primary care and/or behavioral health capacity SHORT TEXT BOX
   - ☐ Initiatives to promote high-value patient referrals SHORT TEXT BOX
   - ☐ Complex care management or population-specific care management programs LONG TEXT BOX
   - ☐ Strategies to keep appropriate secondary care in community settings SHORT TEXT BOX
   - ☐ Initiatives to reduce low-value care[16] SHORT TEXT BOX
   - ☐ Reductions in avoidable inpatient or post-acute utilization SHORT TEXT BOX
   - ☐ Other (please specify) SHORT TEXT BOX
   - ☐ None of the above

2. What are the **top three** challenges faced by the ACO in controlling TME growth? CHECK BOXES, check THREE
   - ☐ Proliferation of open network insurance products
   - ☐ Lack of real-time data for managing care
   - ☐ Inability to identify or track low-value care
   - ☐ Difficulty translating risk contract incentives into incentives for clinicians
   - ☐ Price growth for drugs, medical supplies, or other inputs
   - ☐ Patient preferences for costly providers and/or services
   - ☐ Prices of providers outside of the ACO
   - ☐ Administrative complexity or expenses
   - ☐ Other (please specify) SHORT TEXT BOX

[16] See footnote 14 on page 22 for examples of low-value care.

Part 3: Application for Certification: Affidavit of Truthfulness

The Primary Application Contact or another authorized representative of the Applicant is required to electronically sign and confirm the following statements upon submission of an application for ACO Certification. Additionally, the undersigned understands and acknowledges that the HPC requires Applicants that have received ACO Certification to notify the HPC of any significant changes to the information in the application during the Certification term that make it and/or its Component ACOs no longer able to meet the HPC's Certification criteria.

I, the undersigned, certify that:

1. The information submitted to the HPC for ACO Certification is complete, accurate and true.

2. I am duly authorized to submit this application for HPC ACO Certification on behalf of the Applicant.

Signed on the _____ day of _____, 20____ under the pains and penalties of perjury.

Name: _____

Title: _____

E-Signature: _____

CONFIDENTIALITY AND USE OF INFORMATION SUBMITTED BY ACOs

Through the ACO Certification program, the HPC seeks to promote greater transparency and continuous improvement of the Massachusetts health care system. To support its application for ACO Certification, the Applicant must submit certain information and documents to the HPC. Some of this information may be publicly available, while other information and documents may be of a clinical, financial, strategic, or operational nature that is non-public.

Information Sharing with the Public

At public meetings and in publications, the HPC will discuss and report on certified ACOs using aggregate or non-attributed information submitted for Certification. In addition, the HPC may report on specific certified ACOs using publicly available information and documents, including those listed in Table 1 that are submitted to the HPC for ACO Certification.

The HPC will not disclose, without the consent of the Applicant, non-public information and documents submitted for Certification that are clinical, financial, strategic, or operational in nature, at the individual ACO level (see Table 2 below). The Certification application will provide the Applicant the opportunity to give consent to the HPC to disclose the information listed in Table 2. The HPC will continue to highlight novel approaches and care delivery models, and otherwise promote shared learning through public reporting of the information listed in Table 2, using both aggregate or non-attributed information and individual ACO information for which it has received consent.

Table 1: Information for Public Reporting

Identifying Information
Applicant name (legal and d/b/a) and the name(s) of any Component ACOs.
Applicant Tax Identification Number (TIN) and the TIN(s) of any Component ACOs
Applicant street address
Applicant city
Applicant state
Applicant zip code
Applicant public contact first name
Applicant public contact last name
Applicant public contact prefix
Applicant public contact title
Applicant public contact phone number
Applicant public contact email
Primary application contact first name
Primary application contact last name
Primary application contact title
Primary application contact phone number
Primary application contact email address

PR-1: Governance
Organizational chart(s) of the Governance Structure(s) of the Applicant (and Component ACOs as applicable), including Governing Body, executive committees (including a brief description of the responsibilities of any executive committees), and executive management
PR-2: Risk Contract Information
Name(s) of payer(s) with which Applicant and/or Component ACOs have risk contracts
Year that each risk contract began and expires
Years of risk experience with the payer
Number of attributed patients per risk contract
Whether or not each risk contract is upside-only or includes downside risk

Table 2: Information for Public Reporting If the Applicant Consents

PR-2: Risk Contract Information
Risk contract product types, maximum amount of risk (up- and downside) for which the Applicant and/or its Component ACO was/is responsible under each contract, payment methodology, and description of quality incentives in the payment model
AC-1: Patient-Centered Care
Summaries, developed by the HPC, of ACO activities to monitor patient experience and ACO strategies or initiatives to improve aspects of the patient experience
AC-2: Culture of Performance Improvement
Descriptions, developed by the HPC, of activities or processes the ACO has in place to foster a culture of performance improvement
AC-3: Data-Driven Decision-Making and Care Delivery
Description, developed by the HPC, of initiatives, tools, or protocols used to make information available to providers; description, developed by the HPC, of data feedback or analytics approaches
AC-4: Population Health Management Programs
Description, developed by the HPC, of approach to stratifying patient population and of Population Health Management programs
AC-5: Whole-Person Care
Description, developed by the HPC, of priority areas and goals for behavioral health integration
Description, developed by the HPC, of HRSN screening processes
SI-1: Approaches to Improving Health Equity
Overview of ACO collection and access to data, and summary of ACO steps to promote equity
SI-2: Use of Innovative Care Models
Summary of digital health strategy elements, telehealth strategy supports, and non-clinical supports used in care models
SI-3: Strategies to Control TME Growth
Summaries of most successful strategies and top challenges for controlling TME

APPENDIX

The risk contract information requested in **PR-2** must be uploaded to the submission platform using a template that will be provided.

HPC ACO Certification
Applicant Overview Template PR-2: Risk Contracts

Applicant:

Component ACO Holding Contract (if applicable)	Name of payer *Add rows as necessary*	Product	Fully-insured or self-insured?	Number of years risk experience with this payer	Year current contract began; year current contract expires	Number of attributed patients/covered lives	Financial Risk Terms					Payment methodology	Description of quality incentives in the payment model
							Upside only or upside and downside risk?	Max shared savings rate, if applicable	Max shared loss rate, if applicable	Cap on savings payments, as PMPM or % of budget, if applicable	Cap on shared loss amounts, as PMPM or % of budget, if applicable		
DEF ACO	*Medicare*	*Next Generation ACO*	*Fully-insured*	*8*	*2016; 2021*	*20,000*	*Upside and downside risk*	*75%*	*75%*	*10% or $20 PMPM*	*10% or $20 PMPM*	*FFS payments reconciled against budget*	*Quality score affects spending benchmark (higher performance reduces standard benchmark discount)*
												Prospective capitation	
												Partial prospective capitation (e.g. for primary care)	

Population Health Management Programs information requested in **AC-4** must be uploaded using a template that will be provided.

HPC ACO Certification
Applicant Overview Template 4.2: Population Health Management Programs and Targets

	Program Characteristics				Program Goals, Metrics, and Targets					Program Evolution
Component ACO (if applicable)	Program/ Priority Area	Specific Intervention(s)	Population Targeted	Number of Patients Served	Program Goal(s) / Metric(s)	Actual Performance in Recent Measurement Period	Most Recent Measurement Period	Current Target	Measurement Period for Current	Major Programmatic Changes Made in Past Two Years Based on Data Gathered or Targets Missed (if applicable)
	"ED Frequent Flyer" Care Integration Program	*Care coordinators embedded in ED to share info with ED clinicians and assist with discharge and transfer*	*Top 2% of patients by cost or utilization*	*850*	*Reduction in emergency department visits*	*1% reduction in ED visits relative to CY2018 baseline*	*CY2019*	*5% reduction in ED visits relative to CY2018 baseline*	*CY2020*	*Have added a social worker to the care model in CY2020 to facilitate connections to non-medical services*

Behavioral Health Integration information required **AC-5** must be uploaded using a template that will be provided.

HPC ACO Certification
Applicant Overview Template 5.1 : Behavioral Health Integration Targets and Progress

Brief overview of Applicant's behavioral health integration strategy (max. 150 words)

Component ACO (if applicable)	Priority Area	Types of Support Provided by the ACO	Behavioral Health Integration Goal(s) / Metric(s)	Target for Most Recent Measurement Period	Actual Performance in Recent Measurement Period	Most Recent Measurement Period	Current Target	Measurement Period for Current Target
	Co-location	*Financial (to desgn office space) and infrastructure (shared EHR platform)*	*Proportion of sites with a behavioral health provider on-site*	*15% of primary care practice sites have a PsyD on location*	*18% of primary care practice sites have a PsyD on location*	*CY2019*	*20% of primary care practice sites have a PsyD on location*	*CY2020*
	Information-sharing across settings	*Technical assistance to install new IT system*						