Atrius Health

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January 28, 2016

Catherine Harrison
Senior Manager, Accountable Care
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Dear Ms. Harrison:

On behalf of Atrius Health, I am pleased to provide comments to the Health Policy Commission (HPC) on the proposed Accountable Care Organization (ACO) Certification Standards. We recognize and appreciate the hard work that has been done by the HPC commissioners and staff over the past year on this issue. We also agree with the HPC that ACOs represent a promising model for transforming care delivery through improvements in care coordination and integration, access to services, and accountability for quality outcomes and costs. We hope that our feedback is helpful in your deliberations about state ACO certification standards.

Atrius Health is the Northeast's largest nonprofit independent multi-specialty medical group. The Atrius Health practices—including Dedham Medical Associates, Granite Medical Group, and Harvard Vanguard Medical Associates—together with VNA Care Network Foundation serve 675,000 patients across eastern Massachusetts. A national leader in delivering high-quality, patient-centered coordinated care, the Atrius Health medical groups and home health agency and hospice work together, and in collaboration with hospital partners, community specialists and skilled nursing facilities, to develop innovative, effective and efficient ways of delivering care in the most appropriate setting, making it easier for patients to be healthy. Atrius Health is also a Medicare Pioneer ACO.

As you are aware, Atrius Health has been a leader as a premier ACO in Massachusetts as well as nationally. In 2015 Atrius Health was ranked as the highest on the Centers for Medicare & Medicaid Services (CMS) overall quality score among Pioneer Accountable Care Organizations (ACOs) in Massachusetts and has ranked third highest among Pioneers nationally based on 33 ACO quality measures tracked by CMS.

In addition, Atrius Health was the recipient of the Accountable Care Compass Award last fall by the Massachusetts Hospital Association, in recognition of provider excellence and innovation in the delivery of high-quality, safe and efficient care.

Thank you again for the opportunity to provide our feedback on this important matter. If you have any questions regarding our comments or require further information, please contact me at marci_sindell@atriushealth.org or (617) 559-8323 or Kathy Keough, Director of Government Relations at Kathy_keough@atriushealth.org or (617) 559-8561.

Sincerely,

Marci Sindell
Chief Strategy Officer and Senior Vice President, External Affairs

Atrius Health's perspectives on specific questions posed by the HPC on ACO certification criteria:

1. Do the proposed HPC ACO certification criteria address the most important requirements and capabilities ACOs should have in order to operate successfully as ACOs? Do the certification criteria offer a comprehensive set of standards appropriate for all payers? If not, what other criteria should HPC add or substitute, and why?

We appreciate that HPC is seeking through its ACO certification standards to promote continued transformation in care delivery while ensuring that certification is within reach for systems of varying sizes, organizational models (e.g., hospital-led, physician-led), infrastructure and technical capabilities, populations served, and locations. We also appreciate the need for due diligence by HPC before certifying an organization as an ACO. However, this is a voluntary program, and, as such, each potential ACO must weigh the benefits of participation with the work required to achieve certification.

As stated in more detail below, many of the documentation requirements listed in the proposed certification criteria would be difficult and, in some cases, impossible or impractical to provide. Without modifications as suggested, we believe the proposed standards may deter many providers from seeking state certification as a recognized ACO, regardless of size. We strongly recommend scaling back many of the documentation requirements, moving some domains to "reporting only" or making some questions simply an attestation that the standard has been met. We recommend some criteria be added or substituted. We would like to understand the limits, if any, on how the information provided might be used by HPC in its other capacities, such as Material Impact and various reports. Finally, we have concerns about the amount of proprietary information that might become public in a highly competitive market.

2. Are the proposed criteria appropriately assigned to either the mandatory or reporting only category?

We have made several suggestions where we believe certain mandatory criteria should be moved to the "reporting only" category, particularly in the initial ACO certification period.

3. What is the operational and financial feasibility of implementation for these standards? Specifically, are these criteria feasible for ACOs of varying size, experience, resources, and other salient factors?

As proposed, the standards would take many weeks of work by multiple functional areas across an organization of our size. Atrius Health has not sought NCQA certification as an ACO because of the expense of meeting their requirements. Also see response to question 1.

4. To what degree would ACOs be able to submit existing documents and materials to the HPC, rather than create new documentation, to fulfill the proposed documentation requirements? Do the documentation requirements identifying existing, internal documents add to or reduce the administrative burden of applying for ACO certification?

We can only speak for Atrius Health, however a substantial number of the requirements (both mandatory and reporting only) would require the creation of new documentation to be produced in order to apply for ACO certification. In addition, many of the requirements would require a significant amount of writing and preparation by multiple individuals. We would characterize the administrative burden of applying for ACO certification (at least under the existing proposal) as considerable given that ACO certification is a voluntary program that does not provide a direct mechanism for recouping this investment.

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

No. Given the number of other reporting requirements that providers must produce for various state entities as part of the Chapter 224 in addition to the PCMH documentation for NCQA and the Commonwealth, we request that ACO re-certification occur no more than every two years, with some information required only on the first application and not in subsequent years. More frequently would be a deterrent for providers seeking this voluntary ACO certification status.

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

Based on our experience in the Pioneer ACO, we suggest learning collaborative webinars be held approximately every two months, with good facilitation and participation by ACOs who have demonstrated success. Although in-person meetings are always preferable, realistically these are difficult to schedule and attend, unless meetings are scheduled months in advance and are less frequent. We suggest only one to two in-person meetings per year.

Note that we have other learning collaboratives in which we participate, through the Pioneer ACO model, Group Practice Improvement Network, and American Medical Group Association. A number of other healthcare organizations belong to The Advisory Group and similar consulting forums about ACOs. These national collaboratives provide a broader range of innovation and best practices and sharing with healthcare organizations with which we do not compete for patients and clinicians.

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

No. This would be a clear deterrent to participation in this voluntary program.

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

As noted above, application materials should not be in the public domain. In addition, it should be clear in the certification criteria that ACOs do not have to own all of the services that have been outlined, but rather demonstrate capacity to work with available alternative community resources to provide services to the populations it serves.

Atrius Health's comments on specific proposed HPC ACO certification criteria:

Mandatory Criteria					
Domain	**#**	**Criterion**	**Documentation Requirements**	**Questions for Public Comment**	**Provider Comments**
Legal and governance structures Note: "governance structure" refers to the ACO board and supporting committees.	**1.**	The ACO operates as a **separate legal entity** whose governing members have a fiduciary duty to the ACO, *except* if ACO participants are part of the same health care system.	- Evidence of legal status.		We are assuming than an entity like Atrius Health would be considered a "health system" for this purpose and that our network of preferred hospitals and SNFs would not be required to be "ACO participants' under our governing board for us to participate.
	2.	The ACO provides information about its **participating providers** to HPC, **by Tax Identification Number (TIN)**, for each of the three payer categories (Medicare, MassHealth, commercial).* **To the extent possible, this will be done in coordination with RPO process.*	- List of ACO's participating providers (TINs). - Narrative of why an ACO's participating providers may differ by Medicaid, Medicare or commercial contracts.	At what organizational level would ACOs apply for ACO certification?	ACO's should apply at the level at which risk-based contracts are held (i.e. the same entity applying for RBPO). The documentation requirements potentially impose a burdensome level of detail for ACO applicants to create separate lists of providers by payer categories. While in some cases the differences are a function of the contracting structure, in others it is different because pediatricians do not serve Medicare patients and similar reasons. TINs will show up in multiple ACOs and information will be outdated quickly. The HPC should utilize existing data from the RPO submission and/or request a description of the providers (e.g. all providers in XYZ practice located at…)
	3.	The ACO governance structure includes a **patient or consumer representative.** The ACO has a process for ensuring patient representative(s) can meaningfully participate in the ACO	Written description of where/how the patient or consumer representative role appears within the governance structure,	Describe and give examples of meaningful participation. What evidence should the	The HPC should require that an ACO simply attest that there is a patient or consumer member on the Board and provide the name of that Board member, rather than requiring the documentation

		governance structure.	and how an individual is identified or selected to serve. - Written description of the specific strategies ACO deploys to ensure patient/consumer's meaningful participation. Such strategies may include providing: practical supports (e.g. transportation to meetings, translation of materials); formal or informal training or personal assistance in subject matter and/or skills; a code of conduct for meetings or other governance structure operations that emphasizes an inclusive, respectful approach; or other.	HPC seek to assess meaningful participation?	outlined in the requirements noted in the draft certification standards. That is what we do for Pioneer ACO requirements. It does not seem meaningful to describe strategies for participation if the patient or consumer rep is on the ACO Board.
	4.	The ACO governance structure provides for **meaningful participation of primary care, addiction, mental health (including outpatient), and specialist providers**.	- Written description of official governance structure including the board and committees with members' names, professional degrees (e.g., MD, RN, LCSW, LMHC), titles, and organizations. - Written description of how different provider types are represented in the governance structure of the ACO (i.e. in	What evidence should the HPC seek to evaluate meaningful participation?	The HPC should not be as prescriptive as to how each of the specialists noted must participate in the ACO governance structure, especially when there has been no data or validation of this proposed structure to show that it improves the operation of the ACO. Board governance should be designed to meet the overall needs of the organization, which are many. Not every ACO may have or find the need for primary care providers, addition, mental health and specialist providers to be part of its formal governance structure, but instead may find that meaningful participation can be achieved through

			number, via voting rights, or other), and specific ways ACO ensures meaningful participation of different provider types.		regular reporting to the Board, or some other consultation role to the Board. For example, Atrius Health has a Clinical Advisory Council which serves as a great sounding board for our management and Board of Trustees. . The HPC should move this domain to "reporting only" instead of "mandatory" during the initial certification period to gather additional data about how each ACO is structured. It is difficult to envision that most organizations will do a major restructuring of their Boards in order to meet the requirements for a voluntary program given the financial and political costs of such restructuring.
	5.	The ACO has a **Patient & Family Advisory Council (PFAC) or similar** committee(s) that gathers the perspectives of patients and families on operations of the ACO that regularly informs the ACO board.	- Written description or charter for the PFAC, or similar group of patients, that provides input into ACO operations, or plans to establish such a council, including reporting relationship to ACO board. - Minutes from the most recent PFAC meeting. Note: if an entity within the ACO (e.g. hospital) currently operates a PFAC, the same PFAC could be used to fulfill this criterion so long as the PFAC's scope will be expanded to address ACO-wide issues.		Providers like Atrius Health that cover wide geographic areas should be permitted to have multiple PFAC's or other similar groups to fulfill this requirement. In the past, Atrius Health attempted to create a single PFAC for our Pioneer ACO and our experience was that patients were unwilling to travel to a central location for such a meeting. A description of how the requirement to gather information and update the Board is being met should be sufficient. Submission of minutes should not be required. These may contain sensitive, confidential information and should not be made publicly available.

			ACOs would also need to demonstrate that the PFAC is representative of the whole patient population that the ACO serves.		
	6.	The ACO has a **quality committee** reporting directly to the ACO board, which regularly reviews and sets goals to **improve on clinical quality/health outcomes (including behavioral health), patient/family experience measures, and disparities** for different types of providers within the entity (PCPs, specialists, hospitals, post-acute care, etc.).	- Charter or documentation of the quality committee's charge, members including titles and organizations, meeting frequency, and reporting relationship to ACO board. - Minutes from the most recent quality committee meeting.		A charter, reporting relationship and meeting frequency should be sufficient. Submission of minutes should not be required as they may contain confidential information.
Risk stratification and population specific interventions	**7.**	The ACO has **approaches for risk stratification** of its patient population based on criteria including, at minimum: - Behavioral health conditions - High cost/high utilization - Number and type of chronic conditions - Social determinants of health (SDH) The approach also *may* include: - Functional status, activities of daily living (ADLs), instrumental activities of daily living (IADLs) - Health literacy	- Written description of the risk stratification methodology(ies), including data types and sources, time of data, frequency of updating and criteria used. - If the ACO uses socioeconomic or other demographic information to address social determinants of health outside of risk stratification, a written description of methodology and how data are collected.		We suggest changing "at minimum" to "such as" in the criterion. We would recommend the HPC consider further defining these particular criteria to provide guidance as it relates to social SDH. There are currently no standards that we are aware of with respect to risk stratification of social determinants of health (SDH). We recommend the HPC consider moving this standard to "reporting only" in order to evaluate what is currently being done and make this one area where a technical assistance/learning collaborative focuses their attention.
	8.	Using data from health assessments and	- Written description of	Should the HPC be	ACOs should select the program that best

		risk stratification or other patient information**, the ACO implements one or more programs** targeted at **improving health outcomes for its patient population. At least one of these programs addresses mental health, addiction, and/or social determinants of health.**	qualifying programs, including how participating patients are identified or selected, what the intervention is, the targets/performance metrics by which the ACO will monitor/assess the program, and how many patients the ACO projects to reach with each program. Note: To qualify, a program must address a documented need for the ACO patient population; must have clear measures/outcomes-based approach; and must include/reflect community resources and partnerships as appropriate. A program of any size may fulfill this criterion.	more prescriptive with this requirement (i.e., require more than one program)?	represents their population or for which they have measurable results, and only be required to describe one program. The HPC should not be more prescriptive with this requirement, nor should it dictate that behavioral health or social determinants of health necessarily be one of the programs described as there may be instances where there are other programs or initiatives that will better improve the health of the patients served by the ACO. This is an example of where an ACO would have to generate documentation that does not currently exist.
Cross continuum network: access to BH & LTSS providers	**9.**	ACO **demonstrates and assesses effectiveness of ongoing collaborations** with and referrals to: - Hospitals - Specialists - Post-acute care providers (i.e., SNFs, LTACs) - Behavioral health providers (both mental health and substance use disorders) - Long-term services and supports (LTSS) providers (i.e., home health,	- Names of organizations and narrative or other evidence of how ACO collaborates with each provider type listed here. - Description of how ACO assesses and improves collaborative relationships with each provider type, including documents indicating	What evidence should the HPC seek to evaluate whether ACOs assess the effectiveness of the collaborations? This should be moved to the reporting only category.	The criteria requiring that ACO's demonstrate and assess effectiveness of collaboration with all of the groups listed (particularly LTSS) is not reasonable and is too prescriptive. The amount of documentation required in the draft criteria for all of the entities would be overly burdensome for applicants. We recommend the HPC modify this requirement to a simple attestation that the ACO have a process to access the effectiveness of ongoing collaborations for which it refers and a list of its "preferred

		adult day health, PCA, etc.) - Community/social service organizations (i.e., food pantry, transportation, shelters, schools, etc.)	processes used by the ACO to assess the effectiveness of ongoing collaborations, such as: - Minutes from one Board or committee meeting documenting discussion of results of assessment with different provider types - Summary report on effectiveness of collaboration (e.g., % of providers that refer to collaborative partners) Note: In evaluating the ACO's collaborations and assessments, the HPC will consider whether the ACO's submitted documents show that it sets targets or goals regarding such factors as: - Access - Appropriate breadth of services - Follow-up and reporting - Communication and/or data-exchange capabilities - Quality, cost, and patient experience scores - Extent to which collaborative partners are integrated into other areas of ACO, APMs,		providers". Alternatively, the HPC should move this domain to "reporting only" to allow time for the HPC to gather additional information on what ACO's in the state are doing .Note: For LTSS and other community providers we may access those services through a health plan or intermediary entity (such as an ASAP); we can assess the effectiveness of collaboration with that intermediary entity, but not with the individual providers themselves. The Board does not get involved in ongoing assessment of collaborative partners; that is management's job. Therefore, the HPC should not require applicants to submit minutes from board or committee meetings documenting discussion of results of assessment with different provider types. Furthermore, any meeting minutes regarding the value of our partnerships would include proprietary information. The amount of documentation under consideration for this criterion would likely deter most of those ACO's considering state certification.

			etc.		
	10.	As appropriate for its patient population, the **ACO has capacity or agreements with mental health providers, addiction specialists, and LTSS providers**. Agreements should reflect a categorized approach for services by severity of patient needs. These agreements should also include provisions for access and data sharing as permitted within current laws and regulations.	- Exemplar contract(s), memorandum(s) of understanding, or agreement(s) setting out terms of relationships between ACO and required provider types, including specific standards for access and requirements for clinical data sharing.		The HPC should only require that ACO applicants attest that it has relationships with appropriate provider types to meet the needs of its patients, rather than actually submitting written agreements, as there may be many instances where there are not actual written agreements. For example, for LTSS providers we do not have direct agreements; we may have relationships (with or without a formal agreement) with health plans or ASAPs who hold those agreements. In addition, it is expensive to enter into so many written agreements since they need to be reviewed on both sides by attorneys.
Participation in MassHealth APMs	**11.**	The ACO participates in a **budget-based contract for Medicaid patients by the end of Certification Year 2 (2017)**.* *Budget-based contracts are those that require a provider to accept a population-based contract centered on either a spending target (shared savings only) or a global budget (including down-side risk).	- Written commitment.	Would a relative threshold be more meaningful? That is, measure ACOs' increase in rates of budget-based contracts year over year? Should a relative threshold be different for larger and smaller ACOs?	The HPC should clarify that providers that have risk-based contracts with any of the MCOs meet this requirement. It is unclear from the proposed criteria whether we would meet this standard if we have a budget-based contract for Medicaid with Commonwealth Care Alliance and/or Neighborhood Health Plan. ACO applicants should not have a relative threshold. It would be fine to measure participation year over year.
PCMH adoption rate	**12.**	The ACO reports to HPC on **NCQA and HPC PCMH recognition rates and levels** (e.g., II, III) of its participating primary care providers. The ACO describes its plan to **increase**	- Statement (or other documentation) outlining current PCMH recognition rates. - Narrative explaining	How should the HPC best align its PCMH PRIME certification and ACO certification	Ideally this requirement should not duplicate HPC PCMH requirements and not require duplicate documentation and should parallel the same time period for PCMH requirements.

		these rates, particularly for assisting practices in fulfilling HPC's PCMH PRIME Criteria.	plan for increasing rates, including HPC PCMH PRIME certification application/achievement.	programs?	
Analytic capacity	**13.**	ACO regularly **performs cost, utilization and quality analyses**, including regular trending and forecasting of performance against budget and quality measure targets, and works with practices and providers within the ACO to meet goals and targets. Analysis could be completed by a vendor or in-house. **ACO disseminates reports** to providers, in aggregate and at the practice level, and **makes practice-level results** on quality performance **available to all participating providers** within the ACO.	- Blinded sample cost, utilization, and quality report(s). - Written description or screenshot of how practice-level reports are made transparent and disseminated to providers/practices. - Documentation showing that the analysis is reviewed with providers, and how ACO uses reports to engage providers and practices in setting cost and quality improvement targets. Note: Payer cost and utilization reports would fulfill this requirement, as long as they are disseminated down to the provider level.	Is this a feasible requirement for smaller ACOs?	The HPC should only require a short narrative describing how the ACO conducts cost, utilization and quality analysis. It would be overly burdensome for the HPC to require that ACO applicants submit screenshots and other documentation including how ACOs interact with providers or payers in setting cost and quality improvement targets described in the documentation requirements. Some information may be also be proprietary in nature and should not be in the public domain. Some of the reports belong to the EMR vendor.
Patient and family experience	**14.**	The ACO conducts an annual **survey** (using any evidence-based instrument) or uses the results from an accepted statewide survey to **evaluate patient and family experiences** on access, communication, coordination, whole person care/self-management support, and deploys plans to improve on those results.	- Description of methods used to assess patient satisfaction/experience. - Description of how ACO identifies areas needing improvement and plans to address those areas.		The HPC should ensure that survey instruments such as Press Ganey or Clinician and Group Consumer Assessment of Healthcare Providers and Systems (**CGCAHPS**) questions, as currently employed by the ACO, are acceptable methods for fulfilling these criteria. In addition, the HPC should remove the language "whole person care/self-management support" from the

					required criteria.
Community health	**15.**	ACO describes steps it is taking to advance or invest in the **population health** of one or more communities where it has at least 100 enrollees through a **collaborative, integrative, multi-organization approach** that acknowledges and accounts for the **social determinants of health**.	- Written description of plan to advance population health, along with identification of potential community partners.		Providers/ACOs have limited resources and should only be required to invest in the health of their own patients rather than the community as a whole. We would recommend deletion of the language after the words "population health." Alternatively HPC should move this to "reporting only."

Market and Patient Protection				
Domain		**Criterion**	**Documentation Requirements**	**Provider Comments**
Risk-bearing provider organizations (RBPO)	**16.**	If applicable, the ACO obtains a **risk-based provider organization (RBPO)** certificate or waiver from **DOI**.	- Attestation	Acceptable as written
Material Change Notices (MCNs) filing attestation	**17.**	ACO attests to filing all relevant **material change notices (MCNs)** with **HPC**.	- Attestation	Acceptable as written.
Anti-trust laws	**18.**	ACO attests to compliance with all **federal and state antitrust laws and regulations**.	- Attestation	Acceptable as written.
Patient Protection	**19.**	ACO attests to compliance with HPC's **Office of Patient Protection (OPP)** guidance regarding a **process to review and address patient grievances** and provide notice to patients.	- Description of patient appeals process and sample notice to patients.	The HPC should only require an attestation that it has complied with OPP guidance regarding patient grievances rather than asking for additional documentation.
Quality and financial performance reporting	**20.**	ACO will **report ACO-level performance** on a quality measure set associated with each contract and shared savings / losses for any commercial and public risk contracts for the previous contract year (2015).	- Plan-specific reports of ACO performance on contract-associated quality measures and overall financial shared savings or losses for calendar year 2015.	For some providers such as Atrius Health is not possible to report savings and losses in this way. We would be willing to discuss this in more detail with HPC staff.
Consumer Price Transparency	**21.**	ACO attests that it has taken steps to ensure that providers participating in the ACO have the ability to provide patients with relevant price information and are complying with **consumer price transparency** requirements pursuant to M.G.L. c. 111, § 228(a)-(b).	- Attestation	Acceptable as written.

Reporting Only Criteria					
Domain		**Criterion**	**Documentation Requirements**	**Questions for Public Comment**	**Provider Comments**
Palliative care	**22.**	The ACO provides **palliative care and end-of-life planning**, including: – integrated and coordinated care across network, especially with hospice providers; – training of providers to engage patients in conversations around palliative care to identify patient needs and preferences; and – EHR indication of such decisions	- Written description of how ACO coordinates with and assesses appropriateness of hospice and end-of-life (EOL) planning programs/materials. - Examples of training programs.		Description is fine; training programs are proprietary and should not be required.
Care coordination	**23.**	The ACO has a process to **track tests and referrals across specialty and facility-based care both within and outside of the ACO**.	- ACO policies and procedures or comparable documents describing protocols for tracking tests and referrals as described in the criterion.		Requiring that ACOs track tests and referrals outside of the ACO network is not feasible, given the lag in time of data provided by the payers and should not be a requirement.
	24.	The ACO demonstrates a process for identifying **preferred providers**, with specific emphasis to increase use of providers in the patient's community, as appropriate, specifically for: – oncology – orthopedics – pediatrics – obstetrics	- Written description of ACO's process for identifying preferred providers, including relevant quality and financial analyses. - Documentation of provider communication related to encouraging use of identified providers		We recommend the HPC only require that ACO applicants provide a written description of its processes for identifying and referring patients to preferred providers. It should be noted that patients have open access to obstetrics, where no referral is required; therefore this requirement should be removed altogether. We recommend deletion of the requirement that ACO applicants provide

					documentation of provider communication related to encouraging use of identified providers.
	25.	The ACO has a process for **regular review of patient medication** lists for **reconciliation** and **optimization** in partnership with patients' PCPs.	- ACO policies and procedures or comparable documentation for medication reconciliation and optimization, including how ACO works with individual providers.		The HPC should only require that ACO applicants provide a general description of how it reviews patient medication lists and optimizes partnerships with patient's PCP's rather than the level of detail proposed in the documentation requirements.
	26.	The ACO assesses current capacity to, and develops and implements a **plan of 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); and – setting up protocols to determine how event notifications should lead to changes in clinical interventions	- Written description of current system(s) for direct messaging, sharing of clinical summary documents and lab orders/results, e-prescribing, and other exchange of clinical information between ACO providers, including ability to securely exchange clinical information between providers with different EHRs or no EHR, and by care setting; and capabilities for sharing within and outside ACO.		No comment
Peer support	**27.**	The ACO provides patients and family members access to **peer support programs**, particularly to assist patients with chronic conditions, complex care	- Written description of how the ACO provides peers or links patients and		Applicants should only be required to attest that they provide access to peer

		needs, and behavioral health needs. The ACO also provides training to peers as needed to support them in performing their role effectively.	families to existing community-based peer support programs. - ACO training materials or plans to provide training as needed.		support programs for its patients. The required documentation as proposed would be an administrative burden to applicants. In addition, ACOs should not be required to provide copies of training materials that may include proprietary information in some cases.
Adherence to evidence-based guidelines	**28.**	The ACO monitors **adherence to evidence-based guidelines** and identifies areas where improved adherence is recommended or required. The ACO develops initiatives to support improvements in rates of adherence.	- Written description of methods and/or processes used by the ACO to monitor use of evidence-based guidelines, including: - Specific conditions and methodologies for assessing variation between ACO providers - How the ACO selects areas for improvement in variation if found - Written description of initiatives or plans for initiatives to improve adherence rates.		The HPC should only require a brief description from ACO applicants of what evidence-based guidelines it utilizes, rather than the level of detail proposed by the HPC
APM adoption for primary care	**29.**	The ACO reports the **percentage of its primary care revenue *or* patients that are covered under budget-based contracts.*** **Budget-based contracts are those that require a provider to accept a population-based contract centered on either a spending target (shared savings only) or a global budget (including down-side risk).*	- Report or statement providing percentage, including data, assumptions, methods, and calculations. - Percentage reported for commercial, Medicare and Medicaid separately and in	Are there data collection or other challenges ACOs would face in reporting on this information? Are there other methods of assessing uptake of	This information is already submitted to the Division of Insurance as part of the Risk Bearing Provider Organization (RBPO) certification process and therefore is duplicative and should be removed from the

			aggregate. - Description of barriers faced in accepting higher volume of risk-based contracts.	budget-based contracts that HPC should consider?	certification standard requirements.
Flow of payment to providers	**30.**	The ACO **distributes funds** among participating providers using a methodology and process that are **transparent** to all participating providers. Documentation must include both a description of the methodology and a demonstration of communication to all participating providers.	- ACO participation agreements with providers describing how participating providers are compensated, highlighting if and how the method includes consideration of quality, cost, and patient satisfaction metrics. - Written description or example communication of how the ACO does or does not currently make funds flow methods transparent to all participating providers.		Not all ACOs distribute funds in the way that is contemplated by the HPC's criteria. In some cases, where physicians are employed, no ACO participation agreements are required, management can reset compensation, and funds are reinvested back into the organization. For some ACOs however, the level of detail that may be required to submit could potentially be anti-competitive in nature.
ACO population demographics and preferences	**31.**	The ACO assesses the **needs and preferences** of its patient population with regard to **race, ethnicity, gender identity, sexual preference, language, culture, literacy, social needs (food, transportation, housing, etc.) and other characteristics** 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).	- Description of how the ACO assesses its patient population characteristics. - Description of any training or materials used to train practitioners and staff on meeting these needs. - Description of method for identifying gaps in need and capacity, including plans for addressing such gaps.		We recommend the ACO applicant simply attest that it assesses the needs and preferences of its patient population rather than provide the level of detail outlined in the HPC's proposed certification criteria. Patients are not always interested in reporting overly intrusive information such as described. In addition, it would be overly burdensome for ACO's to provide this level of

					detail.
EHR inter operability commitment	**32.**	ACO **identifies Meaningful Use-certified electronic health record (EHR) adoption** and integration rates within the ACO by provider type/geographic region; **and develops and implements a plan to increase adoption and integration** rates of certified EHRs.	- ACO operational plans for assessing EHR adoption status by provider type (e.g. primary care, behavioral health, and specialty providers) and implementing improvement plans, including timelines		Not sure what is meant by "operational plans". ACO should just report its adoption rates or HPC should set a threshold.
	33.	ACO identifies current **connection rates to the Mass HIway** and has a plan to improve rates over next year.	- ACO operational plans for assessing connectivity to Mass HIway and implementing improvement plans, including timelines.	What challenges would need to be overcome in order for ACOs to connect to and effectively use the HIway?	The biggest challenges faced by providers, including current and prospective ACO's, in improving the current connection rates to the Mass HIway is the current requirement that patients must "opt in" to sharing this information. We strongly encourage that HPC advocate for changes in this requirement to instead give patients the ability to "opt out" of sharing their information via the Mass HIway to increase use of this valuable tool.