Beacon Health Options' Response to the Commonwealth of Massachusetts' Health Policy Commission's Proposed Accountable Care Organization Certification Standards Request for Public Comment

January 29, 2016

INTRODUCTION

Thank you for the opportunity to provide our perspective on the Commonwealth of Massachusetts Health Policy Commission's (HPC) certification standards for Accountable Care Organizations (ACOs). Based on our extensive experience in Massachusetts, including four MassHealth managed care organizations, the Primary Care Clinician Plan, and the Group Insurance Commission, as well as across the country and in the UK, Beacon Health Options (Beacon) bears much expertise in achieving successful outcomes on behalf of approximately 1.5 million members across the Commonwealth.

Behavioral health is an important, yet often overlooked component to integrated care delivery. Despite clear evidence that individuals with medical and behavioral health issues have a high prevalence of co-morbidities, more thought can be given to the role that behavioral health plays in an ACO model and how it can contribute to better outcomes and lower costs. The overall cost of care is disproportionately weighted to medical expense. This imbalance is a result of individuals with treated psychiatric or substance use disorders typically costing two to three times more than those without a behavioral health condition, on average across all market segments. Financial incentives and reimbursement models must be organized in a different way to address total medical expense.

Additionally, individuals with serious mental illness (SMI) are among the most vulnerable members of our society, displaying dramatically reduced lifespans compared to the population norm. Untreated SMI conditions have a pronounced impact on a person's executive functioning and self-care ability. This impact often results in several related health deficits. Appropriate treatment resources and supports have far too often remained unavailable, inaccessible, or disorganized. States and local communities have paid a tremendous price for this situation. The unintended consequences include criminal justice recidivism, increased rates of homelessness, unemployment, and higher use of avoidable emergency room and hospital admissions, or in the worst case, tragic community events.

In order to achieve the results the HPC has outlined in the Proposed ACO certification standards, we recommend HPC be extremely prescriptive in their requirements. For example, we suggest:

- Requiring person-centered care that complements coordination across medical and behavioral health, including care coordination among primary care physicians (PCPs), behavioral health specialists, and other community supports
- Increasing access to wraparound supports (e.g., supported employment, housing, peer supports)
- Requiring evidence-based practices be used and documented
- Supporting changes through value-based payment approaches that allow for shared savings across total medical expenditures

Additionally, we believe enhanced collaboration and data sharing are essential to improving overall outcomes and coordinating for individuals with a behavioral health condition. Therefore, we strongly advocate against over-reaching privacy rules that inhibit providers from sharing information about mental health and substance use disorders. We also encourage ACOs to require the use of a universal data release form among providers to encourage the transfer of information in a more efficient and expeditious manner.

Finally, access to care must be clearly defined. Real access to care is not just about geography and number of providers. It is about ensuring individuals receive the right care, at the right time, in the right setting by quality providers. According to Mental Health America, only one out of five adults with mental illness reported they did not get the mental health services they felt they needed.[1].

[1] "Parity or Disparity: The State of Mental Health in America 2015". Mental Health America, 2015.

Additionally, if an individual waits one day to receive an outpatient behavioral health appointment, the no show rate increases by 25% and an additional 1% every day thereafter[2]. Without proper access to care, individuals are more likely to access services via the emergency room and potentially be admitted or re-admitted to a hospital—all of which could reasonably be avoided.

Therefore, we suggest incorporating the use of advanced technology and innovative pilot programs as one way to facilitate quicker access. Some examples include, but are not limited to:

- Exploring telehealth options, which enables providers and individuals to connect face-to-face online at any time, from anywhere
- Expanding programs like the Massachusetts Child Psychiatry Access Line (MCPAP) and Connecticut's ACCESS Mental Health to provide PCPs with psychiatric consultation and enable individuals to receive behavioral health services in a primary care setting
- Implementing value-based payments (e.g., capitation, episode-of-care payments, pay-for-performance) to incentivize greater access to care

In our response to Question #1 below, we apply our views to the specific criteria provided in the proposed standards, as well as provide our perspective on other criteria where behavioral health is affected. Additionally, we have captured our comments and answers to Questions #2-8 in a section at the end of our response.

[2] Gallucci et al, 2005. Impact of the Wait for an Appointment on the Rate of Kept Appointments at a Mental Health Center.

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?

Domain	#	Criterion	Beacon Comments
Legal Governance	4	The ACO governance structure provides for **meaningful participation of primary care, addiction, mental health (including outpatient), and specialist providers.**	Mental health participation **cannot just be empty talk—it has to involve true, meaningful participation from stakeholders across the behavioral health continuum of care**. This should include modes of participation such as voting rights, leadership, etc. Specifically, we advocate for at least one Community Mental Health Clinic or substance use disorder provider to be included at the Board level with voting rights.
Legal Governance	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…**	Beacon applauds the HPC for explicitly requiring behavioral health outcomes to be tracked by an ACO quality committee. We propose going one step further to **ensure that the HPC is measuring the most important behavioral health outcomes.** These **behavioral health outcomes should not only be those related to mental health expenditures**. The absence of commonly agreed upon metrics for behavioral health outcomes has resulted in de facto focus on spending rather than on care value. We propose that ACO outcomes measurements use ICHOM outcomes definitions such as the PHQ-9 Patient Health Questionnaire. In addition, Beacon advocates for tracking the following measures: • Annual well visit, PCP • Housing status • Social network status • Employment status • Evidence of behavioral health/ primary care collaboration
Risk Stratification	7	The ACO has **approaches for risk stratification** of its patient population based on criteria including, at a minimum: • Behavioral health conditions	One of the major contributors to sub-optimal performance of risk adjustment and other predictive models is that behavioral health conditions are often not included. **Therefore, Beacon fully agrees with mandating the use of behavioral health conditions in risk**

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		• High cost/high utilization • Number and type of chronic conditions	**stratification methodologies**. Further, the data collected can help inform a statewide separate rate cell for the SMI population. This would allow providers to organize around an expensive, needy population and support them with the appropriate resources.
Risk Stratification	8	Using data from health assessments and 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.** **ACO annually evaluates the population health programs** in terms of patient experience, quality outcomes, and financial performance	We agree that pilot programs should be a major component of testing and validating innovative ideas. Included as part of the HPC's requirements should be criteria to ensure programs are clinically sound, evidence-based, and measured, incorporating best practices to improve behavioral health outcomes. Using member self-reported questionnaires is one way to accomplish this. This type of measurement allows us to target where treatment is or is not working along the continuum of care, whether it be social, behavioral, or physical. It also enhances the member's engagement in treatment, thus resulting in improved member experience and outcomes. Additionally, since scalability is a significant challenge in these programs, HPC should require the ACOs to submit a plan for growth if successful.
Continuum Network	9	ACO **demonstrates and assesses the effectiveness of ongoing collaborations** with and referrals to: • Hospitals • Specialists • Post-acute care • Behavioral health providers • Long-term services and supports • Community/social service organizations	Beacon recommends tracking important measures such as **percent of co-location, percent of members getting a behavioral health assessment, and member surveys**. Besides these measures, across Massachusetts and nationally, previous efforts to document integration and collaboration have fallen short for providers, individuals, and communities. True collaboration is not just about relationships and agreements—**it is about true access to care**. This means individuals receive the care they need, at the right time, in the right setting, by quality providers. Therefore, we propose working with the HPC to help make ACOs accountable to measurements of true access, as well as encourage shared access to member information.

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Cross Continuum Network	10	As appropriate for its patient population, **the ACO has capacity or agreements with mental health providers, addiction specialists, and LTSS providers**…these agreements should also include provisions for access and data sharing as permitted within current laws and regulations.	As stated above, collaboration is more than just having agreements in place. It is about ensuring that all members of an individual's care team have access to the information they need to make the best clinical decisions possible and improve overall outcomes. Data privacy legislation stands to limit the exchange of information unless ACOs take active approaches to facilitate communication. We encourage the HPC to require the use of a universal data release form among providers to encourage the transfer of information among providers in a more efficient and expeditious manner.
MassHealth APMs	11	The ACO participates in a **budget-based contract for Medicaid patients by the end of Certification Year 2 (2017).***	Beacon welcomes the change to align payments to value. We believe that the HPC should specify the role of managed care entities in these budget-based contracts, given their experience bearing financial risk. We also agree that there should be different targets for larger vs. smaller ACOs. For example, **the HPC may set targets that APMs account for 50% of ACO total claims expense**, with lower benchmarks for ACOs with <5,000 patients (related to their decreased ability to bear risk).
PCMBH 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.	Beacon does not object to requiring reporting on PCMH recognition rates and levels. However, we believe that implementing PCMHs alone does not achieve true integration. We understand that HPC PCMH PRIME rewards co-location, screening, and comprehensive health assessments that include screening for behavioral health disorders[3]; however, integration requires much more. Leveraging the work of Dr. Jürgen Unützer, an internationally recognized psychiatrist and health services researcher, and his colleagues at the AIMS Center, University of Washington, we embrace and have incorporated the Collaborative Care Model for Integration into our clinical philosophy. In his study,

[3] http://www.mass.gov/anf/docs/hpc/cdpsr/20150911-committee-meeting-presentation-.pdf

Domain	#	Criterion	Beacon Comments
			collaborative care requires five components to produce the intended effect of better health outcomes: 1. Patient-Centered Team Care/ Collaborative Care 2. Population-Based Care 3. Measurement-Based Care 4. Evidence-Based Care 5. Accountable Care A more detailed description of these five components is included as part of Beacon's White Paper on Integration provided as **Appendix 1** to our response.
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**.	**Beacon agrees that the ACO should be required to provide evidence that it is investing in population health**. We believe that technology-based survey tools to track member-reported information and outcomes can help uncover evidence-based insights (e.g., tracking patient progress, optimize treatment, manage behavioral health outcomes). We suggest HPC require that ACOs conduct frequent member surveys to establish evidence reflective of the total population.
Risk-Bearing Provider Organizations (RBPO)	16	If applicable, the ACO obtains a risk-based provider organization (RBPO) certification or waiver from DOI.	**We recommend HPC not allow waivers to be granted for risk-bearing entities.** The ACOs should be responsible for funding and posting any required reserves, such as risk-based capital. Without these reserves, the insurance system may be compromised with members, providers, and the Commonwealth placed at risk.
Care Coordination	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	The ACOs should also develop a list of **preferred providers for mental health and substance use disorders**. Community-based care has been proven effective for behavioral health outcomes. We advocate for enhancing the community tenure of members by requiring ACOs to preferentially refer to Community Mental Health Centers or similar community-based providers over the use of hospitals where appropriate.
Care Coordination	26	The ACO assesses current capacity to, and develops	As a care system, we must encourage proper exchange of information among providers and **not allow the laws**

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		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 • Setting up **protocols** to determine how event notifications should lead to changes in clinical interventions	**intended to protect patient privacy become an obstacle to effective care**. We support the creation of disease registries to allow providers to make educated, real-time decisions about patient care. This will require a high level of technical competency, and should be achieved through partnerships with payers and other organizations.
Peer Support	27	The ACO provides patients and family members access to **peer support programs**, particularly to assist patients with chronic conditions, complex care needs, and behavioral health needs. The ACO also provides training to peers as needed to support them in performing their role effectively.	We fully **embrace and support the use of peers as a key element in an individual's recovery**. However, the use of peers cannot be superficial—it requires appropriate training, clinical support, and supervision to be truly effective. Therefore, we recommend the HPC add specific and detailed peer support requirements for ACOs.
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.	We fully support this criteria as it raises the bar for evidence-based mental health care. We also support evidence-based care as measured specifically by the HEDIS behavioral health measures that focus on integration, such as: • Antidepressant Medication Management - AMM • Metabolic Monitoring for Children and Adolescents on Antipsychotics - APM • Follow-up Care for Children Prescribed ADHD Medication - ADD • Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who are Using Antipsychotic Medications - SSD • Diabetes Monitoring for People with Diabetes and Schizophrenia - SMD • Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia - SMC

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			• Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics - APP • Initiation and Engagement of Alcohol and Other Drug Dependence Treatment - IET • Utilization of the PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults – DMS We also fully support the U.S. Preventive Services Task Force (USPSTF) in their recommendation to screen for depression in the general adult population, including pregnant and postpartum women[4]. This screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.

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

We believe that multiple "reporting only" criteria should be assigned to the mandatory category. These include:

1. **Criterion 23 – Care Coordination and Referral Tracking** – We know that because of the stigma and access issues associated with behavioral health, referrals represent a point in the care process where individuals commonly fall through the cracks. Our data suggests that the longer a referral takes, the less likely an individual is to show up for his or her appointment, and even waiting a single day contributes to a 25% no-show rate.

   We recommend that ACOs not only be required to track referrals, but also be required to document efforts to improve referral efficiency, such as the use of "warm hand-offs" and open access scheduling.

   The purpose of the "warm hand-off" is to establish an initial face-to-face contact between the individual and the behavioral counselor. Also, the handoff confers the trust and rapport the individual has developed with the provider to the behavioral counselor. Many clinicians report that this face-to-face introduction helps ensure that the next appointment will be kept.[5]

   Open access scheduling is a block of time that providers set aside for appointments made within 24 hours. It can be intake, routine, or urgent outpatient appointments. Beacon believes there is an opportunity to provide incentives to providers to adopt open access scheduling such as enhanced rates and guaranteed time blocks. Also, to help with adopting these changes, payers

[4] http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/depression-in-adults-screening1
[5] California Mental Health Services Authority, "How does integrated behavioral health care work?", 2016. http://www.ibhp.org/?section=pages&cid=122

may consider employing a practice transformation vendor that can redesign operations to support open access scheduling.

2. **Criterion 25 – Care Coordination and Medication Review** – We believe that there should be a mandatory metric tied to care coordination and medication reviews. For example, the ACO could be required to share statistics about how often the psychiatrist reviews medical medication before prescribing to a patient.

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 described in Criteria #11, requirements around APMs should be scaled according to ACO size.

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?

No comment.

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?

Anticipating the complexity of setting up an ACO and the significant effort required to stand up the new processes required for it to function properly, we believe the HPC should be closely involved with all of the ACOs in the first five years. This involvement could include the provision of technical assistance and interpretive guidance on regulations, among others. It could also be tied to the certification process, in which case we believe annual re-certification would be appropriate and based on meeting global adoption metrics.

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?

No comment.

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

We are in favor of making the application materials public in order to foster transparency and promote best practices for the health care providers in the Commonwealth.

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

No comment.