CHA Cambridge Health Alliance

HARVARD MEDICAL SCHOOL TEACHING HOSPITAL

January 29, 2016

Health Policy Commission
Attn: Catherine Harrison
50 Milk Street, 8th Floor
Boston, MA 02109
HPC-Certification@state.ma.us
(transmitted via email)

Dear Ms. Harrison,

On behalf of Cambridge Health Alliance (CHA), I am pleased to submit CHA's response to the Commonwealth of Massachusetts, Health Policy Commission's (HPC) ***Request for Public Comment Regarding Proposed Accountable Care Organization (ACO) Certification Standards.*** CHA appreciates the opportunity to share information with the HPC on this important initiative.

If you have any questions regarding CHA's response, please feel free to contact me at:

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CHA looks forward to future collaboration with the HPC on this initiative to develop patient-centered, accountable care in the Commonwealth.

Sincerely,

Lisa Trumble

pp Lisa M. Trumble
Vice President, Accountable Care and Strategic Financial Planning

Attachment

Cambridge Health Alliance (CHA) understands that the Health Policy Commission (HPC) is charged by Chapter 224 of the Acts of 2012 to develop and implement standards of certification for Accountable Care Organizations (ACOs) in the Commonwealth.

CHA offers detailed responses to the following HPC questions:

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?

The proposed HPC ACO certification criteria do appear to offer a comprehensive set of standards that are appropriate for all payers. CHA recommends that the HPC avoid the dissection of various ACO certification criteria at a payer-specific level, due to differences in populations, performance needs, the availability of information, and the incremental burden of more reporting.

CHA encourages the HPC to allow for the maximum amount of flexibility and innovation in the ACO certification process. While the tendency of all interested parties will be to want clear definitions for ACO certification key terms, such as governance and meaningful participation, CHA cautions the HPC about being too prescriptive in these definitions. Both governance and meaningful participation will vary by ACO and that fact should be recognized in the ACO certification definition of key terms.

CHA believes that the actual agreements between the ACO and other parties and documents recording organizational activities such as meeting agendas, meeting minutes, and the like should not be required as a method to demonstrate performance on any given ACO certification criteria. These agreements and documents are confidential and proprietary either in whole or in part. In addition, some of the contemplated documentation, notably the materials required in Criterion 13, could contain confidential patient information or discussions related thereto that constitute protected peer review deliberations otherwise protected from disclosure under M.G.L. c. 111, §§ 204(a) and 205(b) and/ or the federal Patient Safety and Quality Improvement Act of 2005. Delivery of this documentation as currently contemplated would jeopardize important safeguards that the Legislature and Congress have developed to enable providers to improve patient care. CHA understands and appreciates that the draft standards seek to reduce the administrative burden on ACOs by allowing ACOs to deliver existing agreements and documents instead creating new documentation to meet the standards. The standards should provide ACOs with the option of providing descriptions or narratives in lieu of the actual agreements or documents. Such an option would also be less burdensome than allowing for redaction. Further, all such descriptions and narratives would be subject to an overall attestation.

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

Related to the categorization of mandatory or reporting only criteria, CHA offers the HPC comments on the following criteria:

Criteria #3 and #4

From CHA's perspective, Criteria #3 and #4, as written, are overly prescriptive. ACOs can vary greatly geographically, legally, and operationally. All points of view should be considered in clinical design and operational planning. The HPC should recognize that clinical and operational decisions are often made at different levels in different organizations. Prescribing a representational approach may in fact lead to indecision and unintended financial consequences. For these reasons we recommend that this goal be moved to the reporting and informational category.

Criteria #7 & #8

Risk stratification and population specific interventions should be moved to a reporting only category. Risk stratification is more of an art than a science that will require each organization to make internal modifications to their methods by population. While it is important to have the ability to risk stratify a population, the HPC should be concerned with the presence of a methodology and process and not the details of the process, which will vary by organization and population. The HPC should also leverage information provided to the Division of Insurance as part of the Risk Bearing Provider Organization Certification process which requires submission of a risk management and stratification process and/or plan.

The HPC should be commended on the goal to include social determinants in the certification process; CHA views this as a major opportunity for the improvement in healthcare delivery overall. However, CHA cautions the HPC that this data is not widely available today nor is it generally captured in the existing healthcare structures (Electronic Health Records) or tools (Risk Stratification Software). Therefore, the mandatory inclusion of these criteria into the risk stratification process presents challenges. Additionally, the solicitation and capturing of this data is problematic and often complicated by ethnic and literacy barriers. For all these reasons, CHA encourages the HPC to be thoughtful in its approach to requiring any reporting or inclusion of these criteria in the short term and should engage the provider, payer and healthcare technology community in discussions on how to advance this specific goal.

Regarding health improvement goals, the HPC should require that there is a process in place to evaluate performance and to intervene when performance needs to improve and should not prescribe the completion of a certain number of health improvement initiatives or the type of initiatives to be considered. Additionally, the provision of specific goals and performance against these goals should be considered sensitive and proprietary and should not be a reporting requirement to the HPC. Lastly, performance improvement initiatives and interventions will be highly variable and proprietary by ACO depending on their population. For these reasons this section should be reporting only and reporting in the form of a general description.

Criterion #15

CHA agrees that ACOs should have a plan for advancing population health for its attributed members who often encompass many communities and may in fact represent small numbers in these communities. The goals for population health should be aligned with that of the ACO and lives that it is responsible for and should recognize that ACOs may in fact lack the ability, skills and staff to influence the community at large. Concentrating efforts on 100 enrollees is too small of a cohort for consideration of effective community interventions, may not represent the community at large and may in fact distract the ACO from larger more meaningful interventions. For these reasons, this criterion should be moved to reporting only and in the form of a general description or narrative.

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?

Recognition that ACOs have different capabilities and capacities will be important to the implementation of the HPC's certification process and may require a longer transition than initially contemplated. CHA believes a number of these certification criteria will be difficult for certain ACOs in the short term. The HPC should consider a transition period that allows ACOs to develop the necessary skills to meet all the certification requirements and report on progress made for these requirements. Additionally, the HPC should appreciate that some of the suggested certification criteria, e.g. capturing social determinants, LTSS and some quality measures while important may require further investments in information technology and other tools in order to capture the necessary information.

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?

The HPC's requirement for certification should accept where possible exisiting documentation to reduce an already burdensome process for regulatory reporting for healthcare organizations and to the degree possible the HPC should strive to obtain the appropriate information from other governmental bodies to reduce reporting duplication. The HPC should also recognize that contractual terms and periods vary between organizations and between contracts and to the degree that this variation continues using existing reporting would be the least burdensome approach to meeting the expectations of the HPC.

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?

The HPC should not require more frequent certification in the first few years of the program; instead the HPC should monitor existing HPC RPO and DOI RBPO information for exceptions that may require certain organizations to recertify or resubmit additional documentation as a condition of continuing certification.

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?

The HPC should establish learning collaboratives that would allow for ACO's to learn and understand from each other in a more detailed way. The HPC could also publish latest trends in care management, population health analytics, risk stratification, and aggregated comparative performance that would allow ACOs to assess their own performance and structures for opportunities for improvement. The HPC should avoid making these technical assistance programs and forums mandatory for certification purposes.

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

The HPC should recognize that much of the information being requested is proprietary and competitive information and should be protected as such.

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

CHA believes that Chapter 224 offers enough consumer and market protection.

On the following pages, CHA offers responses for each of the proposed HPC ACO certification criteria, documentation requirements, and questions for public comment.

Mandatory Criteria

Domain	#	Criterion	Documentation Requirements	Questions for Public Comment	CHA 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.		Many ACOs are able to perform the required functions under contractual arrangements without creating a separate legal entity. Requiring a separate structure increases the burden and costs of operation for ACOs and may be unnecessary to achieve the objectives articulated by Mass Health and the HPC. Where possible, the HPC should align with federal requirements and programs with regard to legal structure and should allow for flexibility similar to existing Medicare programs.
	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?	Where possible, CHA believes that the HPC should leverage information that is already submitted to the payer community or through the HPC's Registered Provider Organization (RPO) process. The HPC should understand that many ACOs currently have rules and organizational agreements that require members to participate in all risk-based arrangements. In these cases, requesting of a list by payor is unnecessary and will provide no meaningful distinction between payer classes.
	3.	The ACO governance structure	- Written description of	Describe and	The criterion as written is unduly

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		includes a **patient or consumer representative.** The ACO has a process for ensuring patient representative(s) can meaningfully participate in the ACO governance structure.	where/how the patient or consumer representative role appears within the 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.	give examples of meaningful participation. What evidence should the HPC seek to assess meaningful participation?	burdensome and should be aligned with other federal programs (Pioneer and Medicare Shared Savings Programs) to avoid unintended consequences of a truly representational structure and conflicting structures for various products or payers. The HPC should clarify its definition of governance and should recognize specifically that Board placement generally will not achieve the objectives set for by the HPC. Organizational Boards, first and foremost, have a fiduciary responsibility to the ethical and financial operations of the organization and not to a specific class of participants or members. Achieving meaningful participation in decision making and redesign of how health care can be delivered should incorporate the voice of the patient/consumer at the point where patient care decisions are made, where systems of care are redesigned and where quality and patient satisfaction are monitored. In terms of meaningful participation, CHA encourages the HPC to allow for maximum flexibility and cautions the HPC about being too prescriptive

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					in the definition and expectations for documentation.
	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 number, via voting rights, or other), and specific ways ACO ensures meaningful participation of different provider types.	What evidence should the HPC seek to evaluate meaningful participation?	See comments for Criterion #3.
	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		CHA agrees that an effective PFAC is important to achieving the goals set forth by the HPC. Supplying a charter, annual goals and achievements for the PFAC should suffice in demonstrating the effectiveness of this group. Similar to other criterion, the HPC should avoid prescribing the representation on this group so that the structure can operate effectively.

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			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. 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.		Supplying a charter, annual goals and achievements for the Quality Committee should suffice in demonstrating the effectiveness of this group. Meeting minutes or any further detail should be considered confidential and should not be used to satisfy this criterion. As discussed in CHA's response to general question 1 above, the requirement to provide meeting minutes conflicts with M.G.L. c. 111, §§ 204(a) and 205(b) and the federal Patient Safety and Quality Improvement Act of 2005.
Risk stratification and	**7.**	The ACO has **approaches for risk stratification** of its patient population based on criteria	- Written description of the risk stratification methodology(ies),		Please see CHA's response to general question 2 above. CHA believes that this criterion should be moved to a

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population specific interventions		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	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.		reporting only category.
	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.**	- Written description of 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	Should the HPC be more prescriptive with this requirement (i.e., require more than one program)?	Please see CHA's response to general question 2 above. CHA believes that this criterion should be moved to a reporting only category.

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			measures/outcomes-based approach; and must include/reflect community resources and partnerships as appropriate. A program of any size may fulfill this criterion.		
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, adult day health, PCA, etc.) - Community/social service organizations (i.e., food pantry, transportation, shelters, schools, etc.)	- 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 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	What evidence should the HPC seek to evaluate whether ACOs assess the effectiveness of the collaborations?	In order to assess ACO collaborations, the HPC should require a listing of existing collaborating partners instead of meeting minutes and sample collaboration agreements, such as Memorandums of Understanding or contracts. The actual agreements and board or committee discussion related thereto should be considered confidential and proprietary. The HPC should not require evidence of the effectiveness of these collaborations. It is in each ACOs best interest to form these partnerships and establish outcome measures to achieve positive, patient-centered health outcomes. The HPC should rely on the outcomes in terms of Total Medical Expense and quality measures as evidence that agreements, processes, etc are working effectively.

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			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, 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	- Exemplar contract(s), memorandum(s) of understanding, or agreement(s) setting out terms of relationships between ACO and		CHA recommends that this Criterion be combined with Criterion #9.

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		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.	required provider types, including specific standards for access and requirements for clinical data sharing.		
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?	While Massachusetts has a significant presence of ACOs and budget-based risk approaches, the majority are confined to the commercial and Medicare population. Assuming risk for the Medicaid population requires that the ACO assess it's currently abilities and reorganize its structure to manage a more challenging population that has very different needs and support requirements. The presumption that an ACO with positive performance in Commercial and Medicare products could move immediately into Medicaid risk without taking time to assess and build the required capabilities may inhibit the successful advancement of a value based approach for this population. The HPC should allow a greater period of time for this transition.
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 these rates, particularly**	- Statement (or other documentation) outlining current PCMH recognition rates. - Narrative explaining plan for increasing rates,	How should the HPC best align its PCMH PRIME certification and ACO	CHA supports a patient-centered approach to delivering primary care services in general and to its population. CHA believes the best demonstration of this capability is embodied in the NCQA Medical

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		for assisting practices in fulfilling HPC's PCMH PRIME Criteria.	including HPC PCMH PRIME certification application/achievement.	certification programs?	Home recognition process. The HPC should understand that this process requires major investment and time to achieve and maintain and should be judicious in the expectations and timelines for certification. Regarding PRIME status, it is unclear to CHA what incremental benefit would be achieved given the significant costs of adding these PRIME requirements.
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	Is this a feasible requirement for smaller ACOs?	While this is a reasonable goal on the surface the HPC should avoid prescribing the type and level of reporting. The ACO should demonstrate by describing the existence of a performance structure and performance reporting. Samples, descriptions or screenshots should be considered confidential and proprietary and should not be used to satisfy this criterion. It would be helpful to have the HPC engage the payer community on standardization and improved timing of claims and quality data for improved performance reporting. Currently, performance reporting is helpful but is often out-of-date, reducing its effectiveness.

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			disseminated down to the provider level.		
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.		CHA supports the measurement of patient experience of care, but recommends that existing survey processes be used to achieve this measure. The existing survey environment can be confusing and frustrating to patients because they receive multiple surveys from multiple vendors and often are not clear on who they are rating.
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.		CHA agrees that ACOs should have a plan for advancing population health for its attributed members who often encompass many communities and may in fact represent small numbers within these communities. The goals for population health should be aligned with that of the ACO and lives that it is responsible for and should recognize that ACOs may in fact lack the ability, skills and staff to influence the community at large. Additionally, concentrating efforts on 100 enrollees is too small of a cohort for consideration of effective community interventions, may not represent the community at large and may in fact distract the ACO from larger more meaningful interventions. For these reasons, this criterion should be moved to reporting only

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					and eliminate levels or thresholds.

Market and Patient Protection

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Risk-bearing provider organizations (RBPO)	**16.**	If applicable, the ACO obtains a **risk-based provider organization (RBPO)** certificate or waiver from **DOI**.	- Attestation	Attestation should suffice for meeting this requirement and providing additional documentation for an existing program adds undue burden.
Material Change Notices (MCNs) filing attestation	**17.**	ACO attests to filing all relevant **material change notices (MCNs)** with **HPC**.	- Attestation	Attestation should suffice for meeting this requirement and providing additional documentation for an existing program adds undue burden.
Anti-trust laws	**18.**	ACO attests to compliance with all **federal and state antitrust laws and regulations**.	- Attestation	Attestation should suffice for meeting this requirement and providing additional documentation for an existing program adds undue burden.
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.	Attestation should suffice for meeting this requirement and providing additional documentation for an existing program adds undue burden.
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.	Information related to shared savings/losses is proprietary information and should not be shared in detail or by type of contract. The variability in surplus or losses is driven by both contract terms and performance and therefore is a misleading indicator of success over time. The aggregate reporting or a general narrative regarding performance on surpluses or losses would be preferable. The HPC should rely on the Division of Insurance Risk Bearing Provider Organization (RBPO)

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				process for understanding successful and sustainable performance in this area. Regarding quality, there is much work to be done to standardize measures and methods across all payers and within specific payer cohorts. CHA cautions the HPC about public reporting, as it may be both confusing and misleading because of the variation in measures at the levels described above. Additionally, consideration should be given to patients who meet the defined quality measure, but due to transition issues, are not accounted for within the claims data. This specific issue is common and extremely important in the Medicaid population. Not addressing this specific issue has the potential to lead to the delivery of unnecessary services to achieve a reported quality outcome and unadjusted artificially lowers the reported performance of an ACO.
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	Attestation should suffice for meeting this requirement and providing additional documentation for an existing program adds undue burden.

Reporting Only Criteria

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Palliative care	**22.**	The ACO provides **palliative care and end-of-life planning**, including: – integrated and coordinated care	- Written description of how ACO coordinates with and assesses		A written description of the ACO's palliative care and end of life programming and training alone

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		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	appropriateness of hospice and end-of-life (EOL) planning programs/materials. - Examples of training programs.		should be an acceptable method for achieving this goal. Training programs and internal documents should be considered confidential and proprietary and should not be used to satisfy this criterion. Also the Board of Registration of Medicine requires this type of education as part of the relicensing process for physicians.
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.		Tracking referrals across specialty and facility-based care is complicated and lacks a complete data set for robust management and reporting. The HPC should allow a statement of the ACOs process regarding the tracking of referrals to satisfy this measure. The provision of ACO specific policies, procedures, protocols or training programs should be considered confidential and proprietary and should not be used to satisfy this criterion.
	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	- Written description of ACO's process for identifying preferred providers, including relevant quality and financial analyses. - Documentation of provider communication related to encouraging		The HPC should allow a narrative of the ACOs preferred provider program (selection, management and monitoring) to be used to satisfy this measure. The provision of ACO specific analysis, communications and performance should be considered confidential and proprietary and should not be used to

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		– obstetrics	use of identified providers		satisfy this criterion.
	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 allow a statement of the ACOs process regarding medication reconciliation to satisfy this measure. The provision of ACO specific policies, procedures, protocols or training programs should be considered confidential and proprietary and should not be used to satisfy this criterion.
	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.		As written, this criterion is overreaching and assumes a level of capability that does not exist today. A narrative describing the approaches ACOs are taking to achieve real time notification should satisfy this criterion. CHA recommends that the HPC avoid defining what is appropriate notification and at what level or with what partners. ACOs should have the ability to decide internally what partnerships need what level of connectivity and data exchange. Each of these options needs to be balanced with the material nature of the relationship, the relative costs of implementation and ongoing maintenance and data security.
Peer support	**27.**	The ACO provides patients and family members access to **peer support programs**, particularly to	- Written description of how the ACO provides peers or links patients		The HPC should allow a statement of the ACOs process regarding peer support to satisfy this measure. The

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		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.	and families to existing community-based peer support programs. - ACO training materials or plans to provide training as needed.		provision of ACO specific policies, procedures, protocols or training programs should be considered confidential and proprietary and should not be used to satisfy this criterion.
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 allow a narrative of the ACOs Medical Management program to be used to satisfy this measure. The provision of ACO specific condition or variation analysis, or detailed improvement plans should be considered confidential and proprietary and should not be used to satisfy this criterion.
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 aggregate. - Description of barriers	Are there data collection or other challenges ACOs would face in reporting on this information? Are there other methods of	The HPC should leverage existing reporting to CHIA and DOI for this measure. Additionally, ACOs should not have to describe assumptions, methods and calculations as part of this reporting.

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			faced in accepting higher volume of risk-based contracts.	assessing uptake of budget-based contracts that HPC should consider?	
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.		ACOs can provide a high level description of their internal funds flow program. However, copies of documents such as participation agreements, communications, detailed methodologies and provider specific compensation formulas should be considered confidential and proprietary and should not be used to satisfy this criterion.
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	- 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.		The HPC should allow a statement of the ACOs process regarding the assessment of the population's demographics and preferences to meet this measure. However, ACO specific policies, procedures, protocols or training programs, and supporting documents should be considered confidential and

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		provision of interpretation/ translation services and materials printed in languages representing the patient population (5% rule).	- Description of method for identifying gaps in need and capacity, including plans for addressing such gaps.		proprietary and should not be used to satisfy this criterion.
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		CHA suggests that attestation that a group of providers have adopted and implemented a certified EHR is sufficient to meet this criterion, especially for providers that have already implemented and integrated a Meaningful Use-certified EHR at all of their clinical locations and does not have plans to increase adoption or integration rates going forward.
	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?	CHA has been connected to the Mass HIway for more than a year, which allows CHA to send messages to other organizations, but successfully receiving messages from other organizations has been a challenge for a variety of reasons. CHA believes that this requirement should only be included in the certification process when the technical capabilities and the capacity of the Mass HIway Team are at a point to fully develop the appropriate capabilities. CHA would appreciate the opportunity to participate in Mass HIway process improvement discussions.