MHA MASSACHUSETTS HOSPITAL ASSOCIATION

The leading voice for hospitals.

January 29, 2016

David Seltz
Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Dear Executive Director Seltz:

The Massachusetts Hospital Association (MHA), on behalf of its member hospitals and health systems, appreciates the opportunity to submit comments on the Health Policy Commission's (HPC) proposed Accountable Care Organization (ACO) certification standards.

Pursuant to Chapter 224 of the Acts of 2012, the HPC is charged with developing and implementing a voluntary certification program for ACOs. MHA recognizes the challenges inherent in creating a program which will, as defined by the HPC, "promote continued transformation in care delivery while ensuring that certification is within reach for systems of varying sizes, organizational models, infrastructure and technical capabilities, populations served and locations." And we agree that this is a laudable and worthwhile goal to strive for in creating a certification program, provided that the guiding principles allow for flexibility and innovative design and are not overly prescriptive. MHA appreciates that the HPC is giving providers the opportunity to contribute feedback on the proposed standards.

Given that provider organizations come in all shapes and sizes, MHA included all of its members in seeking feedback on the proposed standards. We had extensive discussions with our hospital and Physician Hospital Organization (PHO) members, many of whom already have relevant experience through participation in the Medicare shared savings or Pioneer and Next Generation ACO programs. In addition, our members' comments reflect participation in various commercial payer alternative payment methodologies that require population management, risk stratification, effective collaboration among providers, sound financial management, and many years of experience providing patient care under risk contracts. MHA members are supportive of the ACO concept and are committed to improving care delivery, reducing costs, and to succeeding under alternative payment methodologies.

Unfortunately, the ACO certification standards as drafted raise significant concerns. The proposed requirements are viewed by many in the provider community as extremely burdensome, costly to implement, and are likely to be a disincentive for applying. As opposed to setting forth minimum standards for deeming that an entity is an ACO, some of the criteria are more akin to a payer's contractual requirements. Operational and data requirements are also overly prescriptive and lack clarity as to how they would further the HPC's mission of creating sustainable ACOs. Rather than considering all of these criteria as requirements for basic certification, we suggest the HPC consider some of the more detailed criteria as a foundation for meeting the "Model ACO" status as referenced in Chapter 224.

Given the breadth of these concerns, MHA respectfully recommends that many of the HPC criteria be revised so as not to be so prescriptive and administratively burdensome. MHA and its members would like to work with the HPC to develop criteria that allow for flexibility and reflect the goal of encouraging providers to create patient centered accountable care in the commonwealth.

Overly Prescriptive Criteria

This is the number one concern voiced by our members and affects virtually all of the proposed criteria. Per Chapter 224, the HPC is charged with creating "minimum standards for certified ACOs." In its November 18th presentation to the board, HPC staff summarized key stakeholder feedback, which included the following:

- Do not be prescriptive
- Leverage existing legal/governance structures and programmatic/reporting requirements as much as possible. Avoid redundancy.
- Develop a small set of minimum standards and allow ACOs to innovate beyond that small set.

Our members believe that as drafted, the proposed criteria do not reflect stakeholder feedback. The proposed minimum standards are anything but minimal and are conversely viewed by the provider community as unnecessarily prescriptive, burdensome, and discouraging. Instead of providing standards that will permit flexibility and innovation in ACO development and encourage participation in the state process, this proposal will likely have the opposite effect. Numerous examples of micromanagement are provided in MHA's detailed comments on the proposed criteria. We hope the HPC recognizes that the focus and capabilities of an ACO will vary depending on its resources and the population that it serves and will consequently refrain from imposing restrictive, prescriptive criteria across the board.

One specific example of great concern is the mandate around governance structure. All provider types, including behavioral health, primary care, and specialty services are of importance to an ACO's goal of managing the continuum of care for a diverse patient population. All points of view should be taken into consideration in the operations and

planning of the ACO through various committee processes within an ACO. However, the HPC should not dictate the types of providers represented on the ACO boards. This is an overly prescriptive approach and could deter ACO participation in the HPC process or result in unmanageable boards. Instead, the HPC should encourage ACOs to take into consideration the ACO's provider composition and communities it serves when it forms its board and committees.

Administrative Burden

The HPC's proposed ACO certification is a voluntary program that essentially creates an unfunded significant administrative burden on providers without a proposed funding source for this additional work. And as stated above, the more onerous the demands, the less likely providers will voluntarily seek to participate. It is critical that the HPC create sensible, fair, and meaningful requirements that serve to further the mission of improving health outcomes and reducing costs. It should not impose lengthy, burdensome, complex mandates.

Documentation should not be required simply because the HPC believes it is of interest. Nor should documentation be assumed to be able to capture things like the collaborative efforts across an ACO's network of healthcare providers or meaningful participation by a board member. The proposed HPC criteria appear to indicate that detailed reporting of everyday activities and practices within an ACO will somehow materialize into changing how care is managed. But such reporting requirements cannot fully capture collaboration no matter what their level of detail, nor can they change how care is delivered or managed. As currently drafted, the time, labor and costs required to produce the information required for certification will be viewed as a paperwork exercise that will distract from the real goal of improving care and will be a significant disincentive to apply. Before any reporting is considered mandatory, it should be determined that it serves a clear and demonstrable purpose that both the HPC and ACOs agree is worthy.

The HPC should also consider that this is just one of numerous new mandates on providers, others being registered provider organizations process, risk bearing provider organization certification, notices of material change, Patient Centered Medical Home (PCMH) PRIME certification. Payers, both commercial and government, also continuously add mandates and reporting requirements.

Lastly, it must be noted that there are documentation requirements that duplicate what is already provided to or can be obtained from existing state agencies. Examples include information on participating providers and Tax Identification Numbers (TINs) which can be obtained from the HPC's RPO filings; information about level and nature of risk which can be obtained from the HPC's Registered Provider Organization (RPO) and the Division of Insurance's (DOI) Risk Bearing Provider Organization (RBPO) process.

Payer Mandate
The draft criteria require participation in MassHealth budget based alternative payment methodologies. MHA and our members strongly object to this requirement.

Obtaining a voluntary ACO certification should never be predicated on a requirement to participate in particular government or commercial payer payment methodologies. Providers evaluate alternative payment arrangements based on whether a payer's program will improve the outcomes of its patients and whether the provider group will be able to successfully manage its patients under the requirements of the program. It is inappropriate for the HPC to tie a voluntary certification program to specific contracting arrangements between healthcare providers and payers, commercial or government. Such a requirement would make the use of the term "voluntary" meaningless.

Beyond this overarching compelling reason, this criterion requires an ACO to commit to participating in a MassHealth program that has not yet even been developed. While conversations have occurred, formal negotiations between the state and federal government will take the better part of a year to complete. There is no formal proposal yet and that too will also take time to process with stakeholders. For these reasons, this requirement is entirely inappropriate.

MHA respectfully requests that this mandate be removed entirely from the required criteria.

Costs vs. Benefits
The way the proposed HPC criteria are currently structured, providers must incur significant costs in order to become certified. Many providers already meet many of the proposed criteria as a result of their participation in risk contracts, Medicare ACO programs, and/or patient centered medical homes. The proposed criteria have no provisions for deeming an ACO to be certified in even a subset of the criteria by virtue of their successful participation in any of these other programs. Leveraging existing structures and avoiding redundancy was a key stakeholder feedback. It is also noteworthy that no payers have committed to providing certified ACOs with additional funding for building infrastructure and taking on more costs and risks, developing and implementing programs to improve health outcomes in the surrounding community, providing more comprehensive and timely data, or any other kind of supports that would incentivize providers to become HPC certified.

ACO is currently an unfamiliar term for most consumers, so certification by the HPC is unlikely to attract additional patients. MHA is aware that the HPC has plans for a communications and outreach strategy, but those programs take significant time to develop, roll out and have any effect on increasing consumer awareness and demand for services. Thus, the amount of time, effort and money is likely to exceed for a

considerable period any benefits that may accrue to provider organizations and is a disincentive to pursue the process.

Proprietary and Anti-competitive Concerns
The proposed standards require submission of numerous documents, including minutes from board meetings, details on funds flow, screen shots of practice level reports, etc. These are sensitive and proprietary documents and should not be subject to public disclosure. While the HPC appears to provide some protections, there is still the possibility that some or all of these documents could be made available to the public if the HPC decides that such disclosure should be made in the public interest. More importantly, it is unclear why the HPC would need to collect these documents and how they will be used by the HPC to further improvement in patient care. Again, we believe that the submission of these types of documentation is intrusive, burdensome, and unnecessary and does little to further the mission of ACO certification.

Where Should the HPC Focus Its Efforts?
Several of the criteria focus on documenting relationships with Long Term Services and Supports (LTSS) providers and other community organizations. Instead of fostering collaboration through paperwork and documentation requirements, the HPC could be very helpful in collaborating with other state agencies that already support and/or have existing relationships with LTSS and human service providers. The health care community would greatly value a state effort to compile detailed information about the many community based organizations and making that information known to healthcare providers including ACOs. With this help, increased collaboration would be better achieved and help to improve patient care by factoring in both social as well as medical determinants of health.

Another area where the HPC could be helpful is in facilitating the provision of data by carriers to providers. In order to be successful in entering into risk arrangements and alternative payment methodologies, providers must have timely, accurate data from health plans. Lack of appropriate data has been an ongoing issue and most recently was raised at the October 2015 Cost Trend hearings as the HPC reported that "financial data not timely at all and providers experience volatility in data as claims run out occurs - making it hard to manage." We encourage the HPC to convene the payer community with the goal of developing comprehensive, standardized, timely reports so that providers are comparing apples to apples and have the real time information necessary to manage their patient populations.

Summary
The purpose of an ACO certification process should be to promote quality, advance evidence based practices, coordinate care, reduce costs, and ensure that the public is protected. It is not meant to be a bureaucratic prescriptive exercise in paperwork collection under a banner of promoting what is meant to be an ACO. The success of

ACOs in managing the costs of care and improving patient outcomes cannot be measured by exhaustive attempts to document collaboration among providers, reviewing hundreds of pages of meeting minutes or providing written strategies to demonstrate "meaningful" participation by the consumer representative.

Massachusetts is fortunate to already be rapidly moving towards transforming the delivery system. Twenty-five percent of primary care providers practice in NCQA recognized patient centered medical homes; the APM adoption rate among commercial payers is at least 60% for HMO members; 62 provider groups participate in Medicare's bundled payment initiatives; we have participants in the Pioneer and Next Generation ACO models, etc. The HPC would benefit by leveraging the collective expertise of the commonwealth's providers and collaborating with them to develop criteria that are flexible and encourage innovation that results in "improving health outcomes and quality of care while slowing the growth in overall costs for a specific population of patients" as defined by the Dartmouth Institute.

Thank you for the opportunity to provide feedback on the certification criteria. Given the complexity and granularity of the draft standards, it would be greatly appreciated if the Health Policy Commission could offer specific, detailed, written responses to comments received so that stakeholders can understand the rationale behind each certification requirement before putting out a final draft.

MHA and its members are strongly committed to the ACO concept. We hope to continue to work with the HPC, payers, and others in the healthcare community to ensure that this type of care and payment model can be encouraged in a manner that promotes flexibility, improves quality, is manageable for providers, and contributes to controlling growth of healthcare costs. If you have any questions or would like to discuss these further, please don't hesitate to contact me.

Sincerely,

Timothy F. Gens
Executive Vice President & General Counsel
Massachusetts Hospital Association

CC: Dr. Stuart Altman, Commission Chair

MHA COMMENTS ON HPC PROPOSED ACO CERTIFICATION CRITERIA

January 29, 2016

Mandatory Criteria					
Domain	**#**	**Criterion**	**Documentation Requirements**	**Questions for Public Comment**	**MHA & 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.		Provider organizations aim to have a single ACO entity. Conflicts between HPC requirements and other payer requirements may necessitate multiple ACO structures. Such an outcome would contradict the HPC intent and be burdensome and complex for providers to manage. Fiduciary duty could vary among MassHealth vs Medicare vs HPC certified ACO. State requirements cannot be inconsistent with Medicare requirements.
	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?	It is unclear why the HPC needs this level of detail regarding participating providers; this information is more appropriate to provide to a payer. The relevant question should be whether an ACO has appropriate providers for the patient population it serves. Regardless, this should be done at the highest level and all Registered Provider Organization (RPO) data should be leveraged rather than requiring duplicative reporting. This request also duplicates what is already submitted to health plans and

					should not be required for ACO certification purposes. Reporting by contractual affiliation is administratively burdensome. MHA respectfully requests this criterion be revised to require a general narrative that documents the types of providers participating in the ACO.
	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 governance structure.	- Written description of 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	Describe and give examples of meaningful participation. What evidence should the HPC seek to assess meaningful participation?	Meaningful participation is demonstrated by the fact that the consumer/patient representative has voting rights on the ACO's board and regularly attends board meetings. The HPC other proposed requirements are overreaching and unnecessary beyond the description of how an individual is selected, what the expectations are, and an attestation that he/she is a voting member of the Board and participates in the meetings. MHA respectfully requests that this additional detail be eliminated from the criteria.

			inclusive, respectful approach; or other.		
	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?	MHA views this as overly prescriptive. The governance structure should be representative of the organization. For example, if an ACO is serving a mostly pediatric population one would expect more pediatric specialists to be represented on the board. The HPC should not dictate the specific types of providers represented in the governance structure. Behavioral health, primary care, and the variety of specialty services are <u>all</u> of importance to an ACO's goal of managing the continuum of care for a diverse patient population. All points of view should be taken into consideration in the operations and planning of the ACO through various committee processes within an ACO. However dictating who is on those committees and in what proportions should not be the mandate of the HPC or any other government entity. Creating prescriptive requirements that force current ACO boards to significantly change or to become unmanageable will be a deterrent from participating in this HPC certification process. This will stifle innovation and change within an ACO membership and its ability to govern. MHA respectfully requests this criterion be revised to allow for flexibility with an ACO's governance and committee structure.

					Medicare requirement is that 75% of the board is comprised of providers within the ACO but does not dictate the specialty or level of training required. The HPC should not take a more a prescriptive approach. The HPC should not require "proof" that the board members are meaningful participants; rather the description, governance structure including subcommittees should be evidence that there is sufficiently broad participation. MHA respectfully requests these requirements be eliminated and replaced with a request for a more general narrative description.
	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		Submission of meeting minutes should not be required for purposes of ACO certification. These may contain sensitive, confidential information and should not be made publicly available. While the HPC appears to provide some protections, there is still the possibility that some or all of these documents could be made available to the public if the HPC decides that such disclosure should be made in the public interest. More importantly, it is unclear why the HPC

			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.		would need to collect these documents and how they will be used by the HPC to further improve patient care. MHA believes that the submission of these types of documentation is intrusive, burdensome, and unnecessary and does little to further the mission of ACO certification. We respectfully request these requirements be eliminated from the criterion.
	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.		ACOs should be required to evaluate quality but specifying the committee structure of a private organization should not be the role of the HPC. It should be up to the ACO to determine what committees to form, who should be on them, and what its purpose is. The HPC may require that an ACO have a quality committee along with documentation of its mission, charge, and membership, but should not be more prescriptive than that. Alternatively, if an entity within the ACO already has a quality committee, the same quality committee could be used to fulfill this criterion so long as the scope is expanded to address ACO wide issues. As stated earlier, submission of minutes should not be required. These may contain sensitive, confidential information and should not be made publicly available. MHA believes that the submission of these types of

					documentation is intrusive, burdensome, and unnecessary and does little to further the mission of ACO certification. We respectfully request these requirements be eliminated from the criterion.
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.		Risk stratification is needed for an ACO to evaluate risk but specifying the type of factors should not be mandated by the HPC. Further, detailed descriptions of data and methodology should not have to be reported to the HPC for purposes of certification. A general description of the ACO's approach to risk stratification should be acceptable for certification purposes. MHA recommends that social determinants of health should be moved under the optional approach with functional status and health literacy. While we don't disagree that this is useful information to have, it is extraordinarily difficult to collect and ACOs do not currently have ability to obtain and use this information for risk stratification. It should not be mandatory at this time but perhaps bookmarked for a future reporting criterion.
	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,**	- Written description of qualifying programs, including how participating patients are identified or selected, what the intervention is, the	Should the HPC be more prescriptive with this requirement (i.e., require more than one program)?	The HPC should absolutely not be more prescriptive with this requirement and requirements should in fact be reduced as this is already too prescriptive. There are numerous programs that providers already have in place with payers that focus on improving care for specific conditions

		addiction, and/or social determinants of health.	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.		such as diabetes, congestive heart failure, asthma, etc; to provide detailed reports on each of these is overly burdensome. MHA and providers question how reporting of the specific details of numerous programs is necessary to be certified as an ACO. Perhaps detail on such programs could be required in order to qualify for the HPC's Model ACO but it should not be required for basic certification purposes. ACO practices have differing patient populations, patient health status, and payer mixes. Given this reality, the HPC should not dictate what specific areas these programs should address. There should be ample flexibility for each ACO to determine what program would best improve the health outcomes of its patient population – programs may or may not incorporate behavioral health and/or social determinants of health. MHA respectfully requests this criterion be modified to reduce the level of detail required and to require written description and information on only one program; submitting information about additional programs should be at the discretion of the ACO.
Cross continuum network:	**9.**	ACO **demonstrates and assesses effectiveness of ongoing collaborations** with and referrals to:	- Names of organizations and narrative or other	What evidence should the HPC seek to evaluate whether	This is a very burdensome, overreaching requirement and duplicates what is already reported to the HPC under the

access to BH & LTSS providers		- 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.)	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 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	ACOs assess the effectiveness of the collaborations?	RPO and notices of material change programs (clinical affiliations). The level of detail requested by the HPC is unnecessary. MHA recommends that it be moved to the reporting only category. We also request it be changed so that the ACO provide a general narrative showing that it has processes in place that codify the relationships with its various providers. Providers agree that more can be done to promote relationships with community based providers. State government has substantial relationships through its health and human services programs and should help to make it more efficient for medical and community based providers to connect. Promoting greater awareness of community resources is a worthy goal. However mandating collaboration through documentation is an exercise in futility and inefficiency and doesn't reflect the informal relationships that are developed in the normal course of business that develop naturally among providers. It is inappropriate to expect an ACO to submit board or committee meeting minutes, especially since it can often contain sensitive or proprietary information, to a public agency where it is then publicly available for anyone to review. This requirement alone will be a deterrent to ACO participation in this process.

			- 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.		The government cannot legislate or regulate collaboration and it's not clear what the HPC expects to achieve by attempting to do so. This will instead turn into a massive administratively burdensome paperwork exercise. Rather than expecting detailed assessments around collaborations with numerous provider types and community based services, the narrative should be limited to an explanation of the general process followed by the ACO to collaborate with different provider types.
	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.		MHA opposes the submission of contracts and memorandums of understanding between providers for purposes of ACO certification. For this purpose, an attestation that an ACO has contracts in place that are appropriate for its patient population and that contain access and data sharing requirements should suffice. Sharing contracts with the HPC, which contain proprietary information and could then be made publicly available is unacceptable and unnecessary. This is more akin to a payer contractual requirement; specific contractual terms are not necessary for purposes of a general ACO certification.
Participation in MassHealth	**11.**	The ACO participates in a **budget-based contract for Medicaid patients by the end of Certification Year 2 (2017)**.*	- Written commitment.	Would a relative threshold be more meaningful? That is,	MHA and our members strongly object to this requirement. It is inappropriate to tie a voluntary certification program to

APMs		*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).		measure ACOs' increase in rates of budget-based contracts year over year? Should a relative threshold be different for larger and smaller ACOs?	participating in specific contracting arrangements with any payers, including Medicaid. MHA respectfully requests this be removed entirely from the HPC's criteria. Beyond this overarching compelling reason, this criterion requires an ACO to commit to participating in a Medicaid program that hasn't yet been developed. While conversations have occurred, formal negotiations between the state and federal government will take the better part of a year to complete. There is no formal proposal yet and that too will also take a year to process with stakeholders. For this reason as well, it is entirely inappropriate. If a payer requires an HPC certification, that is between the payer and the ACO. But for a certification process to require a private entity accept a payment methodology from a payer of health care services - commercial or government - that is viewed by the provider community as overreaching and unacceptable. This criterion should be eliminated. Participation in alternative payment arrangement with a payer should not be determined by the government. Providers evaluate participation based on whether a payer's program will improve the outcomes of its patients and whether the provider group will be able to successfully

					manage its patients under the rules of the program. Data sharing capabilities with a payer is another issue providers must take into consideration before entering into an agreement. A mandate that a provider enter into a specific type of risk-based contract with a payer is inappropriate.
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 for assisting practices in fulfilling HPC's PCMH PRIME Criteria.**	- Statement (or other documentation) outlining current PCMH recognition rates. - Narrative explaining plan for increasing rates, including HPC PCMH PRIME certification application/achievement.	How should the HPC best align its PCMH PRIME certification and ACO certification programs?	For many practices, achieving NCQA certification is expensive and burdensome. The PCMH Prime certification program is voluntary. It is not appropriate to expect the HPC to make it mandatory by requiring ACOs commit to increasing participation in this PCMH Prime program as a condition for obtaining the HPC ACO certification. Instead, the HPC could ask whether the ACO's primary care providers incorporate the general principles of PCMH, many of which are duplicated in the ACO requirements. Requiring implementation of a plan for increasing PCMH PRIME certification rates is tantamount to another unfunded mandate on providers.
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.	- Blinded sample cost, utilization, and quality report(s). - Written description or screenshot of how practice-level reports are made transparent and disseminated to	Is this a feasible requirement for smaller ACOs?	The HPC should not regulate this level of detail related to how ACOs disseminate and use data. Any documentation beyond a general statement of process and how cost, utilization, and quality reports are used by the ACO (second bullet) is simply an administratively burdensome paperwork exercise. Submission of this

		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.	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.		detailed information shown as screenshots and documentation showing how ACOs interacts with providers may contain sensitive, confidential information and should not be made publicly available. MHA respectfully request this criterion be revised by removing these detailed submission requirements. A major concern with analytics is getting timely data from the payers. The HPC should work with other state agencies and focus on ensuring payers are progressing in their data sharing capabilities to better enable providers to use such data to manage their patient populations.
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.		MHA and providers support the use of evidence based statewide surveys to evaluate patient and family experience. However, the HPC is too prescriptive as to what it wants evaluated. MHA respectfully requests the survey specifics be eliminated and revised to be suggested areas for questioning. The HPC should also allow for the use of accepted statewide surveys (such as Press Ganey or MHQP) without dictating the precise questions that must be incorporated. It is also not clear what is meant by "whole person care/self-management support" and whether or not there are existing evidence based statewide surveys that measure these.

					MHA supports providing the HPC with an ACO's general process for identifying and acting on areas needing improvement; however requiring submission of specific actions taken on specific issues should not have to be reported to the HPC.
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.		ACOs often serve multiple communities, sometimes even in multiple states. Narrowing it down to a particular geographic location, given that 100 enrollees is a very small number, is challenging and could be very onerous for smaller organizations. Non-profit hospitals already have to do community benefit assessments – would this suffice for ACOs with hospital members? The HPC should consider moving this to the reporting only section.

Market and Patient Protection

Domain		Criterion	Documentation Requirements	MHA & 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	
Material Change Notices (MCNs) filing attestation	**17.**	ACO attests to filing all relevant **material change notices (MCNs)** with **HPC**.	- Attestation	
Anti-trust laws	**18.**	ACO attests to compliance with all **federal and state antitrust laws and regulations**.	- Attestation	Clarifications from state government and attorney general are needed.

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 has not yet released any OPP guidance on appeals and grievances so it's impossible to know exactly what will be required at this point.
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.	This is proprietary information and should not be shared on ACO commercial lines of business. Aggregate reporting or general narrative regarding performance on quality measures would be preferable. MHA respectfully request the criterion be revised to remove these requirements.
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	

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.		***General comment on this entire section****: it's not clear how "reporting only" differs from mandatory criteria. Both involve submission of numerous documents and place a significant administrative burden on providers.* Palliative care should include addressing overall quality of life issues, not simply hospice and EOL planning

	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 tests and services that go outside of the ACO network without referrals is not possible without data provided by payers.
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	- 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		MHA respectfully requests the HPC change the requirement for identifying specific provider groups (oncology, orthopedics, pediatrics, obstetrics) as well as the documentation of provider communications and replace with a more general process statement entailing the ACOs approach to identifying preferred providers. Sharing actual quality and financial analyses with the HPC is unnecessary and is an overreach. ACOs could instead provide a description of the types of analyses that are used in identifying preferred providers. MHA also requests the HPC eliminate documentation of

					provider communication. It the ACOs responsibility to manage its network of providers, not the HPC.
	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.		It is not feasible to expect a review of every type of medication for every patient with every provider. With limited resources and time, providers must prioritize sickest patients and those who are on multiple medications. MHA requests this criterion be revised.
	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.		
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		MHA requests this criterion be revised. ACOs shouldn't be

		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.		required to share their training materials which may include proprietary processes.
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.		A general narrative should suffice otherwise this too will be a burdensome administrative process.
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 faced in accepting higher volume of risk-based contracts.	Are there data collection or other challenges ACOs would face in reporting on this information? Are there other methods of assessing uptake of budget-based contracts that HPC should consider?	This information is already provided to the DOI for RBPO certified entities – see statement from RBPO application. Reporting to state government should be minimized and not duplicated. *The RPBO application states: "Provide a description of the level and nature of risk assumed across all the Provider*

					Organization's contracts, including details about aggregate number of members that are covered under Alternative Payment Contracts, and with respect to those contracts of each entity: (i) with whom the Risk-Bearing Provider Organization has a Contracting Affiliation; and (ii) assumes Downside Risk in its arrangement with the Risk-Bearing Provider Organization." MHA requests this criterion be modified to leverage what is already submitted to the DOI and to reduce micromanagement of ACOs by the HPC.
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 are able to provide high level descriptions of funds flow, copies of generic participation agreements, etc but requesting specific methodologies on funds flow, how providers are compensated, what formulas are used, etc would be anti - competitive and is proprietary and should not be a requirement. MHA is also concerned that the HPC has

					requested this level of detail for purpose of ACO certification, which the HPC clearly states is not meant to address the financial solvency of an ACO or its suitability to operate as a risk-bearing provider organization (RBPO). MHA respectfully requests this criterion be revised.
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.		While this may be done for individual patients, it is extremely complex for providers to assess the needs and preferences of its population at this level of detail. This is an overly prescriptive and unrealistic reporting requirement; one which patients could also find potentially intrusive if they are asked to repeatedly fill out forms inquiring about their "needs and preferences".
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		
	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?	