Massachusetts League
of Community Health Centers

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TO: Health Policy Commission By email: HPC-Certification@state.ma.us
FR: Patricia Edraos, Health Resources/Policy Director
RE: Response regarding ACO Certification requirements
DT: January 28, 2016

Thank you for the opportunity to provide comments on the proposed standards for Certification of Accountable Care Organizations (ACOs).

The ACO Certification program should start from the perspective of considering which components of the system drive costs and which produce savings. Well-managed primary care, including behavioral health and social services results in savings to the system, but has historically (and currently) been culturally and financially treated as less valuable than other components of the system. Without clear guidance from the Commission on this point, the historic dynamic will continue and funding will likely concentrate at the top and more expensive part of the system rather than in a strong base of cost-effective primary care.

The League's position is that all ACOs should be built on a strong primary care base. Given the relative power of large institutions, providing a few board seats to primary care and community representatives is unlikely to ensure this. We therefore recommend that in order to guarantee meaningful input from primary care, not less than 60% of any Certified ACO board of directors should be composed of a combination of primary care providers, patients, and community representatives. We also suggest that in keeping with federal Medicaid requirements, any Certified ACO should be required to ensure access to Federally Qualified Community Health Center (FQHC) and other Essential Community Provider (ECP) services within the ACO or through contractual arrangements.

We strongly urge you to consider adding the provision of oral health services either directly or through contractual relationships, and listing dentists, pharmacists, social service staff, including but not limited to community health workers, to the types of providers which should be part of a Certified ACO.

Care should be taken so that the requirements do not present an undue burden to smaller providers in three specific areas: Information technology, Reporting, and Legal.

Information Technology: Unlike major institutions, smaller providers who have not yet developed workable 'virtual' networks will require significant IT investments in order to meet record integration and inter-operability requirement, preventing their ACO -- should they form one -- from being certified, and quite possibly discouraging their membership in larger ACOs. We are aware of the great deal of work going on related to inter-operability, and suggest that this be an optional requirement until many of the issues that are impeding it are resolved.

Reporting: We strongly urge, as we did regarding PCMH certification, that documentation prepared for the DOI, IRS, DPH, other public entities, and insurors, be accepted by the Commission in satisfaction of its documentation requirements. Reporting to various agencies is a major administrative cost, and a disproportionate expense to smaller providers. Therefore, we also recommend that, to the maximum extent possible, the Commission should be responsible for obtaining this documentation on behalf of any ACO which identifies its existence and location, and provides a release form if necessary.

Legal: Although we agree with the concept that a Certified ACO should be a separate legal entity, and assume that all corporate laws and regulations would apply, we are concerned that it will provide an impetus for ACOs to "make" and not "buy;"that is, develop services and departments instead of working with existing community agencies to integrate existing services. We have seen one instance of this already, where a hospital has hired away staff from a community health center to begin a program that the health center already had in place. Given the significant disparity in financial resources between most hospitals and most community agencies, it is easy to envision more of this sort of activity. Although the Certification process appears not to anticipate controlling market behavior of this type, the Commission could be helpful in clarifying how for-profit, proprietary, and non-profit entities could combine into a new corporation, and whether different rules would apply regarding distribution of funds and savings within a corporation as opposed to among contracting parties. Questions related to EMTALA and HIPAA regulations which at the present impede cost containment and care integration should also be clarified, as should the effect of outdated state regulations. We would appreciate it if before going forward with Certification standards, the Commission would request the Administration, the AGO or the DOI to clarify these points, since smaller organizations with even smaller legal budgets are likely to be unable to do so.

We strongly support provisions which would encourage the integration of behavioral health services, long term support services, and recognition of social determinants of health.

Although it is not clear what re-certification would entail, we recommend longer rather than shorter periods, for example five to ten years with methods in place to provide "spot checks" on compliance during the interval.

If you have questions or would like further information, please email me (pedraos@massleague.org) or call me at 617-988-2236.