TUFTS Health Plan

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January 29, 2016

Health Policy Commission
Attn: Catherine Harrison
50 Milk St., 8th floor
Boston, MA 02109

Dear Ms. Harrison:

On behalf of Tufts Associated Health Maintenance Organization, Inc. ("Tufts Health Plan"), we appreciate this opportunity to provide comments on the Health Policy Commission's (HPC) proposal for Accountable Care Organization (ACO) Certification Standards. Tufts Health Plan has been engaged in value-based contracting with providers in its commercial network for more than 15 years. More than 85% of our HMO members have a primary care provider that participates in a value-based contract. We contract with Integrated Risk Bearing Provider Organizations on behalf of the state's Group Insurance Commission, and we have over 20 years' experience with our Medicare Advantage products offered through Tufts Medicare Preferred. As such, Tufts Health Plan has significant experience developing budgets for and contracting with integrated delivery systems, including ACOs and ACO-like systems.

We appreciate the thoughtful approach HPC has taken in designing this framework, and we feel that the criteria are quite strong in many areas. Our comments are largely focused on ways to make the ACO Standards more robust with respect to market functioning and consumer protections.

We feel that the most critical element for the HPC, and for payers, to understand is the legal structure of the ACO, including its governance, how funds flow among participating providers, and the degree of clinical and financial integration among providers in the ACO, particularly as it relates to contracting in the marketplace. To that end, we have several comments regarding ACOs and market functioning:

ACOs should be required to operate as separate legal entities. The proposed regulations require ACOs to operate as separate legal entities, except when ACO participants are part of the same health care system. This exception should be removed in order to clarify on whose behalf the ACO is acting. Section 15 of Chapter 224 of the Acts of 2012 requires such separation; it reads, in part: "b) The commission shall establish minimum standards for certified ACOs. A certified ACO shall: (i) be organized or registered as a separate legal entity from its ACO participants."

ACOs should be required to disclose flow of payments to providers. This requirement should be moved from the reporting only section of the regulations to mandatory criteria. We believe that the HPC should assess how funds flow among providers in the ACOs, including the proposed methodology for distribution of funds, prior to certifying ACOs. Such disclosure will allow HPC to properly evaluate ACO performance as well as any future consolidation or affiliation requests that are likely to be filed as a result of ACOs forming in the marketplace.

ACOs should be required to disclose information about clinical and financial integration. ACOs should be required to demonstrate to the HPC specific actions they are taking to effect clinical and financial integration among ACO participants. This information can be difficult for payers to ascertain, and in the past, we have seen affiliations lead to providers growing without making acquisitions. The HPC must be able to evaluate this information before ACOs are permitted to negotiate on others' behalf. This requirement should work in conjunction with the other market protections included in the regulations; for example, attestation to compliance with anti-trust laws and filing of appropriate material change notices.

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ACOs should be accountable for improving quality and reducing costs. Currently, the only financial requirement for ACO certification is that the ACO participate in a budget-based contract with MassHealth by year 2. We believe there should be additional requirements for the ACOs to demonstrate that they are satisfying the state's goals of improving quality, reducing costs and moving toward value-based care. These should include:

- **Requiring minimum thresholds for participation of primary care providers in value based contracts**. Currently, the proposed regulations require ACOs to report the percentage of revenue or percentage of patients in budget arrangements. These requirements should be strengthened to set minimum levels of participation in budget arrangements, including for members in the commercial market

- **Meeting the state's cost growth benchmark.** The proposed regulations require ACOs to report quality and financial information at the ACO-level. However, there should be an explicit requirement that the ACO does not exceed the state's cost growth benchmark of 3.6% in order to be certified in the future. This requirement should include public reporting to the Center for Health Information and Analysis on ACO performance and public reporting of an ACO's Total Health Care Expenses, including accountability for physical health, behavioral health and pharmacy expenses

- **Reducing Total Medical Expense (TME).** The promise of ACOs is increased accountability and better care coordination, which should lead to lower costs over time. There should be explicit requirements for the ACO to demonstrate it is improving quality and reducing TME on an ongoing basis.

ACOs should be required to have minimum panel sizes. The HPC should require minimum panel sizes, among all payers, to ensure that an ACO's patient population is sufficiently large to appropriately assess quality and outcomes. Panel sizes help mitigate random variation that may not be fully captured through other means like risk adjustment. They also serve as a means to protect consumers against financial risk to ACOs from certain high-cost outliers. As such, we recommend aligning the HPC's requirement with those used by the Center for Medicare and Medicaid Services (CMS) for its ACO programs. Namely:

- An ACO taking on upside-only, or shared savings risk should have a minimum patient panel of 5,000 among all payers, in alignment with the CMS Medicare Shared Savings Program.

- An ACO taking on both upside and downside risk should have a minimum patient panel of 10,000 among all payers, in alignment with the CMS Next Generation ACO model.

- If the number of attributed patients drops below the mandated amount, the ACO should be required to submit a corrective action plan to the HPC for increasing patient numbers.

In addition to these comments, we feel that there are a number of areas where the certification requirements could be strengthened to offer stronger consumer protections. Consumers of the Commonwealth are guaranteed a number of protections through relevant insurance statutes, notably MGL Chapter 1760, or regulations, notably 211 CMR 52.00. The HPC should carefully consider how these protections will be preserved by consumers participating in ACOs. More generally, we believe the regulations should include a more formal process to monitor ACOs once they are certified in order to ensure satisfactory levels of performance regarding patient access protections, beneficiary due process, customer service levels, consistency of practice with policies and procedures, and accuracy and completeness of member information communications. These external accountability processes will

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be an important element in maintaining stakeholder confidence in the ACOs as they function over time and should be designed concurrently with the certification criteria. A few examples are included below:

Transparency around complaints and grievances. The proposed regulations require ACOs to attest that they have a process to review complaints and grievances. This requirement should be strengthened, and the Office of Patient Protection (OPP) should report publicly the number and type of appeals and grievances for ACOs, both internal and external appeals, including those related to mental health and substance abuse, as OPP does for insurance carriers.

Transparency around member and provider satisfaction levels. The proposed regulations require ACOs to evaluate patient and family experience. Such surveys should be extended to include satisfaction of an ACO's participating providers. The results should be made available publicly and evaluated by the HPC to determine if the ACO is fulfilling its mission.

Publication of provider directories. ACOs should be required to publish provider directories and update them accordingly. The provider directories should contain a list of all participating providers in the ACO, including information on which providers are accepting new patients, the provider's location, contact information, and specialty. The directories should be made available electronically and in other accessible formats, and be updated at least monthly.

Publication of medical necessity criteria. ACOs should be required to publish their evidence-based medicine / medical necessity criteria and protocols which are not licensed or proprietary on a publicly accessible website, which is easily accessible to the general public.

Thank you for your consideration of our comments. We look forward to continuing to work with HPC on ACOs in the future.

Sincerely,

Kristin Lewis
Vice President, Government Affairs & Public Policy
Tufts Health Plan