UMass Memorial HealthCare, Inc. - UMass Memorial ACO
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Dear David, Katie and the HPC Staff,

I would like to submit just a few comments on the Health Policy Commission's proposed Accountable Care Organization certification standards on behalf of UMass Memorial Healthcare System. As you know I have been very involved in the MassHealth and HPC's workgroups on the development of these criteria over the past few months and so I know you have heard my thoughts. I appreciate being part of those groups and want to thank you for all of your efforts to convene and lead those meetings. I also want to thank you for listening and putting much thought into the development of these draft criteria that clearly reflect many of the discussions we have had.

I wanted to let you know that I was also part of the MHA feedback meetings on this and I have seen their draft response and fully support their comments and suggestions so I will not repeat what they have already said. While you have heard a lot from me on this topic (hopefully you are not tired of hearing from me!) through those discussions, I would like to add a few points on certain key proposed criteria.

Overall for each of the criteria it would be good if the format for filling the requirement is met via their inclusion in a Medicare ACO program or another Payer program and that could be noted at the beginning of the application. This then would automatically trigger certain HPC criteria as being fulfilled with no additional reporting needed. For example, if my ACO states that it is an active participant of an MSSP program and provides documentation as such, then my ACO has meet criteria #1 (separate legal entity) and would not need to provide HPC with any further documentation.

On Criteria #1, the corporate structure and governance, I spoke with our legal folks about it. Here is what they said:
An Accountable Care Organizations is generally defined as a group of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their patients. I think HPC will need to clearly define what constitutes an ACO and distinguish it from the mass of groups out there doing risk contracting that do not want ACO designation. For example, the group of providers in any Blue Cross Alternative Quality Contract could meet the definition of an ACO. However, none of those providers are interested in forming an accountable care organization.

For those who purposely wish to form accountable care organizations, then I agree that for all practical purposes they would need to operate under a single legal entity, primarily due to governance oversight. However, the language as stated could be interpreted to mean that each ACO is required to be a separate and distinct entity. If that's the intent, then I think it should be considered very carefully. For example, let's say providers A,B,C, D and E form an accountable care organization called "APlus Healthcare, Inc." which is the legal entity taking risk under a contract with Blue Cross. APlus Healthcare, Inc. has another risk contract with Tufts, but the only providers participating in that risk arrangement are A,B,C and D (E has a Tufts contract with better terms). Here we have a group of providers participating under Tufts which is not the same group of providers that is participating in the Blue Cross contract. Depending how its defined, this second group of providers could be deemed to be a separate ACO requiring formation of a separate legal entity, and I'm not sure what purpose that would serve.

On the definition, here's one suggestion:

"Accountable Care Organization ("ACO") is defined as: (1) a group of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high quality care to their patients with the intention of entering into risk type contracts under one or more commercial and/or governmental

payer programs; and/or (2) hold themselves out as an Accountable Care Organization. Nothing herein is intended to require that each ACO provider participate in every payer contract entered into by the ACO. Nothing herein is intended to limit an ACO from using multiple trade names representing sub-groups of providers within its ACO. For example, an ACO could have the legal name "APlus Accountable Care, Inc." and also hold itself out as "APlus – Blue Cross Accountable Care" and "APlus Medicare Accountable Care", each with a different set of providers.

Here's a suggestion for changing the language:

"The ACO operates within a legal entity formed for the purpose of operating an accountable care organization and whose governing members have a fiduciary duty to the ACO, except if ACO participants are part of the same health care system."

The above definition and criterion would be one way to provide flexibility for ACO's to have payer contracts with different subgroups of providers who participate in the ACO.

In Criteria #4 I do not agree with your criteria even though we might very well have no problem meeting it. I understand your desire for behavioral health and substance abuse providers to have meaningful participation in the integrated care of ACO beneficiaries; however, I feel that being prescriptive on this is not appropriate or necessary. The MSSP program dictates that the board be made up essentially of its participants. I think mandating the types of providers is going too far as there are types of providers other than those you list that may be more appropriate and very different for different types of ACO programs. I would suggest that the ACO can inform the HPC of its board composition but not be mandated other than to be representative of the particular ACO program that the board has been formed to govern.

On Criteria #9 I do have to disagree with the need for the ACO to provide such a high level of detail on our relationships with the providers you list. Maybe this could be solved by asking for a detail narrative from the ACO as to how it identifies and works with the right cross continuum providers that provide essential services to its ACO members. The ACO will be collaborating with various types of providers in all care continuum services as by its nature it is held accountable for that care from a quality and cost standpoint. The HPC may want to ensure the ACO has the structure and a process with which to do that work but not necessarily require detail listings, assessments and outcomes related to those relationships. That just seems to go too far.

Overall these criteria do feel overwhelming and I hope will be further streamlined once you receive and review comments from MHA and others.

Thank you for the opportunity to be involved in the workgroups and meetings and to be able to provide feedback again through this process. If you have any questions or if I can help going forward, please let me know,

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