COMMONWEALTH OF MASSACHUSETTS

HEALTH POLICY COMMISSION

Final Accountable Care Organization (ACO) Certification Standards

For Certification Year 1

April 2016

Introduction

The Health Policy Commission (HPC), established under Chapter 224 of the Acts of 2012, is an independent state agency whose mission is to advance a more transparent, accountable, and innovative health care system through independent policy leadership and investment programs.

The HPC is charged with developing and implementing standards of certification for Accountable Care Organizations (ACOs) in the Commonwealth. After a significant stakeholder engagement process, including a formal public comment process, on April 27, 2016, the HPC Board unanimously approved a final set of ACO certification criteria for the first year of ACO certification.

The final criteria are shown in Table 1 below. **Please note that the HPC will develop an implementation guide for providers with additional details on the documentation requirements and evaluation standards associated with each of the criteria by August 2016.**

Table 1: Final HPC ACO certification criteria

Pre-requisites		
#	**Criterion**	**Documentation Requirements (under development)**
1.	ACO has obtained, if applicable, a **risk-bearing provider organization (RBPO)** certificate or waiver from **DOI**.	- Attestation/check box
2.	ACO has filed all required **Material Changes Notices (MCNs)** with the **HPC**.	- Attestation/check box
3.	ACO is in compliance with all **federal and state antitrust laws and regulations.**	- Attestation/check box
4.	ACO is in compliance with the HPC's **Office of Patient Protection (OPP)** guidance regarding an **appeals process to review and address patient complaints** and provide notice to patients.	- Attestation/check box

Assessment Criteria			
Domain	**#**	**Criterion**	**Documentation Requirements (under development)**
Patient-centered, accountable governance structure	**1.**	The ACO has an identifiable and unique governing body with authority to execute the functions of the ACO. The ACO provides **for meaningful participation in the composition and control of the governing body for its participants** or their representatives.	- Governing body charter and organizational chart, including titles and clinical degrees/specialty for provider representatives. Indicate which ACO participant each governing body member represents. If there are participating providers not reflected in the governing body, provide a narrative with rationale. - Description of the types of risk contracts (commercial, Medicare and Medicaid) that this governing body oversees, including a narrative description of how participating providers participate in different risk contracts (Medicare, Medicaid, commercial).
Patient-centered, accountable governance structure	**2.**	The ACO governance structure is designed to serve the needs of its patient population, including by having at least one **patient or consumer advocate within the governance structure *and* having a Patient and Family Advisory Committee.**	- *Governance structure* is: governing body, committees, and executive management team(s). - Provide all committee charters and organizational charts depicting governing committees and executive management team(s), including titles and clinical degrees/specialty, if relevant. - Identify the patient(s) or the consumer advocate(s) in the materials provided for criterion 1. - Include PFAC description or charter, including meeting frequency and relationship to the governing board. Multiple, local PFACs would also fulfill this criterion. - Text of or link to a public-facing narrative about how the governance

			structure is designed to meet the needs of the ACOs patient population.
Patient-centered, accountable governance structure	**3.**	The ACO governing body regularly **assesses the access to and quality of care** provided by the ACO, in measure domains of access, efficiency, process, outcomes, patient safety, and patient experiences of care, **for the ACO overall and for key subpopulations (i.e. medically or socially high needs individuals, vulnerable populations),** including measuring any racial or ethnic disparities in care. The ACO has **clear mechanisms for implementing strategies to improve its performance** and supporting provider **adherence to evidence-based guidelines**.	- Performance dashboard(s) with measure name and performance detail and a description of how often the governing body reviews the dashboard *(at least quarterly).* - Governing body meeting minutes (redacted if necessary) from a recent meeting when the dashboard was reviewed. - A narrative description of the ACO's mechanisms/process for implementing and executing on strategies to continuously improve quality performance on dashboard metrics and increase use of evidence-based guidelines
Participation in quality-based risk contracts	**4.**	The ACO has **at least one substantive quality-based risk (up or downside) contract with a payer,** OR the ACO commits to participating in such a contract with MassHealth. ACO must report the name of each carrier, type of contract (e.g. one-sided or two-sided risk) and final performance on all quality measures associated with the contract(s) for past two performance periods.	- Report the name of the carrier(s) with which the ACO has a meaningful quality-based risk contract - Report ACO-level final quality performance on the measures associated with each up or downside risk contract for the last two performance years (if applicable) OR - Narrative commitment to participation in a MassHealth ACO model

Population health management programs	**5.**	The ACO routinely **stratifies** its entire patient population and uses the results to **implement programs** targeted at **improving health outcomes for its highest need patients.** At least one program addresses **behavioral health** and at least one program addresses **social determinants of health** to reduce health disparities within the ACO population.	- Description of risk stratification approach, including frequency. An ACO may use payer reports to meet this requirement.
			- For each program (one addressing BH, one addressing SDH), a description that includes:
			  - How participating patients are identified or selected;
			  - The specific interventions;
			  - The targets/performance metrics by which the ACO will monitor/assess the programs, and the ACO's actual performance for the most recent measurement period;
			  - Number of patients in the programs or that the ACO projects the programs will reach; and
			  - Any linkages to community resources or organizations.
			- A single program that addresses both BH and SDH would satisfy this criterion; ACO could describe additional programs.
			- *Social determinants of health are:* environmental conditions in which people are born, live, learn, work, play, worship, and age that affect a wide range of health, functioning, and quality-of-life outcomes and risks. *(Healthy People 2020)*

Cross continuum care: coordination with BH, hospital, specialist, and long-term care services	**6.**	To coordinate care and services across the care continuum, the ACO **collaborates** with providers outside the ACO as necessary, including: - Hospitals - Specialists, including any sub-specialties - Long-term care providers (i.e., SNFs, LTACs) - Behavioral health providers (both mental health and substance use disorder providers) Providers and facilities within the ACO collaborate to coordinate care, including **following up on tests and referrals across care rendered within the ACO.**	- A list of key clinical partners, including strategic clinical affiliations, that ensure the ACO provides cross-continuum care. - Narrative regarding how the ACO collaborates with each category of clinical partners (hospitals, specialist, long-term care and behavioral health). ACO must provide evidence that collaboration in each of the 4 categories (hospitals, specialists, LTC providers, and BHPs) includes at least 3 of the following factors: 1. Measurement of quality, patient experience, and cost 2. Access and appropriate breadth of services 3. Use of team-based care, including case conferences/collaborative clinical programs 4. Communication and/or data-exchange (incl. interoperability) procedures and capabilities 5. Access to and coordination with community-based providers/services 6. Comprehensive care transition protocols - Description of ACO processes for tracking and following up on tests and referrals across providers and facilities within the ACO, including behavioral health providers (if within the ACO).

Required Supplemental Information Questions			
Criterion	**#**	**Certification Question**	**Response Format/Fields (under development)**

Supports patient-centered primary care	**1.**	How does the ACO support patient-centered primary care transformation? Please describe plans to increase PCMH recognition rates, including any plans to achieve PCMH PRIME certification.	- Does your ACO currently include NCQA recognized PCMHs? (Yes/No)
			  – If yes, fill in % of practices with NCQA recognition
			- Does your ACO currently include practices with PCMH recognition through another org? (check all that apply, and fill in %)
			  – Joint Commission
			  – URAC
			  – AAAHC
			  – Other ____
			  – None of the above
			- ACO supports PCMH by (check all that apply):
			  – Financial support/supplemental payments to practices
			  – TA to practices
			  – Infrastructure (e.g. EHR)
			  – None of the above
			- Do you currently have plans to achieve HPC PCMH PRIME certification? (Yes/No)
			  – If yes, general narrative describing plans
			- Narrative about other ways ACO supports patient-centered primary care

Assesses needs and preferences of ACO patient population	**2.**	How does the ACO assess the needs and preferences of its patient population with regard to race, ethnicity, language, culture, literacy, gender identity, sexual orientation, income, housing status, food insecurity history, and other characteristics?
		
		How does the ACO use this information to inform its operations and care delivery to patients?
			- ACO assesses its patient population on the following: (check all that apply)
			  – Race
			  – Ethnicity
			  – Language
			  – Culture
			  – Literacy
			  – Education
			  – Gender identity
			  – Sexual orientation
			  – Income
			  – Housing status
			  – Access to transportation
			  – Interpretation/translation needs
			  – Food insecurity
			  – History of abuse/trauma
			  – Other
			- Does the ACO use a standard assessment tool to gather these data? (Yes/No)

			– If yes, commercial tool or proprietary? (select one) – If no, what method does ACO use? (free text) - Does the ACO utilize these data to inform operations and care delivery? (Yes/No) – If yes, brief narrative of how – If no, list key barriers/reasons - Does the ACO align and benchmark patient panel-specific data elements in comparison to broader population health data elements from community health needs assessments done by hospitals within the ACO or in the regions in which the ACO operates? (Yes/No) – If yes, brief narrative of how – If no, list key barriers/reasons
Supports community-based health programs	**3.**	How does the ACO use the information gathered in the criterion above to develop and support community-based policies and programs aimed at addressing social determinants of health to reduce health disparities within the ACO population?	- Using information gathered in the previous criterion, the ACO (check all that apply): – Funds/invests in existing community-based programs that address the impacts of SDH – Runs programs in collaboration with organizations in the community to address the impacts of SDH – In collaboration with community partners, supports policy and/or environmental changes that address SDH – Other – None of the above - Provide a brief narrative description for each checked box above
Supports patient-centered advanced illness care	**4.**	To what extent has the ACO established processes and protocols for identifying, counseling, and planning for advanced illness care? To what extent has the ACO established collaborations with providers/facilities focused on advanced illness care?	- Does the ACO have a process to identify patients for advanced illness care? (Yes/No) - Does the ACO have advanced care planning processes (including advanced directives and authorizing a healthcare proxy) or policies for participating providers, with a focus on engaging with patients and their families, on topics such as symptoms, spiritual health, preferences, etc.? (Yes/No) – If yes, narrative description of how ACO providers are trained or supported in developing advanced care plans for ACO patients - Are advanced care plans integrated into the ACO's EHR(s)? (Yes/No) - ACO has formal relationships with providers trained in advanced illness, palliative and hospice care (check all that apply): – Within the ACO – Outside the ACO – No formal relationship(s) – brief narrative describing

			relationship

Performs quality, financial analytics and shares with providers	**5.**	How does the ACO conduct performance analyses, including measure domains of access, efficiency, process, outcomes, and patient safety?
		
		Does the ACO generate its own reports, collaborate with a vendor, or rely on payer reports?
		
		What process does the ACO have to disseminate reports to providers, in aggregate and at the practice level?
			- ACO performs the following types of analyses (check all that apply):
			  – Efficiency (e.g. readmissions, avoidable admissions)
			  – Quality outcomes
			  – Quality process
			  – Access
			  – None of the above
			- Check all that apply:
			  – ACO develops its own reports
			  – ACO uses payer reports
			  – ACO collaborates with vendor for reporting
			  – None of the above
			- Does the ACO disseminate reports to providers? (select from drop-down menu)
			  – Yes, in aggregate
			  – Yes, in aggregate and at the practice level
			  – No
			- Types of measures used for quality performance (check all that apply)
			  – Claims-based process measures
			  – Clinical health outcomes that require clinical data
			  – Patient surveys
			  – Patient reported outcome measures (PROMs)
			  ▪ If so, which PROMs measures?
			  – None of the above
			- Brief narrative of dissemination process

Evaluates and seeks to improve patient experiences of care	**6.**	Describe how the ACO evaluates patient and family experience on access, communication, and coordination.
		
		What survey tool does the ACO employ? What is the frequency of such evaluation?
		
		How does the ACO develop plans, based on evaluation results, to improve patient and family experience?
			- ACO utilizes one or more of the following survey tools to assess patient and family experience (check all that apply)
			  – Press Ganey
			  – CAHPS (C/G, PCMH)
			  – Proprietary tool
			  – Other _____
			  – None of the above
			- How frequently does ACO field survey tool(s)? (select from drop-down menu)
			  – Annually
			  – Quarterly
			  – Monthly
			  – Other _____
			  – None of the above

			- General narrative of how ACO utilizes survey results to improve P/F experience

Distributes shared savings or deficit in a transparent manner	**7.**	How does the ACO distribute funds among participating providers? What is the process for making distribution and/or reinvestment decisions? Please include methodology(ies) used.
		
		How does the ACO take into consideration quality, cost, and patient experience data when developing its methodology?
			- General narrative of how ACO distributes funds/reinvests
			- ACO considers the following when developing distribution methodology (check all that apply):
			  – Quality
			  – Cost
			  – Efficiency
			  – Patient experience data
			  – Adoption of HIT
			  – Other _____
			  – None of the above
			- General narrative of how each is used

Commits to advanced health information technology (HIT) integration and adoption	**8.**	What is the ACO providers' connection rate to the Mass HIway?
		
		What is the ACO's plan to increase adoption and integration rates of certified EHRs and connection rates to the Mass HIway?
		
		What are the ACO's plans and timelines to increase the current capacity for interoperability and real-time event notification between entities within and outside the ACO?
			- Current connection rate of ACO providers to Mass HIway (fill in %)
			- Percent of entities within ACO capable of interacting with interoperable EHRs, including real-time notification (fill in %)
			- Percent of entities outside the ACO with which interoperability and real-time event notification are possible (fill in %)
			- The ACO has specific plans to increase rates of (check all that apply):
			  – Connection to Mass HIway
			  – Adoption and integration of certified EHRs
			  – Interoperability and real-time event notification
			  – Patient access to EHR
			  – Decision support tools embedded within the EHR
			  – None of the above
			- For all checks above, brief narrative of plan
			- Types of providers with whom ACO has prioritized rate increase (check all that apply)
			  – PCPs
			  – SCPs
			  – Community-based orgs.
			  – SNFs, long-term care orgs.
			  – Other _____
			  – None of the above

Commits to consumer price transparency	**9.**	How does the ACO encourage its participating providers to make price information available to consumers as required under state law and regulations?	- The ACO has written policies and procedures for participating providers to, at the request of a patient, disclose the allowed amount or charge of an admission, procedure, or service within two working days (Yes/No) – If yes, brief narrative description

			– If no, brief narrative description of challenges/barriers or other rationale for not doing so - The ACO supports consumers to obtain information on the costs they may incur for services rendered by ACO participating providers: – From insurers (Yes/No) – In other ways (Yes/No) - If yes (to either), brief narrative of how