COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

Proposed 2019 Accountable Care Organization (ACO)
Certification Standards

Request for Public Comment

December 18, 2018

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I.   Introduction

The Health Policy Commission (HPC) 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 ACO Certification program was developed pursuant to the state's landmark health care cost containment law, Chapter 224 of the Acts of 2012, which requires the HPC to "establish a process for certain registered provider organizations to be certified as accountable care organizations," (ACOs) and to create a process for designating "model ACOs."

The ACO Certification program aims to complement existing local and national care delivery transformation efforts by setting statewide standards that encourage the provision of value-based, high-quality, and cost-effective care for all ACO patients. The program defines core competencies that are relevant to any ACO patient population and applicable to a range of provider organizations, from those with substantial experience in value-based care delivery to those newly transitioning to risk-based payment and care delivery models. In 2017, the first year of the ACO Certification program, the HPC certified 17 ACOs that met those standards.

The goals of the ACO Certification program include the following:
- Create a set of multi-payer standards for ACOs to enable care delivery transformation and payment reform;
- Build knowledge and transparency about ACO approaches;
- Facilitate learning across the care delivery system; and
- Align with and complement other standards and requirements in the market, including those promulgated by other state agencies (e.g., the DOI's Risk-Bearing Provider Organization process) and health care payers/purchasers.

The vision for the ACO Certification program is two-fold: 1) to contribute to the evidence base on how ACOs achieve improvements in quality, cost, and access, and 2) to evaluate ACOs on quality outcomes and cost performance rather than structural or process requirements.

In keeping with this vision, the HPC is proposing some updates to the set of requirements for certification in 2019, and a potential voluntary new Distinction program for certified ACOs. The proposed standards in this Request for Public Comment will apply to ACOs seeking to renew or achieve certification for the first time in 2019 and 2020. The Distinction program would recognize ACOs that that have achieved performance improvements in the domains of the Triple Aim — improved health outcomes, better care, and lower cost — plus health equity, and make commitments to continue improving. The HPC is seeking to define detailed requirements for the Distinction program in 2019, for a potential launch of the program in 2020.

The HPC is requesting public comment on the proposed 2019 ACO Certification standards and associated proposed documentation requirements detailed below, as well as the proposed new Distinction program. Please note that responses to this Request for Public Comment are subject to public disclosure pursuant to the Massachusetts Public Records Law, chapter 66 of the General Laws, and may be posted on the HPC website.

Responses to this Request for Public Comment must be received by the HPC by **5:00 PM, February 8, 2019** and may be submitted via email to HPC-Certification@mass.gov or in hard copy to:

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

Additionally, the HPC will hold a public listening session on January 23, 2019, at 10:00 a.m. at:

Health Policy Commission
50 Milk St., 8th floor
Boston, MA 02109

Expected Timeline

Date	Event
September 2018 – February 2019	Overall stakeholder engagement period
December 18, 2018-February 8, 2019	Public comment period
January 23, 2019	Public listening session
February 27, 2019	HPC Care Delivery Transformation Committee review and approval of 2019 program requirements
Spring-Summer 2019	Provider engagement and training on 2019 program
Summer-October 1, 2019	2019 certification application period for ACOs (for effective date of January 1, 2020)
December 31, 2019	HPC issues certification results
January 2019-December 2019	HPC reports on 2019 certification results and completes Distinction program design
TBD 2020	Distinction program launch

II.   Proposed 2019 HPC ACO Certification Program

A. Overview

For 2019, the HPC proposes an application format and sections similar to 2017, with some updates:
1. a **Background Information** section that includes pre-requisite attestations as well as questions regarding the ACO's mission, the primary care providers and hospitals that participate in the ACO, and information on the ACO's risk contracts.
2. an **Assessment Criteria** section that includes five standards and documentation requirements that are substantially similar to the 2017 Assessment Criteria; and
3. a section for **Supplemental Questions** that includes questions divided into two categories: "Adding to the Evidence Base," and "Emerging Topics."

These sections are described in detail below.

The HPC also proposes to maintain the approach of requiring the Applicant for ACO Certification to be the health care provider or provider organization that has common ownership or control of any separate contracting entities that hold risk contracts. Certification will be granted at the Applicant level, inclusive of Component ACOs.

B. Criteria and Documentation Requirements

This section details the proposed 2019 HPC ACO Certification requirements, including Background Information questions, Assessment Criteria and associated documentation requirements, and topics for the Supplemental Questions. For definitions of capitalized terms, please refer to the 2017 Application Requirements and Platform User Guide.

i. Background Information

Pre-requisites
As a pre-requisite to certification, each Applicant will be required to attest, via a check-box, to the following five statements:
1. Applicant has obtained, if applicable, one or more Risk-Bearing Provider Organization (RBPO) certificate(s) or waiver(s) from the DOI.[1]
2. Applicant has filed all required Material Change Notices (MCNs) with the HPC, if applicable.[2]
3. Applicant is in compliance with all federal and state antitrust laws and regulations.
4. Applicant is in compliance with the HPC's Office of Patient Protection (OPP) regulations (958 CMR 11.00), if applicable,[3] regarding establishing a patient appeals process.
5. Applicant has at least one Substantive, Quality-based Risk Contract with a public or private payer in the Commonwealth.

Summary of Applicant Organization
1. Brief narrative describing the organization, history, and mission of the Applicant and the Component ACOs.
2. List of Massachusetts regions, as defined by the HPC[4], in which the Applicant and/or any Component ACOs provide care
3. Organizational chart(s) of the Governance Structure(s) of the Applicant (and Component

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[1]An entity is required to obtain an RBPO certificate or waiver if it is a provider organization that both manages treatment of a group of patients and bears downside risk for those patients according to the terms of an alternative payment contract. *See* DOI's Bulletin 2014-05 for more information. *See also* 211 CMR 155.00. Provider organizations are certified from March 1st of a particular year to February 28th of the next year.

[2]As outlined in the MCN FAQs published by the HPC on July 27, 2016, the formation of an ACO for the purpose of solely establishing Medicaid or Medicare contracts does not require an MCN filing at this time. The full set of FAQs can be found at http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/material-change-notices-cost-and-market-impact-reviews/forms.html.

[3] Pursuant to OPP regulations, 958 CMR 11.02, this appeals process does not apply to any MassHealth (Medicaid), Medicare, or Medicare Advantage patients. See https://www.mass.gov/files/documents/2018/10/02/958%20CMR%2011.00_Posted%20September%202018.pdf.

[4] The HPC defines 15 regions of Massachusetts. Details and specifications are provided at https://www.mass.gov/files/documents/2016/07/uc/2013-cost-trends-report-technical-appendix-b3-regions-of-massachusetts.pdf.

ACOs as applicable), including Governing Body, executive committees, and executive management, and indicating the location of a patient or consumer representative role within each Governance Structure.

ACO Participants
1. For the Applicant and each Component ACO if applicable, a list of primary care practices (site level) and hospitals that participate in each risk contract held by the Applicant/Component ACO. If this information is available through the Massachusetts Registration of Provider Organizations (MA-RPO) program (e.g., in the Contracting Entity file, Physician Roster file, etc.) as part of the 2018 or 2019 filing, the Applicant may state that the relevant information is available through the MA-RPO program.
2. If the Applicant or any Component ACO holds more than one risk contract, a narrative description of any differences in the categories of providers that participate in each risk contract (e.g. employed primary care physicians participate in all risk contracts; contracting affiliate physicians only participate in the Medicare risk contract). If this information is available through the Massachusetts Registration of Provider Organizations (MA-RPO) program (e.g., in the Contracting Entity file) in the 2018 or 2019 filing, the Applicant may state that the relevant information is available through the MA-RPO program.

Applicants may be asked to review the information available from the MA-RPO program, confirm its accuracy, and provide updates or clarifications, as necessary.

Risk Contract Information
1. Completion of an Excel template (see Appendix for proposed template) to report:
    a. Name of payer, risk contracts, and product type (e.g., PPO, HMO, fully-insured, self-insured)
    b. Year when contract began and year of expiration
    c. Number of attributed patients
    d. Payment methodology (e.g., fully capitated, sub-capitated)
    e. Quality incentives in the risk contract
    f. Member management fee/infrastructure payment
    g. Financial risk terms for each contract:
        i. Full or partial risk
        ii. Upside only or upside and downside risk
        iii. Maximum shared savings and shared loss rates
        iv. Any cap on shared savings or losses

Risk Contract Performance
1. Completion of Excel template to report quality performance on all measures included in risk contracts from the Massachusetts Aligned Measure Set[5] for the two most recent

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[5] In 2017 the Executive Office of Health and Human Services (EOHHS) convened a Quality Alignment Taskforce to recommend to the Secretary an aligned measure set for use in global budget-based risk contracts, defined as inclusive of commercial ACO and MassHealth ACO contracts. The Taskforce developed a recommended aligned measure set for voluntary adoption by private and public payers and by providers in global budget-based risk contracts. For more information about the Taskforce and its work, see the Taskforce report at https://www.mass.gov/how-to/ma-eohhs-quality-alignment-taskforce-report-on-work-through-july-2018.

performance years (see Appendix for proposed template, including a list of the relevant measures)

2. Final quality performance on ambulatory measures[6] not included in the Massachusetts Aligned Measure Set for the two most recent performance years

ii. Assessment Criteria

For each of the Assessment Criteria and associated documentation requirements, each Applicant (and/or Component ACO, as applicable) will be required to provide updated documentation/responses or to attest that their 2017 response remains fully accurate and applicable. In the case of an attestation, no additional documentation will be required.

1. Governance Structure

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.

Documentation Requirements:
a. Excerpts of **Governing Body by-laws** or other authoritative documents that demonstrate the Governing Body's authority to execute the functions of the ACO**.** If the Applicant has Component ACOs with unique Governing Bodies the Applicant must provide separate by-laws or other authoritative documents for each Governing Body.

b. **Governance Structure key personnel template** (use template provided)**,** including the following identifying information for Governing Body members, executive committee members, and executive management staff (e.g. COO, CEO, CMO, CFO, strategy officer):
    i. Name (first and last)
    ii. Title and clinical degree/specialty (if applicable)
    iii. Role within the Governance Structure (i.e. Governing Body member, executive committee member, or executive management)
    iv. Attestation that ACO Participants have at least 75% control of the Governing Body
If the Applicant has Component ACOs with unique Governance Structures, the Applicant must provide responses for (i)-(iv) for each Governance Structure, using a separate tab in the template.

2. Patient / Consumer Representation

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***

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[6] Applicants are not required to report quality performance on any hospital quality measures included in their risk contracts.

having a patient and family advisory committee.

Documentation Requirements:
    a. Description of at least one patient and family advisory committee or other group that is composed of patients, families, and/or consumer advocates. An Applicant meets this requirement by having either a single committee that represents patients and families served by the Applicant and all of its Component ACOs, or by having multiple committees (e.g. one per Component ACO). The description must include:
        i. Committee's reporting relationship within the Governance Structure; and
        ii. Meeting frequency.

    b. Is the Applicant using one or more existing hospital-based Patient and Family Advisory Council(s) (PFAC) to satisfy this requirement?
        ☐ Yes
        ☐ No
    If yes, provide excerpted meeting minutes of most recent PFAC meeting where issues pertaining to the ACO(s) were discussed.

    c. Text of or link to a publicly available narrative demonstrating one or more ways the Governance Structure(s) seeks to be responsive to the needs of its patient population. Examples of an acceptable narrative include:
        - A statement appearing on a website describing how the Component ACO acts as patient-centered organization.
        - A patient newsletter blurb providing information about how a patient/consumer representative could participate in a patient/family advisory committee
        - A pamphlet or posted sign in a provider's office that tells patients/consumers how to provide feedback to the Component ACO on patient experience and care issues.
        - A summary posted on a website of patient/family advisory committee activities that highlights the results of patient-focused improvement activities.

3.	Performance Improvement Activities

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**.

Documentation Requirements:
    a. Narrative of how the Governing Body(ies) assesses performance and sets strategic performance improvement goals, no less frequently than annually. If the Applicant has Component ACOs with unique Governing Bodies the narrative must describe how each

Governing Body assesses performance and sets strategic performance improvement goals. The narrative must include:
- A description of the selection process for performance metrics; and
- A description of how performance improvement goals set by the Governing Body(ies) are used in setting provider improvement targets.

b. Performance dashboard(s) with measure name detail and a description of how often the Governing Body(ies) reviews the dashboard and related strategic goals (at least annually). The dashboard may be uploaded as an editable file (e.g. Excel document) or as a screenshot. An Applicant with multiple Component ACOs that use different dashboards must submit a separate dashboard and description for each Component ACO. If actual performance data are not available for one or more of the dashboard measures, it is acceptable to submit a dashboard without measure values.
- The dashboard must include at least one measure in each of the following domains:
  - Process (e.g., access, patient safety)
  - Efficiency
  - Outcomes
  - Patient Experience
- The dashboard must indicate which measures are stratified by sub-population and by which sub-populations (e.g., payer type (Medicaid, commercial), race/ethnicity or other socioeconomic factors). At least one measure must be stratified by a sub-population.

4.	Population Health Management Programs

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.

Documentation Requirements:
a. Description of the Applicant's approach to stratifying its patient population (inclusive of the populations served by any Component ACOs), including:
  i. Frequency, which must be at least annually;
  ii. Factors on which stratification is completed (e.g., ED use, functional status, presence of chronic conditions);
  iii. Whether the reports used for stratification are generated by payers, by the Applicant using its own stratification methodology, or by the Applicant using proprietary software from a vendor; and
  iv. If the Applicant's approach to stratification differs by subpopulation (e.g. Medicare, Medicaid, commercial), a summary of the differences in the approaches used.

b. Description of at least one program operated by the Applicant and/or any of its Component ACOs that addresses BH and at least one program that addresses SDH including:
   i. How participating patients are identified or selected;
   ii. The specific interventions, including staffing model (e.g., community health workers, social workers);
   iii. The targets/performance metrics by which the ACO monitors/assesses the program, and the ACO's actual performance for the most recent measurement period;
   iv. Number of patients in the program or that the ACO projects the program will serve; and
   v. Any linkages to community resources or organizations.
   A single program that addresses both BH and SDH may be used to satisfy this requirement.

5.	Cross-continuum Care

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 services and supports (LTSS) (including both facility-based and community-based services and providers)
- Behavioral health providers (BHPs) (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**.

Documentation Requirements:
1. Does the Applicant and/or its Component ACOs include specialists, LTSS, and/or BH providers among its ACO Participants? Yes/No
   a. If yes, provide the names of those specialists, LTSS and/or BH providers (at the organization level; individual clinician names and/or NPIs not required).

2. Does the Applicant and/or its Component ACOs have written agreements to collaborate with hospitals, specialists, LTSS, and/or BH providers that are not ACO Participants? Yes/No
   a. If yes, provide the names of those hospital(s), specialists, LTSS, and/or BH providers.
      i. Select which factor(s) are considered when entering into written agreements with hospitals, specialists, LTSS, and/or BH providers that are not ACO Participants :
         – Measurement of quality, patient experience, and cost
         – Access (i.e., wait times, availability)

- Use of team-based care, including case conferences/collaborative clinical programs
- Communication and/or data-exchange (incl. interoperability) procedures and capabilities
- Access to and coordination with community-based providers/services
- Comprehensive care transition protocols

    b. If no, does the Applicant and/or its Component ACOs have other arrangements with hospitals, specialists, LTSS, and/or BH providers, and/or plans to enter into written agreements to collaborate with hospitals that are not ACO Participants? Yes/No

        i. If yes, briefly describe such other arrangements and/or plans.

        ii. If no, briefly explain.

iii. Proposed 2019 Supplemental Questions

The HPC proposes that the 2019 Supplemental Questions section include two types of questions to address distinct, complementary goals: adding to the evidence base, and highlighting ACO activities in emerging areas of focus in care delivery transformation. Responses to these questions may inform future "model ACO" standards and other ACO Certification program updates.

The HPC seeks input on the topic areas and questions proposed below, and which topics should be prioritized for inclusion in the ACO Certification application; the HPC intends to include only a subset of the topics/questions proposed below. The questions may be modified to collect standardized responses – i.e. in the form of yes/no, check boxes/multiple choice, and/or short text responses. Applicants with multiple Component ACOs will be directed to provide responses that best describe the overall characteristics or approach across the Applicant and all of its Component ACOs.

Section 1: Adding to the Evidence Base
Questions in this section will be aimed at adding to and/or filling identified gaps in the current evidence base.

Distribution of Shared Savings and Performance-Based Provider Compensation
How does the ACO incorporate risk-based incentives into its participating provider compensation model? How are quality, cost, and patient satisfaction data considered?

Providing High-value Care
How does the ACO efficiently manages resources to provide high-quality, affordable care? How does the ACO redirect community-appropriate care to high-value community settings and support patients to make high-value choices? What are the ACO's protocols or guidelines to encourage appropriate use of lower-cost drugs and imaging?

Behavioral Health Integration into Primary Care

How does the ACO support access to patient-centered primary care and behavioral health care? What is the ACO's strategy for supporting its primary care practices to achieve and sustain patient-centered medical home and behavioral health integration capabilities, and other complementary strategies (e.g. "reverse integration")?

Advanced Health Information Technology-enabled Care Coordination

How does the ACO use interoperable electronic health records (EHRs) among ACO Participants to facilitate care coordination, two-way clinical exchange capabilities with non-ACO Participant providers, and health information technology-based care management programs?

Coding

Does the ACO have an explicit strategy and/or goals related to risk coding? How many staff does the Applicant-level ACO have to support coding? Does the ACO provide guidance to clinicians or other staff regarding coding?

Market Functioning

What are the ACO's strategies for reducing leakage and managing referrals? Does ACO consider price variation in managing referrals?

Section 2 - Emerging Topics
Questions in this section will explore ACO approaches to emerging areas of focus in integrated, patient-centered care delivery

Workforce

How are newer provider types, such as recovery coaches and community health workers, being incorporated into ACO care models and/or population health management programs?

Integrated, Innovative Care Models

Does the ACO offer the following types of services / care models, or have future plans to do so: patient-centered advanced illness care, oral health integration, medication for addiction treatment strategy, crisis care, telemedicine, and/or paramedicine/mobile integrated health?

Community Partnerships to Address Social Determinants of Health

How does the ACO and its participating providers collaborate with community-based organizations to address the social determinants of health, such as food insecurity, housing stability, and early childhood, development for its risk population?

iv. Confidentiality of Proposed 2019 ACO Certification Data

Through the ACO Certification program, the HPC seeks to promote greater transparency and continuous improvement of the Massachusetts health care system. Some of the information submitted by Applicants to the ACO Certification program is made publicly available, while other information and documents may be of a clinical, financial, strategic, or operational nature that is non-public, and is discussed only in the aggregate.

For 2019, the HPC proposes to report on specific certified ACOs using publicly available information and the information listed in Table 1 below that is submitted to the HPC for ACO Certification.

Table 1: Proposed 2019 Information for Public Reporting

Applicant name (legal and d/b/a) and the name(s) of any Component ACOs.
Applicant Tax Identification Number (TIN) and the TIN(s) of any Component ACOs
Applicant address
Applicant contact name and contact information
Primary application contact name and contact information
Summary of Applicant organization, including   1. Brief narrative describing the Applicant's organization, history and mission   2. List of Massachusetts regions in which the Applicant or any Component ACOs provide care; and   3. Organizational chart(s) of the Governance Structure(s) of the Applicant (and Component ACOs as applicable), including Governing Body, executive committees, and executive management, and indicating the location of a patient or consumer representative role within each Governance Structure.
ACO Participants, including: 1. List of participating primary care practices (site level) and hospitals   2. Narrative of any differences between the categories of providers that participates in each risk contract
Name(s) of payer(s) with which Applicant and its Component ACOs have quality-based risk contracts; year that each contract began and expires; whether or not the contract is upside-only, or includes downside-risk; and number of attributed patients per contract
Description of patient and family advisory committee(s)
Publicly available narrative demonstrating one or more ways the Governance Structure(s) seeks to be responsive to the needs of its patient population.

The HPC will not disclose, without the consent of the Applicant, non-public information and documents submitted for Certification that are not listed and Table 1 and are clinical, financial, strategic, or operational in nature. The Certification application will provide the Applicant the opportunity to give consent to the HPC to disclose information other than those elements listed in Table 1.

III. Proposed ACO Distinction Program

The HPC is proposing to create a voluntary Distinction program for certified ACOs. This new program would recognize ACOs that have achieved improvements in the domains of the Triple Aim — health outcomes, improved care, and reduced cost — plus health equity, and commit to specific strategic plans to continue improving. The HPC seeks feedback from stakeholders on both the concept and technical design of the program.

The HPC proposes to grant Distinction for a two or three-year term and to base Distinction on two components – (1) demonstrated improvement on selected measures and (2) strategic plans for continued improvement – described in further detail below. Distinction would be granted at the HPC-certified Applicant level.

Performance Reporting
The Applicant would be required to submit data to the HPC demonstrating that it had made statistically significant improvement over the last two years in its performance on the following domains:
1. Cost (e.g., total medical expense (TME) or total cost of care (TCoC))
2. Access (e.g., Emergency Department (ED) utilization or pediatric well visits)
3. Quality (e.g. chronic disease control, depression remission)
4. Health equity (e.g. performance improvement on at least one of the above measures stratified by a factor such as race, income, language, etc.)

The HPC would select one measure for each domain. Because Distinction would be granted at the Applicant level, Applicants would be required to show improvement in the selected measures across all risk contracts or risk contract categories (i.e. commercial, Medicare, Medicaid).

Applicants also would be required to provide a narrative describing how the performance improvements were achieved, which would be used to facilitate learning across the system.

Strategic Planning
Applicants would submit a strategic plan committing to continuing to improve performance going forward on a measure in each of these domains selected by the HPC, as well as on improving health equity. The results of these commitments and plans would be the basis for re-evaluating the Applicant for Distinction at the end of the Distinction term.

IV. Questions for Public Comment

The HPC is seeking public input on the 2019 ACO Certification program overall, including the specific proposed certification criteria, and the proposed new Distinction program for certified ACOs. Respondents are asked to consider the following questions in drafting their comments:

1. Do the proposed 2019 Assessment Criteria reflect reasonable expectations for ACO capabilities in important operational areas? If not, how should they be modified?

2. Do the proposed 2019 Supplemental Questions in each category ("Adding to the Evidence Base" and "Emerging Topics") reflect the topics of greatest importance? If not, how should they be modified? Which of the proposed questions are the most important in each category?

3. Does the proposed Background Information section include appropriate questions for understanding the type, size, experience, patient population, and other key organizational characteristics of the ACO? If not, how should they be modified?

4. Do you have any questions or concerns about using MA-RPO data to identify hospitals and primary care practices participating in the ACO?

5. On the whole, are the certification criteria appropriate for ACOs of varying types, sizes, levels of experience, etc., and all ACO patient populations? If not, why, and how should they be modified?

6. Does the proposed 2019 HPC ACO Certification program appropriately balance the need for a rigorous certification program with the provider administrative burden that may be associated with certification?

7. Do you support the HPC's proposal to offer a Distinction program for certified ACOs that recognizes performance improvement in health outcomes, care, cost, and health equity? Why or why not?

8. What is the most appropriate duration of time for ACO Distinction - two years? Three years?

9. For the Distinction program, what are the most appropriate measures for cost, quality and access? Is it feasible for ACOs to report the TME or TCoC at the Applicant level, across all risk contracts or risk contract categories?

10. For the Distinction program, how should the HPC evaluate improvements in health equity? What should Applicants be required to demonstrate with regard to health equity in order to achieve Distinction?

11. For seeking Distinction in 2020, what are the most recent two years of internal data that ACOs will have on cost, quality, access and equity?

12. What standards should the HPC use to evaluate strategic plans submitted by Applicants for Distinction? Should the HPC select metrics for Applicants' strategic plans, or should Applicants select their own metrics for strategic plans?

Appendix

A. Risk Contract Information Proposed Template

HPC ACO Certification
Applicant Overview Template 1: Risk Contracts

Applicant:
Component ACO
(if applicable):

#	Name of payer *Add rows as necessary*	Product	Fully-insured or self-insured?	Year contract began; year contract expires	Number of attributed patients/covered lives	Financial Risk Terms						Payment methodology	Description of quality incentives in the payment model	What is the member management fee or infrastructure payment, if applicable?
						Full or partial risk contract?	Upside only or upside and downside risk?	Max shared savings rate, if applicable	Max shared loss rate, if applicable	Cap on savings payments, as % of budget or PMPM, if applicable	Cap on shared loss amounts, as % of budget or PMPM, if			
1	Medicare	Next Generation ACO	Fully-insured	2016; 2018	20,000	Partial risk	Upside and downside risk	90%	90%	10%	10%	FFS payments reconciled against budget	Quality score affects spending benchmark (higher performance reduces standard benchmark discount)	Hierarchical Condition Category risk scores (factors include diagnoses, age, sex and whether the patient is community-based or living in a skilled nursing facility)
2												Prospective capitation		
3												Partial prospective capitation (e.g. for primary care)		
4														
5														
6														
7														
8														
9														
#														

B. Risk Contract Performance Proposed Template

<table>
<tr><td colspan="3" align="center">**HPC ACO Certification**</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="3" align="center">**Applicant Overview Template 2: Risk Contract Performance**</td><td></td><td></td><td></td><td></td></tr>
<tr><td colspan="3" align="center">**Instructions**</td><td></td><td></td><td></td><td></td></tr>
</table>

Purpose

This template is for ACO Certification Applicants to submit performance data on risk contract quality measures. The HPC has provided a template with the quality measures included in the Aligned Measure Set pre-populated. Instructions on how to correctly fill out the template are below.

The Aligned Quality Measure set was established by the Executive Office of Health and Human Services Quality Alignment Taskforce, whose goal is to reduce administrative burden on provider organizations operating under mutliple, non-aligned measure sets in their ACO risk contracts, and to focus provider quality improvement efforts on state health opportunities and priorities.

Three categories from the Aligned Measure Set are included in this template:
  - The Core Set includes measures that payers and ACOs are expected to use in all global budget contracts
  - The Menu Set includes all other measures from which payers and ACOs may choose to supplement the Core measures
  - The Monitoring Set includes measures that the Taskforce identified to be a priority area of interest, but because recent performance was high, or data not currently available, were not endorsed for Core or Menu Set use.

Please see the EOHHS Quality Alignment Taskforce report for more information:
https://www.mass.gov/how-to/ma-eohhs-quality-alignment-taskforce-report-on-work-through-july-2018

Instructions

In this template, please fill in performance for the most recent two performance years (2017 and 2018, if available). Use the "Notes" column (V) to note any minor differences between the measure included in the aligned set and the version used in your contracts. Applicants should submit performance from contracts that meet the definition of "substantive quality-based risk contracts," (p. X of the PUG). Please add columns as necessary to accomodate all of your relevant risk contracts. Applicants should omit Medicare Advantage, PACE, and SCO contracts.

Measures:
If your risk contracts include ambulatory measures other than those in the aligned set, please add them as follows:
1) provide details on the measure by completing columns B, C, and G (it is not necessary to complete other columns);
2) fill in performance for the most recent two performance years (2017 and 2018). Please only submit ambulatory quality measures, it is not necessary to add hospital quality measures and performance.

Applicant:									

								Contract information	**Name of Payer**		Contract 1
									Name of Product		

Aligned Measure Set Category	Measure Name	NQF Number	NQF Endorsed?	Steward	CMS Number	Description	Domain	Measure Type	Populations	Data Source	PY 17	PY 18
Core measures	Controlling High Blood Pressure	NA	No	National Committee for Quality Assurance		The percentage of ACO attributed members 18-64 years of age who had a diagnosis of hypertension (HTN) and whose BP was adequately controlled during the measurement year based on the following criteria: •ACO attributed members 18–59 years of age whose BP was <140/90 mm Hg. • ACO attributed members 60–64 years of age with a diagnosis of diabetes whose BP was <140/90 mm Hg. • ACO attributed members 60–64 years of age without a diagnosis of diabetes whose BP was <150/90 mm Hg.	Chronic Illness Care - Physical Health	Outcome	Adult	Claims/Clinical Data		
	Comprehensive Diabetes Care: Hemoglobin A1c Poor Control (>9.0%)	0059	Yes	National Committee for Quality Assurance	CMS122	Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c > 9.0% during the measurement period	Chronic Illness Care - Physical Health	Outcome	Adult	Claims/Clinical Data		
	CG-CAHPS[1] (MHQP[2] version)[3]	0005 (Modified)	NA	MHQP		Composites: Getting Timely Appointments, Care and Information; How Well Providers Communicate; Providers' Use of Information to Coordinate Patient Care, Helpful, Courteous, and Respectful Office Staff; Patient's Rating of Provider	Patient Experience, Patient/ Provider Communication; Relationship-centered Care	Patient Experience	Children, Adolescent, Adult	Survey		
	Initiation and Engagement of Alcohol and Other Drug Abuse or Dependence Treatment (either the Initiation or Engagement Phase)	0004	Yes	National Committee for Quality Assurance	CMS137	Percentage of adolescent and adult patients with a new episode of alcohol or other drug (AOD) dependence who received the following: • Initiation of AOD Treatment. The percentage of patients who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. • Engagement of AOD Treatment. The percentage of patients who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit	Chronic Illness Care - SUD	Process	Adolescent, Adult	Claims/Clinical Data		
	Depression Screening and Follow-Up (CMS or NCQA)	NA	No	National Committee for Quality Assurance		Percentage of members 12 years of age and older who were screened for clinical depression using a standardized tool and, if screened positive, who received follow-up care. • Depression Screening. The percentage of members who were screened for clinical depression using a standardized tool. • Follow-Up on Positive Screen. The percentage of members who screened positive for depression and received follow-up care within 30 days.	Prevention/Early Detection - Mental Health	Process	Adolescent, Adult	Electronic Clinical Data Systems/MassHealth		
	Depression Response – Progress Towards Remission (MNCM)	1884/1885		Minnesota Community Measurement		Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate a response to treatment at six or twelve months defined as a PHQ-9 score that is reduced by 50% or greater from the initial PHQ-9 score. This measure applies to both patients with newly diagnosed and existing depression identified during the defined measurement period whose current PHQ-9 score indicates a need for treatment.	Prevention/Early Detection - Mental Health	Outcome	Adult	Clinical Data		
	Depression Remission (MNCM)	0710/0711		Minnesota Community Measurement	CMS159	Adult patients age 18 and older with major depression or dysthymia and an initial PHQ-9 score > 9 who demonstrate remission at six or twelve months defined as a PHQ-9 score less than 5. This measure applies to both patients with newly diagnosed and existing depression whose current PHQ-9 score indicates a need for treatment. The Patient Health Questionnaire (PHQ-9) tool is a widely accepted, standardized tool [Copyright © 2005 Pfizer, Inc. All rights reserved] that is completed by the patient, ideally at each visit, and utilized by the provider to monitor treatment progress. This measure additionally promotes ongoing contact between the patient and provider as patients who do not have a follow-up PHQ-9 score at twelve months (+/- 30 days) are also included in the denominator.	Prevention/Early Detection - Mental Health	Outcome	Adult	Clinical Data		
	Depression Remission or Response (HEDIS)	NA	No	National Committee for Quality Assurance		Percentage of members 12 years of age and older with a diagnosis of depression and an elevated PHQ-9 score, who had evidence of response or remission within 4 to 8 months of the elevated score. • Follow-Up PHQ-9. The percentage of members who have a follow-up PHQ-9 score documented within the five to seven months after the initial elevated PHQ-9 score. • Depression Remission. The percentage of members who achieved remission within five to seven months after the initial elevated PHQ-9 score. • Depression Response. The percentage of members who showed response within five to seven months after the initial elevated PHQ-9 score.	Chronic Illness Care - Mental Health	Outcome	Adolescent, Adult	Electronic Clinical Data Systems/MassHealth		

Health Policy Commission Proposed ACO Certification Standards
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	Measure	NQF #	Menu	Steward	CMS #	Description	Domain	Type	Population	Data Source		
Menu measures	Childhood Immunization Status (Combo 2)	0038	Yes	National Committee for Quality Assurance	CMS117	Percentage of children that turned 2 years old during the measurement year and had specific vaccines by their second birthday	Prevention/Early Detection - Physical Health	Process	Children	Claims/Clinical Data		
	Immunizations for Adolescents (Combo 10)	1407	Yes	National Committee for Quality Assurance		Percentage of adolescents that turned 13 years old during the measurement year and had specific vaccines by their 13th birthday	Prevention/Early Detection - Physical Health	Process	Adolescent	Claims/Clinical Data		
	Influenza Immunization	0041	Yes	AMA-PCPI (American Medical Association-convened Physician Consortium for Performance Improvement)	CMS147	Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization	Prevention/Early Detection - Physical Health	Process	Children, Adolescent, Adult	Clinical Data		
	Chlamydia Screening	0033	Yes	National Committee for Quality Assurance	CMS153	Percentage of women ages 16 to 24 that were identified as sexually active and had at least one test for Chlamydia during the measurement year	Prevention/Early Detection - Physical Health	Process	Adolescent	Claims/Clinical Data		
	Breast Cancer Screening	0034	Yes	National Committee for Quality Assurance	CMS130	Percentage of adults 50-75 years of age who had appropriate screening for colorectal cancer	Prevention/Early Detection - Physical Health	Process	Adult	Claims/Clinical Data		
	Cervical Cancer Screening	0032	Yes	National Committee for Quality Assurance	CMS124	Percentage of women 21-64 years of age, who received one or more Pap tests to screen for cervical cancer	Prevention/Early Detection - Physical Health	Process	Adult	Claims/Clinical Data		
	Colorectal Cancer Screening	2372	Yes	National Committee for Quality Assurance	CMS125	Percentage of women 50-74 years of age who had a mammogram to screen for breast cancer	Prevention/Early Detection - Physical Health	Process	Adult	Claims/Clinical Data		
	Asthma Medication Ratio	1800	Yes	National Committee for Quality Assurance		Percentage of patients 5–64 years of age who were identified as having persistent asthma and had a ratio of controller medications to total asthma medications of 0.50 or greater during the measurement year	Chronic Illness Care - Physical Health	Process	Children, Adolescent, Adult	Claims		
	Comprehensive Diabetes Care: Eye Exam	0055	Yes	National Committee for Quality Assurance	CMS131	Percentage of patients 18-75 years of age with diabetes who had a retinal or dilated eye exam by an eye care professional during the measurement period or a negative retinal exam (no evidence of retinopathy) in the 12 months prior to the measurement period	Chronic Illness Care - Physical Health	Process	Adult	Claims/Clinical Data		
	Comprehensive Diabetes Care: Blood Pressure Control (<140/90 mm Hg)	0061	Yes	National Committee for Quality Assurance		Percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent blood pressure (BP) reading is <140/90 mm Hg during the measurement year	Chronic Illness Care - Physical Health	Outcome	Adult	Claims/Clinical Data		
	Metabolic Monitoring for Children and Adolescents on Antipsychotics	2800	Yes	National Committee for Quality Assurance		Percentage of children and adolescents 1-17 years of age who had two or more antipsychotic prescriptions and had metabolic testing.	Prevention/Early Detection - Physical Health	Process	Children, Adolescent	Claims		
	Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment	1365	Yes	AMA-PCPI (American Medical Association-convened Physician Consortium for Performance Improvement)	CMS177	Percentage of patient visits for those patients aged 6 through 17 years with a diagnosis of major depressive disorder with an assessment for suicide risk	Chronic Illness Care - Mental Health	Process	Children, Adolescent	Clinical Data		
	Follow-Up After Hospitalization for Mental Illness (7-Day)	0576	Yes	National Committee for Quality Assurance		Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an OP visit, an intensive OP encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: 1) the percentage of members who received follow-up within 30 days of discharge, 2) the percent of members who received follow-up within 7 days of discharge	Chronic Illness Care - Mental Health	Process	Children, Adolescent, Adult	Claims		
	Follow-Up After Hospitalization for Mental Illness (30-Day)	0576	Yes	National Committee for Quality Assurance		Percentage of discharges for members 6 years of age and older who were hospitalized for treatment of selected mental health disorders and who had an OP visit, an intensive OP encounter, or partial hospitalization with a mental health practitioner. Two rates are reported: 1) the percentage of members who received follow-up within 30 days of discharge, 2) the percent of members who received follow-up within 7 days of discharge	Chronic Illness Care - Mental Health	Process	Children, Adolescent, Adult	Claims		
	Follow-up After Emergency Department Visit for Mental Health (7-Day)	NA	No	National Committee for Quality Assurance		The percentage of emergency department (ED) visits for members 6 years of age and older with a principal diagnosis of mental illness, who had a follow-up visit for mental illness. Two rates are reported: 1. The percentage of ED visits for which the member received follow-up within 30 days of the ED visit (31 total days). 2. The percentage of ED visits for which the member received follow-up within 7 days of the ED visit (8 total days).	Chronic Illness Care - Mental Health	Process	Children, Adolescent, Adult	Claims		
	Continuity of Pharmacotherapy for Opioid Use Disorder	3175	Yes	RAND Corporation		Percentage of adults 18-64 years of age with pharmacotherapy for opioid use disorder (OUD) who have at least 180 days of continuous treatment	Chronic Illness Care - SUD	Process	Adult	Claims/Clinical Data		
	Use of Imaging Studies for Low Back Pain	0052	No	National Committee for Quality Assurance	CMS166	Percentage of patients 18-50 years of age with a diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI, CT scan) within 28 days of the diagnosis	Acute Care	Process	Adult	Claims		

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	Measure	ID		Steward		Description	Domain	Type	Population	Data Source		
Monitoring measures	Well-Child Visits in the First 15 Months of Life	1392	Yes	National Committee for Quality Assurance		Percentage of children that turned 15 months old during the measurement year and had zero, one, two, three, four, five, or six or more well-child visits with a PCP during their first 15 months of life	Prevention/Early Detection - Physical Health	Process	Children	Claims/Clinical Data		
	Well-Child Visits in the 3rd, 4th, 5th, and 6th Years of Life	1516	Yes	National Committee for Quality Assurance		Percentage of children ages 3 to 6 that had one or more well-child visits with a PCP during the measurement year	Prevention/Early Detection - Physical Health	Process	Children	Claims/Clinical Data		
	Adolescent Well-Care Visit	NA	No	National Committee for Quality Assurance		Percentage of adolescents ages 12 to 21 that had at least one comprehensive well-care visit with a PCP or an OB/GYN practitioner during the measurement year	Prevention/Early Detection - Physical Health	Process	Adolescent	Claims/Clinical Data		
	Comprehensive Diabetes Care: Hemoglobin A1c Testing	0057	Yes	National Committee for Quality Assurance		Percentage of members 18-75 years of age with diabetes (type 1 and type 2) who received an HbA1c test during the measurement year	Chronic Illness Care - Physical Health	Process	Adult	Claims		
	Comprehensive Diabetes Care: Medical Attention for Nephropathy	0062	Yes	National Committee for Quality Assurance	CMS134	Percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period	Chronic Illness Care - Physical Health	Process	Adult	Claims/Clinical Data		
	Contraceptive Care – Postpartum	2902	Yes	U.S. Office of Population Affairs		Among women ages 15 through 44 who had a live birth, the percentage that is provided: 1) A most effective (i.e., sterilization, implants, intrauterine devices or systems (IUD/IUS)) or moderately (i.e., injectables, oral pills, patch, ring, or diaphragm) effective method of contraception within 3 and 60 days of delivery. 2) A long-acting reversible method of contraception (LARC) within 3 and 60 days of delivery. Two time periods are proposed (i.e., within 3 and within 60 days of delivery) because each reflects important clinical recommendations from the U.S. Centers for Disease Control and Prevention (CDC) and the American College of Obstetricians and Gynecologists (ACOG). The 60-day period reflects ACOG recommendations that women should receive contraceptive care at the 6-week postpartum visit. The 3-day period reflects CDC and ACOG recommendations that the immediate postpartum period (i.e., at delivery, while the woman is in the hospital) is a safe time to provide contraception, which may offer greater convenience to the client and avoid missed opportunities to provide contraceptive care	Maternity Care	Outcome	Adolescent, Adult	Claims		
	Prenatal & Postpartum Care - Timeliness of Prenatal Care	1517	No	National Committee for Quality Assurance		Percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. • Rate 1: Timeliness of Prenatal Care. The percentage of deliveries that received a prenatal care visit as a patient of the organization in the first trimester or within 42 days of enrollment in the organization. • Rate 2: Postpartum Care. The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery	Maternity Care	Process	Adolescent, Adult	Claims/Clinical Data		
	Incidence of Episiotomy	0470	Yes	Christiana Care Health System		Percentage of vaginal deliveries (excluding those coded with shoulder dystocia) during which an episiotomy is performed	Maternity Care	Process	Adolescent, Adult	Claims/Clinical Data		