COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

Proposed Accountable Care Organization (ACO) Certification Standards

Request for Public Comment

December 9, 2015 – January 29, 2016

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I. 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. An ACO is generally defined as a group of physicians, hospitals, or other providers whose mission is to improve health outcomes and quality of care while slowing the growth in overall costs for a specific population of patients.[1] The HPC believes that ACOs represent a promising model for transforming care delivery through improvements in care coordination and integration, access to services, and accountability for quality outcomes and costs.

The purpose of the certification program is to complement existing local and national care transformation and payment reform efforts, validate value-based care, and promote investments by all payers in efficient, high-quality, and cost-effective care across the continuum. HPC certification of ACOs will complement, not replace, requirements and activities of other state agencies by evaluating core competencies for ACOs in care delivery. ACO certification will not address the financial solvency of an ACO or its suitability to operate as a risk-bearing provider organization (RBPO).

To support the movement toward patient-centered, accountable care in the Commonwealth, the HPC is developing a holistic programmatic framework, including:

1. Developing an all-payer, all-patient ACO certification standards by examining current state and national models and engaging extensively with local stakeholders;
2. Collaborating with MassHealth and Group Insurance Commission (GIC) to develop ACO standards that align with their principles for system transformation;
3. Creating a technical assistance program to provide support to providers seeking to achieve ACO certification and/or improve their performance as ACOs through best-practice sharing;
4. Developing a communications and outreach strategy to promote the benefits and value of ACO certification for providers, payers, and consumers;
5. Enhancing market and patient protection, including increasing patient access to services, especially for vulnerable populations;
6. Developing an evaluation framework for ACOs including data collection, information gathering, dissemination of best practices, and longer-term measurement of ACO total medical expenditure and quality; and
7. Informing future product design and contracting policies by objectively validating ACOs in the Commonwealth (e.g., ACO tiering).

Through its ACO certification standards, the HPC seeks to promote continued transformation in care delivery while ensuring that certification is within reach for systems of varying sizes, organizational models (e.g., hospital-led, physician-led), infrastructure and technical capabilities, populations served, and locations.

[1] The Dartmouth Institute, *Accountable Care Organization Learning Network Toolkit* 8 (2011).

The HPC seeks public comment on the proposed ACO certification standards and associated proposed documentation requirements detailed below. The HPC also seeks public input on other aspects of the certification program, including the design of technical assistance. While the HPC ACO certification program aligns with MassHealth's payment reform program, the Executive Office of Health and Human Services is independently engaging with stakeholders around development of its reform program. Questions and comments for this public comment should focus on and specifically address HPC ACO certification. 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, January 29, 2016.** Responses may be submitted via email to HPC-Certification@state.ma.us 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 hearing on January 6, 2016 at 11:30 a.m. at:
Health Policy Commission
50 Milk St., 8th floor
Boston, MA 02109

II. Proposed HPC ACO Certification Framework

A. Approach

For the first year of the ACO certification program, the HPC proposes three categories of certification criteria. The categories are:

- Mandatory criteria: ACOs must demonstrate that they meet these criteria in order to be certified by the HPC.

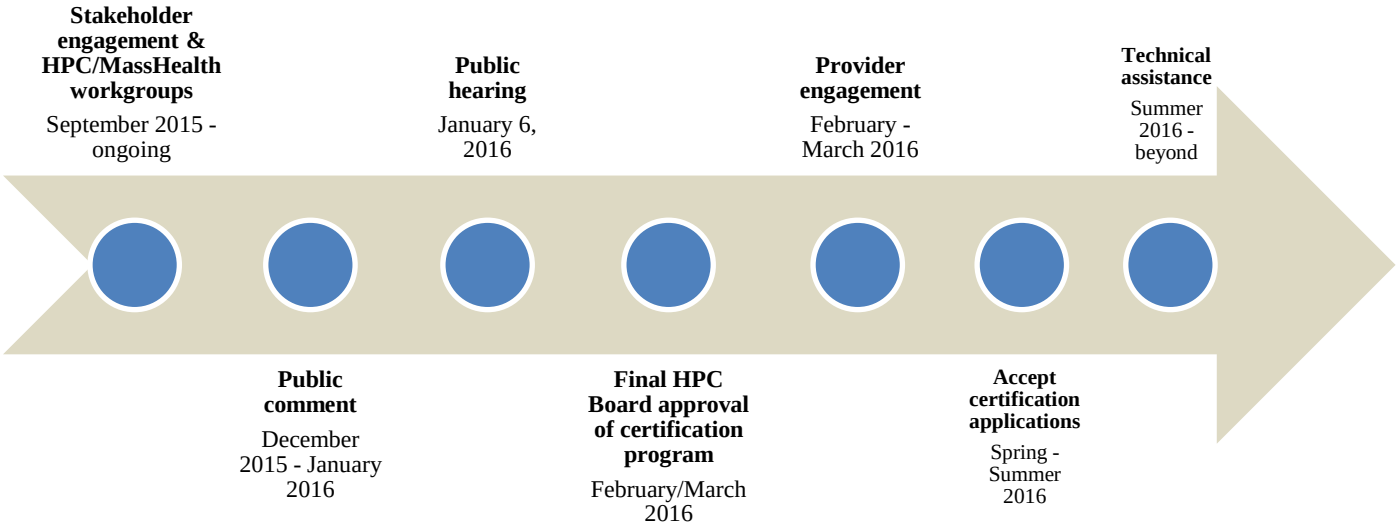
- Market and patient protections: ACOs seeking certification by the HPC must attest to being in compliance with all legal and regulatory requirements related to market and patient protection.

- Reporting only criteria: ACOs seeking certification by the HPC must describe their activities in certain areas. The HPC will review but not qualitatively assess ACOs' responses to these criteria. The information collected will inform future updates to the certification program.

B. Criteria and Documentation Requirements

Table 1 lists HPC proposed criteria and associated documentation requirements. Please note that the documentation requirements for ACO applicants may include submission of nonpublic, clinical, financial, strategic or operational documents and information. The HPC shall not disclose such information and documents without the consent of the ACO applicant submitting the required information and documents, except in summary form in evaluative reports or when the HPC believes that such disclosure should be made in the public interest after taking into account any privacy, trade secret or anticompetitive considerations. The confidential information and documents received from ACO applicants shall not be public records and shall be exempt from disclosure under clause Twenty sixth of section 7 of chapter 4 or section 10 of chapter 66.

C. Expected timeline for ACO certification program development and launch



D. Questions for Public Comment

The HPC seeks input on the proposed certification framework, individual criteria, and documentation requirements. In particular, Table 1 lists criteria-specific questions, on which the HPC is especially interested in receiving public comment. Overall, the HPC would like respondents' perspectives on the following questions:

1. Do the proposed HPC ACO certification criteria address the most important requirements and capabilities ACOs should have in order to operate successfully as ACOs? Do the certification criteria offer a comprehensive set of standards appropriate for all payers? If not, what other criteria should HPC add or substitute, and why?

2. Are the proposed criteria appropriately assigned to either the mandatory or reporting only category?

3. What is the operational and financial feasibility of implementation for these standards? Specifically, are these criteria feasible for ACOs of varying size, experience, resources, and other salient factors?

4. To what degree would ACOs be able to submit existing documents and materials to the HPC, rather than create new documentation, to fulfill the proposed documentation requirements? Do the documentation requirements identifying existing, internal documents add to or reduce the administrative burden of applying for ACO certification?

5. Chapter 224 of the Acts of 2012 indicates a two-year period for ACO certification. Should the HPC re-certify ACOs more frequently during the first years of certification?

6. The HPC intends to develop a technical assistance program to support ACO transformation. This may include HPC's analysis of information collected through the certification process in aggregate, and the identification of best practices among ACOs. What are the best modes by which to share this information with the market? What other types of technical assistance would be most useful to ACOs?

7. Do you favor the HPC making public the application materials submitted for ACO certification?

8. What policies, if any, should the HPC adopt in its certification program to prevent negative impacts on competition?

Table 1: Proposed HPC ACO certification criteria, documentation requirements, and questions for public comment

Mandatory Criteria				
Domain	**#**	**Criterion**	**Documentation Requirements**	**Questions for Public Comment**
Legal and governance structures Note: "governance structure" refers to the ACO board and supporting committees.	**1.**	The ACO operates as a **separate legal entity** whose governing members have a fiduciary duty to the ACO, *except* if ACO participants are part of the same health care system.	- Evidence of legal status.	
	2.	The ACO provides information about its **participating providers** to HPC, **by Tax Identification Number (TIN)**, for each of the three payer categories (Medicare, MassHealth, commercial).* **To the extent possible, this will be done in coordination with RPO process.*	- List of ACO's participating providers (TINs). - Narrative of why an ACO's participating providers may differ by Medicaid, Medicare or commercial contracts.	At what organizational level would ACOs apply for ACO certification?
	3.	The ACO governance structure includes a **patient or consumer representative.** The ACO has a process for ensuring patient representative(s) can meaningfully participate in the ACO governance structure.	- Written description of where/how the patient or consumer representative role appears within the governance structure, and how an individual is identified or selected to serve. - Written description of the specific strategies ACO deploys to ensure patient/consumer's meaningful participation. Such strategies may include providing: practical supports (e.g. transportation to meetings, translation of materials); formal or informal training or personal assistance in subject matter and/or skills; a code of	Describe and give examples of meaningful participation. What evidence should the HPC seek to assess meaningful participation?

			conduct for meetings or other governance structure operations that emphasizes an inclusive, respectful approach; or other.	
	4.	The ACO governance structure provides for **meaningful participation of primary care, addiction, mental health (including outpatient), and specialist providers**.	- Written description of official governance structure including the board and committees with members' names, professional degrees (e.g., MD, RN, LCSW, LMHC), titles, and organizations. - Written description of how different provider types are represented in the governance structure of the ACO (i.e. in number, via voting rights, or other), and specific ways ACO ensures meaningful participation of different provider types.	What evidence should the HPC seek to evaluate meaningful participation?
	5.	The ACO has a **Patient & Family Advisory Council (PFAC) or similar** committee(s) that gathers the perspectives of patients and families on operations of the ACO that regularly informs the ACO board.	- Written description or charter for the PFAC, or similar group of patients, that provides input into ACO operations, or plans to establish such a council, including reporting relationship to ACO board. - Minutes from the most recent PFAC meeting. Note: if an entity within the ACO (e.g. hospital) currently operates a PFAC, the same PFAC could be used to fulfill this criterion so long	

			as the PFAC's scope will be expanded to address ACO-wide issues. ACOs would also need to demonstrate that the PFAC is representative of the whole patient population that the ACO serves.	
	6.	The ACO has a **quality committee** reporting directly to the ACO board, which regularly reviews and sets goals to **improve on clinical quality/health outcomes (including behavioral health), patient/family experience measures, and disparities** for different types of providers within the entity (PCPs, specialists, hospitals, post-acute care, etc.).	- Charter or documentation of the quality committee's charge, members including titles and organizations, meeting frequency, and reporting relationship to ACO board. - Minutes from the most recent quality committee meeting.	
Risk stratification and population specific interventions	**7.**	The ACO has **approaches for risk stratification** of its patient population based on criteria including, at minimum: - Behavioral health conditions - High cost/high utilization - Number and type of chronic conditions - Social determinants of health (SDH) The approach also *may* include: - Functional status, activities of daily living (ADLs), instrumental activities of daily living (IADLs) - Health literacy	- Written description of the risk stratification methodology(ies), including data types and sources, time of data, frequency of updating and criteria used. - If the ACO uses socioeconomic or other demographic information to address social determinants of health outside of risk stratification, a written description of methodology and how data are collected.	
	8.	Using data from health assessments and risk stratification or other patient information**, the ACO implements one or more programs** targeted at **improving health outcomes for its patient population. At least one of these programs addresses mental health, addiction, and/or social determinants of health.**	- Written description of qualifying programs, including how participating patients are identified or selected, what the intervention is, the targets/performance metrics by which the ACO will	Should the HPC be more prescriptive with this requirement (i.e., require more than one program)?

		ACO **annually evaluates the population health programs** in terms of patient experience, quality outcomes, and financial performance.	monitor/assess the program, and how many patients the ACO projects to reach with each program. Note: To qualify, a program must address a documented need for the ACO patient population; must have clear measures/outcomes-based approach; and must include/reflect community resources and partnerships as appropriate. A program of any size may fulfill this criterion.	

Cross continuum network: access to BH & LTSS providers	**9.**	ACO **demonstrates and assesses effectiveness of ongoing collaborations** with and referrals to:
		- Hospitals
		- Specialists
		- Post-acute care providers (i.e., SNFs, LTACs)
		- Behavioral health providers (both mental health and substance use disorders)
		- Long-term services and supports (LTSS) providers (i.e., home health, adult day health, PCA, etc.)
		- Community/social service organizations (i.e., food pantry, transportation, shelters, schools, etc.)
			- Names of organizations and narrative or other evidence of how ACO collaborates with each provider type listed here.
			- Description of how ACO assesses and improves collaborative relationships with each provider type, including documents indicating processes used by the ACO to assess the effectiveness of ongoing collaborations, such as:
			  - Minutes from one Board or committee meeting documenting discussion of results of assessment with different provider types
			  - Summary report on effectiveness of
				What evidence should the HPC seek to evaluate whether ACOs assess the effectiveness of the collaborations?

			collaboration (e.g., % of providers that refer to collaborative partners) Note: In evaluating the ACO's collaborations and assessments, the HPC will consider whether the ACO's submitted documents show that it sets targets or goals regarding such factors as: - Access - Appropriate breadth of services - Follow-up and reporting - Communication and/or data-exchange capabilities - Quality, cost, and patient experience scores - Extent to which collaborative partners are integrated into other areas of ACO, APMs, etc.	
	10.	As appropriate for its patient population, the **ACO has capacity or agreements with mental health providers, addiction specialists, and LTSS providers**. Agreements should reflect a categorized approach for services by severity of patient needs. These agreements should also include provisions for access and data sharing as permitted within current laws and regulations.	- Exemplar contract(s), memorandum(s) of understanding, or agreement(s) setting out terms of relationships between ACO and required provider types, including specific standards for access and requirements for clinical data sharing.	
Participation in MassHealth APMs	**11.**	The ACO participates in a **budget-based contract for Medicaid patients by the end of Certification Year 2 (2017)**.*	- Written commitment.	Would a relative threshold be more

		**Budget-based contracts are those that require a provider to accept a population-based contract centered on either a spending target (shared savings only) or a global budget (including down-side risk).*		meaningful? That is, measure ACOs' increase in rates of budget-based contracts year over year? Should a relative threshold be different for larger and smaller ACOs?
PCMH adoption rate	**12.**	The ACO reports to HPC on **NCQA and HPC PCMH recognition rates and levels** (e.g., II, III) of its participating primary care providers. The ACO describes its plan to **increase these rates, particularly for assisting practices in fulfilling HPC's PCMH PRIME criteria.**	- Statement (or other documentation) outlining current PCMH recognition rates. - Narrative explaining plan for increasing rates, including HPC PCMH PRIME certification application/achievement.	How should the HPC best align its PCMH PRIME certification and ACO certification programs?
Analytic capacity	**13.**	ACO regularly **performs cost, utilization and quality analyses**, including regular trending and forecasting of performance against budget and quality measure targets, and works with practices and providers within the ACO to meet goals and targets. Analysis could be completed by a vendor or in-house. **ACO disseminates reports** to providers, in aggregate and at the practice level, and **makes practice-level results** on quality performance **available to all participating providers** within the ACO.	- Blinded sample cost, utilization, and quality report(s). - Written description or screenshot of how practice-level reports are made transparent and disseminated to providers/practices. - Documentation showing that the analysis is reviewed with providers, and how ACO uses reports to engage providers and practices in setting cost and quality improvement targets. Note: Payer cost and utilization reports would fulfill this requirement, as long as they are	Is this a feasible requirement for smaller ACOs?

			disseminated down to the provider level.	
Patient and family experience	**14.**	The ACO conducts an annual **survey** (using any evidence-based instrument) or uses the results from an accepted statewide survey to **evaluate patient and family experiences** on access, communication, coordination, whole person care/self-management support, and deploys plans to improve on those results.	- Description of methods used to assess patient satisfaction/experience. - Description of how ACO identifies areas needing improvement and plans to address those areas.	
Community health	**15.**	ACO describes steps it is taking to advance or invest in the **population health** of one or more communities where it has at least 100 enrollees through a **collaborative, integrative, multi-organization approach** that acknowledges and accounts for the **social determinants of health**.	- Written description of plan to advance population health, along with identification of potential community partners.	

Market and Patient Protection			
Domain		**Criterion**	**Documentation Requirements**
Risk-bearing provider organizations (RBPO)	**16.**	If applicable, the ACO obtains a **risk-based provider organization (RBPO)** certificate or waiver from **DOI**.	- Attestation
Material Change Notices (MCNs) filing attestation	**17.**	ACO attests to filing all relevant **material change notices (MCNs)** with **HPC**.	- Attestation
Anti-trust laws	**18.**	ACO attests to compliance with all **federal and state antitrust laws and regulations**.	- Attestation
Patient Protection	**19.**	ACO attests to compliance with HPC's **Office of Patient Protection (OPP)** guidance regarding a **process to review and address patient grievances** and provide notice to patients.	- Description of patient appeals process and sample notice to patients.
Quality and financial performance reporting	**20.**	ACO will **report ACO-level performance** on a quality measure set associated with each contract and shared savings / losses for any commercial and public risk contracts for the previous contract year (2015).	- Plan-specific reports of ACO performance on contract-associated quality measures and overall financial shared savings or losses for calendar year 2015.
Consumer Price Transparency	**21.**	ACO attests that it has taken steps to ensure that providers participating in the ACO have the ability to provide patients with relevant price information and are complying with **consumer price transparency** requirements pursuant to M.G.L. c. 111, § 228(a)-(b).	- Attestation

		Reporting Only Criteria		
Domain		**Criterion**	**Documentation Requirements**	**Questions for Public Comment**
Palliative care	**22.**	The ACO provides **palliative care and end-of-life planning**, including: – integrated and coordinated care across network, especially with hospice providers; – training of providers to engage patients in conversations around palliative care to identify patient needs and preferences; and – EHR indication of such decisions	- Written description of how ACO coordinates with and assesses appropriateness of hospice and end-of-life (EOL) planning programs/materials. - Examples of training programs.	
Care coordination	**23.**	The ACO has a process to **track tests and referrals across specialty and facility-based care both within and outside of the ACO**.	- ACO policies and procedures or comparable documents describing protocols for tracking tests and referrals as described in the criterion.	
	24.	The ACO demonstrates a process for identifying **preferred providers**, with specific emphasis to increase use of providers in the patient's community, as appropriate, specifically for: – oncology – orthopedics – pediatrics – obstetrics	- Written description of ACO's process for identifying preferred providers, including relevant quality and financial analyses. - Documentation of provider communication related to encouraging use of identified providers	
	25.	The ACO has a process for **regular review of patient medication** lists for **reconciliation** and **optimization** in partnership with patients' PCPs.	- ACO policies and procedures or comparable documentation for medication reconciliation and optimization, including how ACO works with individual providers.	
	26.	The ACO assesses current capacity to, and develops and implements a **plan of improvement** for:	- Written description of current system(s) for direct	

		– sending and receiving **real-time event notifications** (admissions, discharges, transfers); – utilizing **decision support rules** to help direct notifications to the right person in the ACO at the right time (i.e., prioritized based on urgency); and – setting up **protocols** to determine how event notifications should lead to changes in clinical interventions	messaging, sharing of clinical summary documents and lab orders/results, e-prescribing, and other exchange of clinical information between ACO providers, including ability to securely exchange clinical information between providers with different EHRs or no EHR, and by care setting; and capabilities for sharing within and outside ACO.	
Peer support	**27.**	The ACO provides patients and family members access to **peer support programs**, particularly to assist patients with chronic conditions, complex care needs, and behavioral health needs. The ACO also provides training to peers as needed to support them in performing their role effectively.	- Written description of how the ACO provides peers or links patients and families to existing community-based peer support programs. - ACO training materials or plans to provide training as needed.	

Adherence to evidence-based guidelines	**28.**	The ACO monitors **adherence to evidence-based guidelines** and identifies areas where improved adherence is recommended or required. The ACO develops initiatives to support improvements in rates of adherence.	- Written description of methods and/or processes used by the ACO to monitor use of evidence-based guidelines, including:
			  - Specific conditions and methodologies for assessing variation between ACO providers
			  - How the ACO selects areas for improvement in variation if found
			- Written description of initiatives or plans for initiatives to improve	

			adherence rates.	
APM adoption for primary care	**29.**	The ACO reports the **percentage of its primary care revenue *or* patients that are covered under budget-based contracts.*** **Budget-based contracts are those that require a provider to accept a population-based contract centered on either a spending target (shared savings only) or a global budget (including down-side risk).*	- Report or statement providing percentage, including data, assumptions, methods, and calculations. - Percentage reported for commercial, Medicare and Medicaid separately and in aggregate. - Description of barriers faced in accepting higher volume of risk-based contracts.	Are there data collection or other challenges ACOs would face in reporting on this information? Are there other methods of assessing uptake of budget-based contracts that HPC should consider?
Flow of payment to providers	**30.**	The ACO **distributes funds** among participating providers using a methodology and process that are **transparent** to all participating providers. Documentation must include both a description of the methodology and a demonstration of communication to all participating providers.	- ACO participation agreements with providers describing how participating providers are compensated, highlighting if and how the method includes consideration of quality, cost, and patient satisfaction metrics. - Written description or example communication of how the ACO does or does not currently make funds flow methods transparent to all participating providers.	
ACO population demographics and preferences	**31.**	The ACO assesses the **needs and preferences** of its patient population with regard to **race, ethnicity, gender identity, sexual preference, language, culture, literacy, social needs (food, transportation, housing, etc.) and other characteristics** and develops plan(s) to meet those needs. This includes provision of interpretation/translation services and materials printed in languages representing the patient population (5% rule).	- Description of how the ACO assesses its patient population characteristics. - Description of any training or materials used to train practitioners and staff on meeting these needs. - Description of method for identifying gaps in need and capacity, including plans for	

			addressing such gaps.	
EHR interoperability commitment	**32.**	ACO **identifies Meaningful Use-certified electronic health record (EHR) adoption** and integration rates within the ACO by provider type/geographic region; **and develops and implements a plan to increase adoption and integration** rates of certified EHRs.	- ACO operational plans for assessing EHR adoption status by provider type (e.g. primary care, behavioral health, and specialty providers) and implementing improvement plans, including timelines	
	33.	ACO identifies current **connection rates to the Mass HIway** and has a plan to improve rates over next year.	- ACO operational plans for assessing connectivity to Mass HIway and implementing improvement plans, including timelines.	What challenges would need to be overcome in order for ACOs to connect to and effectively use the HIway?