COBTH

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Ms. Catherine Harrison
Health Policy Commission
50 Milk Street, 8th Floor
Boston, MA 02109

Dear Ms. Harrison:

On behalf of the Conference of Boston Teaching Hospitals (COBTH) and its members, I would like to thank the Health Policy Commission (HPC or the Commission) for this opportunity to provide comments on the Commission's proposed Accountable Care Organization (ACO) Certification Standards. In making these comments we recognize and appreciate the significant amount of effort and thought the Commissioners and the staff of the HPC have put into the proposed criteria. We hope the feedback COBTH and its individual members provide will help establish a certification standard that meets the goals established under Chapter 224 by enhancing collaborations and recognizing the value of varied approaches an ACO may have to meet the needs of its patient population.

Several COBTH member hospitals will be submitting comments addressing concerns specific to their hospitals and or patient populations. Our comments, structured as responses to the eight questions posed by the HPC, highlight broad themes that represent concerns of all of our members, they are that ACO certification should:

- allow and encourage innovation and flexibility;
- recognize and build on existing certification models such as Medicare;
- minimize additional administrative burden and cost on applicants by using existing sources of data and allowing attestation to many of the required elements.

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?

While the proposed capabilities describe one form of an ACO, they do not recognize that other existing models may be as, or more, successful in meeting goals. The current health care marketplace recognizes multiple ACO and alternate payment models. The Blue Cross Blue Shield AQC as well as other ACO programs established and certified by the Centers for Medicare and Medicaid Services (CMS) are two such structures.

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Brigham and Women's Hospital · Cambridge Health Alliance · Carney Hospital · Dana-Farber Cancer Institute · Lahey Hospital & Medical Center
Massachusetts Eye and Ear · Massachusetts General Hospital · St. Elizabeth's Medical Center · Tufts Medical Center · VA Boston Healthcare System

COBTH recommends that the HPC extend its certification to those ACO programs which meet Medicare ACO standards and evaluate existing programs based on already established criteria. Further, we do not feel it is appropriate to require providers to participate in NCQA/PCMH-Prime as a pre-requisite for HPC ACO certification. This requirement represents a significant barrier to certification for many providers who feel NCQA to be extremely time-consuming and too expensive to participate in without clear evidence of return.

Instead, to meet the PCMH requirement we recommend the HPC ask instead: "whether the ACO's primary care providers incorporate general principals of PCMH." Requiring such attestation will allow for flexibility while reducing the overall financial burden PCMH certification represents.

Certification should not be used as a way to mandate benefits or methods of care delivery that payers are not currently required to reimburse. For example, legislative efforts to require coverage for telemedicine services have been met with stiff opposition from the insurance industry. Requiring ACOs to provide such services with no requirement for reimbursement puts the ACO at a significant disadvantage.

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

There do not appear to be any clear distinctions between "mandatory" and "reporting only" criteria. The same level of detail is required for both, placing a significant administrative burden on any provider seeking certification. We recommend that applicants be allowed to 'attest' that such "reporting only" topics have been addressed and, when necessary and available, provide general information and narratives to show how each topic has been addressed.

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?

Operational Barriers: ACO Governance Structure

COBTH and its members believe that the HPC's criteria outlining the governance structure of an ACO is overly prescriptive, subjective and in some cases contradicts current Medicare standards. Further, for some existing ACOs to meet the proposed requirements they would need to restructure their current governance structure.

Provider organizations need the freedom to structure their ACO governance board in a manner that is consistent with their system. When organizations have this freedom, care connections may be built between individuals and specialists necessary to meet the needs of an ACO's patient population. For example, an organization that serves a largely pediatric population will have more pediatric specialists on its board.

Specifying the types of providers and participants who should sit on an ACO's board will severely limit an ACO's innovation potential. Care delivery is the business of hospitals; they have a strong grasp of the needs of the individuals and the populations they serve. Dictating the representatives of an ACO's board could be a significant disincentive to seeking HPC certification.

Likewise, specifying which subcommittees should be established within the governance structure and how those committees should operate, fails to recognize structures already in place and successful. Specifically, hospitals should have the freedom to select the members and scope of both their Patient and Family Advisory Council (PFAC) and quality committees. Where groups are already established the HPC should recognize their sufficiency in terms of ACO certification. We recommend that the HPC adopt a governance requirement similar to the Medicare requirement that 75% of an ACO board be comprised of providers within the ACO.

Furthermore we advise the HPC to remove the requirement that ACOs demonstrate 'meaningful participation' of its board members. Such standard is vague and highly subjective. Certification should be based on attestation that voting board members satisfactorily participate in ACO governance, an explanation of what expectations there exist for board members, and a brief description of their operations and subcommittees. Requiring board and subcommittee meeting minutes be submitted to the HPC could make public confidential and proprietary information which is not needed for the ACO certification process.

Financial Barriers

Many providers feel that NCQA/PCMH-Prime standards are far too expensive absent evidence of their efficacy. This is especially burdensome to smaller providers where the fee alone for NCQA certification is $400,000 which providers must pay every three years to keep their certification. Furthermore this cost does not reflect the time and labor involved in attaining NCQA certification the total cost of which many providers are unwilling to undertake. We recommend that the HPC leverage existing structures for their certification to not force providers to build a new infrastructure that meets the HPC's standards.

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?

In general most, if not all, criteria require written documentation (narratives, internal documents) as opposed to attestation, deeming, or self-certification, which is incredibly time consuming and without any measurable value to ACOs. As we mentioned previously clear differences in the level of information required for "mandatory" and "reporting" criteria would help reduce administrative burden.

Additionally much of the documentation required for ACO certification is information that is already provided to the HPC and other state agencies. The HPC's Registered Provider

Organization (RPO) filings as well as the Division of Insurance's Risk Bearing Provider Organization Process (RBPO) application should be a primarily source for much of the required information.

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?

Fulfilling the proposed certification application requirements involves a significant amount of work and expense, we do not recommend more frequent recertification.

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?

It would be helpful for the HPC to foster and support opportunities for providers and community organizations to increase their collaboration. By working in conjunction with other state agencies, the HPC could compile detailed information about the many community based organizations that may or may not have relationships with providers. Sharing this information with providers would benefit the system as a whole by ensuring that any and all resources for patients are utilized effectively.

Furthermore, the HPC could help facilitate the provision of carrier data to providers to ensure providers have the most current and accurate data to work from when designing ACOs and working within their alternative payment methodologies.

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

COBTH and its members do not favor making public the application materials submitted for ACO certification for the reasons specified under question eight.

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

The proposed standards for ACO certification require submission of documents that may be proprietary in nature. Providing specific information about ACO methodologies, methods and formulas of compensation, training materials, payment and funds flow information as well as board minutes have potential anti-competitive implications. While the HPC has afforded some protections for data submitted there is no guarantee of protection. Further, much of the proprietary information requested does not appear to have a connection to the improvement of

patient care. We respectfully request that submission of these materials be removed from the certification process as the burden and privacy concerns associated with producing them outweighs their questionable necessity.

COBTH and its members are committed to promoting and embracing alternative payment methodologies and hope the Commission's certification process becomes a useful tool in achieving high quality value driven health care. We believe that by increasing the flexibility and reducing the administrative burden such an end can be achieved. If you have any questions or would like to discuss any of these matters further please do not hesitate to contact COBTH.

Sincerely,

John Erwin
Executive Director