APPLICATION REQUIREMENTS AND PLATFORM USER GUIDE (PUG)

Accountable Care Organization Certification Program: Learning, Equity, and Patient-Centeredness (LEAP) 2024-2025

MASSACHUSETTS
HEALTH POLICY COMMISSION

ABOUT THE HEALTH POLICY COMMISSION

The Massachusetts Health Policy Commission (HPC) is an independent state agency charged with monitoring health care spending growth in Massachusetts and providing data-driven policy recommendations regarding health care delivery and payment system reform. The HPC's mission is to advance a more transparent, accountable, and equitable health care system through its independent policy leadership and innovative investment programs. The HPC's goal is better health and better care – at a lower cost – for all residents across the Commonwealth.

EXECUTIVE DIRECTOR LETTER

Dear Stakeholders,

I am pleased to announce the release of the 2024-25 Application Requirements and Platform User Guide (PUG) for the Accountable Care Organization (ACO) Certification program. This certification cycle continues the Health Policy Commission's Learning, Equity, and Patient-Centeredness (LEAP) standards, first implemented in 2021, which seek to position the ACO model as a catalyst for learning and improvement among health care organizations. The LEAP standards encourage ACOs to pursue evidence-based and data-driven strategies to improve care delivery.

Since its inception in 2017, the ACO Certification program has served to provide all-payer standards for ACO care delivery and transparent information for the public on ACO structures and operations. As of 2023, the HPC has certified seventeen ACOs that collectively represent more than 3 million attributed commercial, Medicare, and MassHealth patients in the Commonwealth. We look forward to building on that success with you through our fourth round of certifications.

The extraordinary stresses of the past few years and the heroic efforts of health care providers to navigate them have underscored the importance of nimble, learning organizations. The LEAP 2024-25 standards will continue to emphasize organizational capacity for adaptation, learning, and innovation, while providing a framework for advancing health equity-focused efforts to encourage better health and better care for all residents across the Commonwealth. In this new application cycle, the core certification criteria remain the same as in the prior cycle, but we have taken this opportunity to strengthen and focus the program's health equity component.

This year we will begin a process to understand ongoing ACO progress and commitments to improving health equity via three broad categories of activity: making organization-wide strategic commitments to improving health equity, harnessing data to identify and address health inequities, and engaging patients in the design of interventions to close these inequities. We look forward to using this framework to promote progress over time as we all continue to learn together and explore ways to improve health equity in the Commonwealth. Additionally, we intend to explore opportunities to couple certification with opportunities for continued learning, via voluntary peer-to-peer engagement or technical assistance opportunities for the Certified ACOs.

Thank you for your continued participation in this collaborative process. If you have any questions or concerns, please feel free to reach out to the HPC's ACO program staff at HPC-Certification@mass.gov at any time.

Thank you,

David Seltz
Executive Director

TABLE OF CONTENTS

ABOUT THE HEALTH POLICY COMMISSION 2
EXECUTIVE DIRECTOR LETTER 3
TABLE OF CONTENTS 4
GLOSSARY OF TERMS 5
ABBREVIATIONS 7
INTRODUCTION 8
HPC Accountable Care Organization Certification Program: ACO LEAP 2024-25 8
Alignment with MassHealth 9
APPLICANT FOR CERTIFICATION 10
Definition of Applicant 10
Applicant Responsibilities 10
TERM OF CERTIFICATION 11
Deadline to Apply and Duration of Certification 11
Significant Changes to an Applicant During the Term of Certification 11
CERTIFICATION REQUIREMENTS AND APPLICATION 11
Part 0: Application Portal Access 12
Part 1: Intent to Apply 12
Part 2: Application for Certification 13
Pre-Requisite Uploads 14
Assessment Criteria 15
Health Equity Requirement 15
AC-1: Patient Centered Care 20
AC-2: Culture of Performance Improvement 22
AC-3: Data-Driven Decision-Making and Care Delivery 24
AC-4: Population Health Management Programs 27
AC-5: Whole-Person Care 28
Supplemental Information 30
Part 3: Application for Certification: Affidavit of Truthfulness 32
CONFIDENTIALITY AND USE OF INFORMATION SUBMITTED BY ACOs 33
Information Sharing with the Public 33
APPENDIX I: Application Templates 35
APPENDIX II: Sample Application Responses 37

GLOSSARY OF TERMS

ACO Participant	A health care provider or an entity identified by a tax identification number (TIN) through which one or more health care providers bill, that alone or together with one or more other ACO Participants comprise an ACO.
Applicant	The health care provider or provider organization applying for HPC ACO Certification, which must have common ownership or control of any and all of the corporately affiliated contracting entities that enter into risk contracts on behalf of one or more health care providers.
Component ACO	A contracting entity, with a unique Governing Body, over which the Applicant has partial or complete common ownership or control and that enters into one or more risk contracts on behalf of one or more health care providers.
Governance Structure	The Governing Body, the committees that report to that Governing Body, and executive management/leadership team(s) that support the work of that Governing Body. Applicants with multiple Component ACOs may have multiple Governance Structures.
Governing Body	A group of ACO Participant representatives, patients/consumer advocates, and others that formulates policy and directs the affairs of an ACO, e.g., a board of directors or similar body that routinely meets to conduct ACO business and has a fiduciary duty to an ACO. An Applicant may have one Governing Body for all ACO business or multiple Governing Bodies that each conducts the business of a Component ACO.
Health	A state of physical, mental, and social well-being.
Health Equity	The opportunity for everyone to attain their full health potential. In a condition of health equity, no one is disadvantaged from achieving this potential because of his or her social position (e.g., class, socioeconomic status) or socially assigned circumstance (e.g., race, gender, ethnicity, religion, sexual orientation, geography, etc.).
Health Inequity(ies)	Differences in health status and mortality rates across population groups that are systemic, avoidable, unfair, and unjust. These differences are rooted in social and economic

injustice, and are attributable to social, economic and environmental conditions in which people are born, grow, live, work and age.

Health-Related Social Needs The immediate daily necessities that arise from the inequities caused by the social determinants of health. These needs are often defined by a lack of access to basic resources like stable housing, public safety, healthy food, physical and mental healthcare, income support, transportation, emergency services, and environments free of life-threatening toxins.

Learning Health System As defined by the National Academy of Medicine (formerly the Institute of Medicine), a health care system in which science, informatics, incentives, and culture are aligned for continuous improvement and innovation, with best practices seamlessly embedded in the care process, patients and families active participants in all elements, and new knowledge captured as an integral by-product of the care experience.

Risk-Bearing Provider Organization A provider organization that manages the treatment of a group of patients and bears downside risk according to the terms of an alternative payment contract and has received a certificate or waiver from the Division of Insurance (DOI) in accordance with 211 CMR 155.00.

Risk Contract Contracts with a public or commercial payer for payment for health care services that incorporate a per member per month budget against which claims costs are settled for purposes of determining the withhold returned, surplus paid, and/or deficit charged, including contracts that subject the ACO to very limited or minimal "downside" risk or "upside" risk/shared savings only. Risk contracts should include incentives (e.g., required thresholds on quality measures in order to receive a portion of shared savings) based on an ACO’s performance on valid, nationally-endorsed, well-accepted measures of health care quality.

ABBREVIATIONS

ACO	Accountable Care Organization
BHI	Behavioral Health Integration
CAHPS	Consumer Assessment of Healthcare Providers and Systems
CMS	Centers for Medicare and Medicaid Services
DOI	Division of Insurance
EHR	Electronic Health Record
EOTSS	Executive Office of Technology and Security Services
HER	Health Equity Requirement
HMO	Health Maintenance Organization
HPC	Health Policy Commission
HRSN	Health-Related Social Needs
LEAP	Learning, Equity, and Patient-Centeredness
MCN	Material Change Notice
OPP	Office of Patient Protection
PFAC	Patient and Family Advisory Council
PPO	Preferred Provider Organization
PUG	Platform User Guide
RBPO	Risk-Bearing Provider Organization
RELD	Race, Ethnicity, Language, and Disability
RPO	Registration of Provider Organizations
SOGIS	Sexual Orientation, Gender Identity, and Sex
TIN	Tax Identification Number

INTRODUCTION

HPC Accountable Care Organization Certification Program: ACO LEAP 2024-25

The HPC is charged with developing and implementing all-payer standards of certification for accountable care organizations (ACOs) in the Commonwealth. Through these standards, the HPC seeks to promote continued transformation in care delivery while ensuring that certification is within reach of provider organizations of varying sizes, experience, organizational models (e.g., community-hospital anchored, physician-organization anchored), infrastructure, technical capabilities, populations served, and locations.

The purpose of the HPC ACO Certification program is to complement existing local and national care transformation and payment reform efforts, encourage value-based care delivery, and promote investments by all payers in high-quality and cost-effective care across the continuum. HPC certification of ACOs complements, but does not replace, requirements and activities of other state agencies. ACO Certification does not assess the ACO's suitability to operate as a Risk-Bearing Provider Organization (RBPO), which is under the purview of the Division of Insurance (DOI).

This year, ACO Certification will continue to recognize the heterogeneity among ACOs in the Commonwealth while focusing on the ACO model as a catalyst for learning and improvement. The ACO LEAP 2024-25 certification standards continue the program's emphasis on learning, equity, and patient-centeredness.

Learning. The ACO LEAP standards encourage ACO success by recognizing structures, processes, and approaches conducive to effectively learning from their experiences over time. The standards are designed to allow for a variety of ACO approaches to meeting core principles consistent with the "Learning Health System" framework developed by the National Academy of Medicine (formerly the Institute of Medicine).[1]

Equity. Health care delivery organizations have an important role to play as partners in ensuring that everyone in the Commonwealth has the opportunity to attain their full health potential. As ACOs learn from their experiences over time, it is critical that this process includes exploring ways to improve Health Equity to ensure that no one is disadvantaged from achieving his or her health potential because of his or her social position (e.g., class, socioeconomic status) or socially assigned circumstance (e.g., race, gender, ethnicity, religion, sexual orientation, geography, etc.).

Patient-centeredness. The ACO LEAP 2024-25 framework continues the program's focus on patient engagement and incorporating patient voices to guide population health management programs and whole-person care delivery. Understanding patients' preferences and needs and implementing interventions to meet both continues to be a core function of ACOs.

[1] Institute of Medicine. 2013. Best Care at Lower Cost: The Path to Continuously Learning Health Care in America. Washington, DC: The National Academies Press. https://doi.org/10.17226/13444.

Alignment with MassHealth

Since 2018, MassHealth has supported accountable and integrated models of care through a set of investments under a restructured federal 1115 Demonstration Waiver.[2] Under the renewed waiver, starting in spring 2023 MassHealth continues to advance the path of accountable care while making important refinements to improve quality, member experience, and total cost of care. MassHealth recognizes two ACO models (Accountable Care Partnership Plan and Primary Care ACO), each with its own set of contractual requirements.[3] While the HPC ACO Certification is designed to be an all-payer, all-patient program, the HPC has collaborated extensively with MassHealth to align ACO Certification with its requirements and minimize administrative burden wherever possible. ACOs under both MassHealth models are required to achieve HPC ACO Certification by the start of the first performance year and maintain certification throughout the contract period.

[2] For more information on the 1115 MassHealth Demonstration Waiver, see https://www.mass.gov/service-details/1115-masshealth-demonstration-waiver.
[3] For more information on the Massachusetts Delivery System Reform Incentive Program, see https://www.mass.gov/info-details/massachusetts-delivery-system-reform-incentive-payment-program.

APPLICANT FOR CERTIFICATION

Definition of Applicant

A health care provider or provider organization may own or control other entities that establish risk-based contracts with one or more other payers (contracting entities). In keeping with the all-payer nature of the ACO Certification program, the health care provider or provider organization applying for certification (the Applicant) must have **partial or complete common ownership or control of any and all corporately affiliated[4] contracting entities** that enter into risk contracts on behalf of one or more health care providers (Component ACOs). All entities meeting the definition of Component ACOs must be included in the Applicant's application for Certification.

If all criteria are met, the HPC will certify the Applicant, inclusive of its Component ACOs.

Example 1: A provider organization holds a risk-based contract with a commercial payer. It also fully controls two additional contracting entities that hold risk-based contracts with Medicare and MassHealth, respectively. The provider organization with the commercial risk-based contract must serve as the Applicant for Certification, and the two additional entities are Component ACOs.

Example 2: A provider organization holds a risk-based contract with a commercial payer. It also has (1) complete control of a contracting entity that holds a risk-based contract with MassHealth, and (2) 33% ownership of a contracting entity that holds a risk-based contract with Medicare. The provider organization with the commercial risk-based contract is the Applicant for Certification, and the two additional entities are Component ACOs.

Example 3: A provider organization holds a risk-based contract with MassHealth. It is controlled by a parent organization that (1) controls another contracting entity that holds a commercial risk-based contract, and (2) owns 50% of a contracting entity that holds a risk-based contract with Medicare. The parent organization is the Applicant for Certification, and all three organizations holding risk-based contracts must be included as Component ACOs in the Application.

Please contact the HPC at HPC-Certification@mass.gov for assistance in identifying the proper Applicant for Certification.

Applicant Responsibilities

The HPC ACO Certification is intended to be applicable to ACOs with varying sizes, contracting structures, and internal organizations. Responsibility for the ACO's strategic direction, for example, may be invested in the Applicant organization or with Component ACOs. Applicant organizations and/or Component ACOs may also vary in degree of influence over day-to-day operations and finances of participating practices.

The ACO LEAP standards focus on ACOs' contributions to transforming care delivery through

[4] A corporate affiliation is any relationship between two entities that reflects, directly or indirectly, a partial or complete controlling interest or partial or complete common control.

various mechanisms such as centralized infrastructure or administration, provision of strategic and clinical guidance to practices, and/or ACO-wide decision-making. The standards are compatible with organizations coupling centralized programming with local flexibility for implementation.

Applicants must show that they meet the Assessment Criteria inclusive of any Component ACOs, or they must show that each Component ACO meets the standards individually. Additional guidance is provided below regarding how this requirement applies to the Assessment Criteria and Supplemental Information questions. The HPC also recognizes that some Applicants are part of a larger health system that may address the topics covered in the certification requirements through system-wide strategies or approaches. The Applicant may rely on the approach of the larger system to meet the requirements for certification, provided that the Applicant (and its Component ACOs, if applicable) can show that it adopts and consistently implements the given system-level approach.

TERM OF CERTIFICATION

Deadline to Apply and Duration of Certification

In general, the term of HPC ACO Certification is two years from the date that the HPC awards certification.

For Applicants that are certified in the fall of 2023, the application deadline will be October 2, 2023, and the term of Certification will be from January 1, 2024, to December 31, 2025. For Applicants that are certified in the fall of 2024, the application deadline will be October 1, 2024, and the term of Certification will be from January 1, 2025, to December 31, 2026.

Significant Changes to an Applicant During the Term of Certification

The HPC requires Applicants that have received ACO Certification to notify the HPC of any significant changes to the information in the application during the Certification term. Significant changes are changes to the Applicant's organization or operations that render it and/or its Component ACOs no longer able to meet the HPC's ACO Certification criteria. In addition, the HPC may request other updates from Applicants during the Certification term, so the HPC has accurate information about certified ACOs for public reporting purposes.

To notify the HPC of a significant change or provide updates at any time, please email HPC-Certification@mass.gov.

CERTIFICATION REQUIREMENTS AND APPLICATION

The HPC ACO Certification application is completed and submitted using a web-based application hosted by the Executive Office of Technology and Security Services (EOTSS). Applicants must first gain access to the application portal, then complete an Intent to Apply form prior to accessing the full application.

Part 0: Application Portal Access

An Applicant for certification must designate a Primary Application Contact person to request login credentials for the application portal and complete the Intent to Apply form. The link to the application portal will be available on the HPC website. To request login credentials, the Primary Application Contact must provide the following information:

Field	Format
Prefix	Text box
First name	Text box
Last name	Text box
Title	Text box
Email address	Text box
Applicant organization name	Text box

The HPC will review and approve the Primary Application Contact's request for credentials or contact the individual with any questions regarding the request. **Please note**: the HPC will provide detailed guidance on accessing and using the application portal in separate training materials.

Part 1: Intent to Apply

After receiving login credentials, the Primary Application Contact must log into the application portal and complete and submit an Intent to Apply form. The form requests certain preliminary information about the Applicant as follows:

Field	Format
Applicant name (legal and d/b/a)	Text box
Applicant Tax Identification Number (TIN)	Digits (usually up to 9)
Applicant street address	Text box
Applicant city	Text box
Applicant state	Drop-down box
Applicant zip code	5 digits
Component ACO name(s) (legal and d/b/a)	Text box(es)
Component ACO TIN(s)	Digits
Applicant Public Contact first name	Text box
Applicant Public Contact last name	Text box
Applicant Public Contact prefix	Drop-down box
Applicant Public Contact title	Text box
Applicant Public Contact phone number	Text box
Applicant Public Contact email	Text box
Primary Application Contact first name	Text box

Applicant information will be pre-populated in the ITA but should be reviewed by the Primary Application Contact.

Primary Application Contact is an application portal user and the person designated to be the HPC's primary contact for purposes of ACO certification.

Primary Application Contact last name	Text box
Primary Application Contact prefix	Drop-down box
Primary Application Contact title	Text box
Primary Application Contact phone number	Text box
Primary Application Contact email	Text box

In addition, each Applicant must attest, **via a check-box**, to the following six Pre-Requisite statements on the Intent to Apply form:

1. Applicant has obtained, if applicable, one or more **Risk-Bearing Provider Organization (RBPO)** certificate(s) or waiver(s) from the **DOI.**[5]
2. Applicant has filed all required **Material Change Notices (MCNs)** with the **HPC**, if applicable.[6]
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)** guidance, if applicable,[7] regarding establishing a **patient appeals process**.
5. Applicant has at least one **risk contract** with a public or private payer in the Commonwealth.
6. Applicant has an identifiable and unique **Governing Body** with authority to execute the functions of the ACO.

An Applicant must attest to all six of the above statements to be considered eligible to seek ACO Certification.

The HPC will review an Applicant's submitted ITA and contact the Primary Application Contact with any questions or requests for revisions. If the ITA is approved by the HPC, the HPC will review and approve, as appropriate, requests for login credentials submitted by any other ACO staff. All ACO users will then have access to and may begin completing the application for Certification.

Part 2: Application for Certification

The ACO Certification requirements are organized into three categories: **Pre-Requisite Uploads**, **Assessment Criteria** (including completion of the **Health Equity Requirement document**), and **Supplemental Information**. An Applicant must meet all of the Pre-Requisites and demonstrate that it meets all of the Assessment Criteria in order to receive HPC ACO

[5]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.

[6]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.

[7] Pursuant to OPP guidance, Bulletin HPC-OPP-2016-01, this appeals process does not apply to any MassHealth (Medicaid), Medicare, or Medicare Advantage patients. *See* http://www.mass.gov/anf/budget-taxes-and-procurement/oversight-agencies/health-policy-commission/regulations/20160506-bulletin-rbpo-appeals-final.pdf.

Certification. In addition, an Applicant must provide complete responses to the Supplemental Information questions.

Pre-Requisite Uploads

Applicants are required to provide additional documentation within the application to support two of the Pre-Requisite check boxes as indicated below.

For Pre-Requisite Upload #1:

- ☐ Provide an organizational chart(s) of the Governance Structure(s), including Governing Body, executive committees, and executive management. If the Applicant has Component ACOs with unique Governance Structures, the Applicant must provide a separate organizational chart for each Governing Body. UPLOAD

- ☐ Identify the name of the Governing Body and briefly describe the key responsibilities of any executive committees in the Governance Structure LONG TEXT BOX and UPLOAD

For Pre-Requisite Upload #2:

1. For each of the risk-based contracts established by the Applicant and/or its Component ACOs,[8] complete an Excel template (see Appendix) to report:
    a. Name of payer, risk contracts, and product type (e.g., PPO, HMO, fully-insured, self-insured)
    b. Number of years risk experience with payer, and year when current 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, including incentives to improve health equity
    f. Financial risk terms for each contract:
        i. Upside only or upside and downside risk
        ii. Maximum shared savings and shared loss rates
        iii. Any cap on shared savings or losses

    UPLOAD using template provided

Risk Contract Performance

1. Report ACO-level final quality performance on the measures associated with each up- or downside risk contract for the last performance year for which these data are available (if applicable).[9] UPLOAD

[8] The Applicant should report only on current contracts directly held by the Applicant and/or its Component ACOs (not risk contracts in which you may participate but that are held by other organizations).

[9] If Applicant is unable to submit performance information because it has yet to receive final performance information from payer(s), the Applicant should submit the list of quality measures upon which the Applicant and any Component ACO(s) will be measured under current contract(s) and any interim performance information it has received.

Assessment Criteria

The HPC will evaluate Applicants for certification using the Assessment Criteria and associated documentation requirements detailed in this guide. The Applicant and each of its Component ACOs must meet each of the Assessment Criteria to receive HPC ACO Certification. **Where applicable, an Applicant with multiple Component ACOs that use different approaches or initiatives must submit separate documentation for each Component ACO**. (Note: If an Applicant does not itself hold risk contracts, then only its Component ACOs must meet the criteria). In the criteria descriptions below, the HPC uses "the ACO" to signify each risk contract-holding entity included in the application (i.e., each Component ACO and those Applicant organizations that themselves hold risk contracts). The HPC may request clarifying or additional information if a submission is incomplete.

For several of the Assessment Criteria, the application offers flexibility by providing options for the documentation requirements. For Assessment Criteria AC-1, AC-2, and AC-3, Applicants may select an approach from a menu of options. Where appropriate, Applicants are encouraged to submit Primary Source Documents (e.g., existing internal materials such as guidelines, memoranda, presentations, reports, tools, etc.) to show that the criteria are met. In cases where no suitable Primary Source Documents exist, the Applicant may provide an original narrative.

All Primary Source Documents submitted must have been produced within the past two years and broadly representative of the Applicant's and/or Component ACOs' current approach to meeting the standard set forth in each Assessment Criterion.

Health Equity Requirement

In recognition of the important role that health care providers, and ACOs in particular, have in promoting Health Equity, the ACO Certification program will begin to track progress on ACO capacity to design, implement, and refine interventions, programs, and/or processes to advance Health Equity for their patients consistent with an emerging national consensus on key organizational activities and competencies for addressing Health Inequities. To capture this information, Applicants must complete and upload a new Health Equity Requirement (HER) document. This first use of the HER document will establish a foundational understanding of the ACOs' Health Equity activities and competencies, and provide a basis for tracking their evolution in future certification cycles.

The HER document tracks ACO progress on three discrete activities or competencies: using data to develop interventions to improve Health Equity; engaging patients in the development of such interventions; and making ACO-wide strategic commitments to Health Equity. Applicants are required to report on the following for each identified activity: UPLOAD, using template provided

a. *Status* - For each activity, Applicants must select from a dropdown menu a status that best reflects the Applicant's and/or each Component ACO's current approach. Status options within each category represent a continuum of potential progress for ACOs.
b. *Short description or example* of the Applicant's progress to-date to illustrate specifically how the Applicant and/or each Component ACO has achieved the status selected.
c. *Short description of plans or commitments* for progress in the next two years.

Applicants must report on these data elements for the Applicant and/or each Component ACO.

An Applicant satisfy(ies) the Health Equity Requirement by completing the HER document (see Appendix), and demonstrating that it and/or each Component ACO meets or exceeds the required status for the Data-Driven Interventions activity.

Specific guidance related to activity statuses and thresholds is provided below. Table 1, Table 2, and Table 3 identify milestones that define each activity status. The HPC anticipates that the milestones associated with each status may evolve in future certification cycles as ACOs' Health Equity competencies evolve.

Data-Driven Interventions

Activity: The ACO **uses race, ethnicity, language, and/or disability (RELD) and sexual orientation, gender identity, and sex (SOGIS) data** to inform and aid its quality improvement, care delivery, and/or population health management processes in closing inequities.

ACO Status Response Options

Each status option in Table 1 below is defined by associated milestones. An ACO must have achieved each associated milestone to have reached a status.

Table 1: Data-Driven Interventions Status Options and Associated Milestones

	ACO Status Response Options	Associated Milestones
DOES NOT meet standard for Certification	ACO has not taken steps in this area	✓ No efforts to collect RELD SOGIS data for the majority of ACO-attributed patients or in a majority of ACO-participating practices
	DATA COLLECTION ONLY: ACO has implemented some RELD SOGIS data collection, but is not generating stratified metrics for leadership and/or providers	✓ The ACO has identified and adopted a standard for RELD SOGIS data collection, or ACO is receiving patient self-reported data from payer(s)[10] ✓ Staff charged with collection of patient-reported RELD SOGIS data receive training on how to appropriately explain to patients its purpose and use ✓ ACO collects (or receives from payer(s)) some standardized patient self-reported RELD SOGIS data for a majority of its attributed patients or in a majority of ACO-participating practices
Meets Standar	**INEQUITIES MONITORING ONLY:** ACO is generating and using stratified metrics to identify and monitor Health Inequities	All 'Data Collection Only' milestones, plus: ✓ ACO is stratifying access, efficiency, process, outcomes, patient safety, and/or patient experiences of care metric(s) by some patient self-reported RELD SOGIS

[10] For an example of standards for data collection see: Massachusetts EOHHS Quality Alignment Taskforce. "Health Equity Data Standards and Accountability Framework Recommendations." https://www.mass.gov/info-details/eohhs-quality-measure-alignment-taskforce#health-equity-data-standards-and-accountability-framework-recommendations-

	ACO Status Response Options	Associated Milestones
		variable(s) to identify and monitor Health Inequities among its patient population ✓ ACO is periodically reviewing some stratified metric(s) with ACO leadership and/or providers (e.g., via inclusion in performance dashboards) to identify Health Inequities ***For LEAP 2024-25 certification, ACO must be stratifying at least one metric tracked at the ACO level using at least one RELD SOGIS variable***
	INTERVENTION(S) DESIGNED/ IMPLEMENTED: ACO is using stratified metrics to inform design and implementation of interventions to close identified Health Inequities	All 'Inequities Monitoring Only' milestones, plus: ✓ ACO has begun to implement intervention(s) or modification(s) to an existing population health management program to close an identified Health Inequity ✓ The ACO is tracking process and outcome metrics to track short- and long-term progress of the intervention
	INTERVENTION(S) EVALUATED/ REFINED: ACO is using data-driven strategies to improve the effectiveness of its equity-focused interventions	All 'Interventions Designed/Implemented' milestones, plus: ✓ The ACO is in the process of developing or has implemented plans to scale or refine the intervention to improve its effectiveness on tracked metrics

As noted in Table 1, the Applicant and/or each Component ACOs must meet a minimum standard with respect to this activity in order to achieve LEAP 2024-25 certification.

Patient Engagement

Activity: To inform design and implementation of care delivery interventions and/or population health management programs with an equity focus, the ACO meaningfully **engages with patients experiencing the targeted Health Inequity**.

These engagements should be distinct from population-level monitoring of patient experience as detailed in AC-1 (e.g., PFACs, patient experience surveys, etc.). For the HER, ACO processes for patient engagement are expected to reflect meaningful engagement that is directed specifically to **patients and/or their caregivers and families experiencing or impacted by the Health Inequity** the intervention aims to address.

ACO Status Response Options
Each status option in Table 2 below is defined by associated milestones. An ACO must have achieved each associated milestone in order to have reached a status.

Table 2: Patient Engagement Status Options and Associated Milestones[11]

	ACO Status Response Options	Associated Milestones
Reporting Meets Standard for Certification	**N/A**	✓ ACO has neither designed nor implemented any equity-focused interventions
	ACO **has not engaged** patients in design and implementation	✓ The ACO has developed and/or implemented equity-focused interventions, but has not engaged with patients experiencing the targeted Health Inequity
	ACO has **informed** patients about design and implementation	✓ The ACO has developed and/or implemented equity-focused interventions, and has established unidirectional communication with patients experiencing the targeted Health Inequity to provide information about the design and/or implementation of the intervention(s) (e.g., through mailers, phone calls, text messages, resource sheets at point of care, etc.)
	ACO has **consulted** patients on design and implementation	All 'informed' milestones, plus: ✓ ACO has established bidirectional communication with patients experiencing the targeted Health Inequity regarding the design and/or implementation of an equity-focused intervention (e.g., via town halls, interviews, focus groups, feedback in care settings, etc.) ✓ Information and feedback from patients experiencing the targeted Health Inequity is used to inform program design and/or implementation
	Patients **share in decision-making** with the ACO on design and implementation	All 'consulted' milestones, plus: ✓ ACO has established a bidirectional relationship with patients experiencing the targeted Health Inequity where decision-making power is shared with patients in the process of designing and/or implementing an equity-focused intervention. Patients experiencing the targeted Health Inequity have leadership opportunities, drive idea generation, or otherwise actively guide program design and/or implementation

At this time, there is no minimum standard for the Patient Engagement activity; responses are "reporting-only" in the LEAP 2024-25 standards. Minimum requirements will be introduced in future ACO Certification application cycles.

Strategy

Activity: The ACO has **articulated a vision for advancing Health Equity** in its strategic plan(s), has **set explicit goals** for advancing Health Equity across its risk population(s), and is **using ACO operational infrastructure** (including, but not limited to incentives, technology, training/education) to achieve Health Equity goals articulated in the strategic plan.

[11] Status options represent a simplified version of the Massachusetts Continuum of Community Engagement available at: https://www.mass.gov/doc/community-engagement-guidelines-for-community-health-planning-ms-word-doc/download

ACO Status Response Options

Each status option in Table 3 below is defined by associated milestones. An ACO must have achieved each associated milestone in order to have reached a status.

Table 3: Strategy Status Options and Associated Milestones

	ACO Status Response Options	Associated Milestones
Reporting Meets Standard for Certification	ACO has not taken steps in this area	✓ ACO has not articulated an explicit vision or goals with respect to advancing Health Equity in its patient population
	ACO has incorporated Health Equity in strategic plan(s) and set explicit goals	✓ ACO has articulated an organization-wide vision for advancing Health Equity broadly across its risk population(s) in strategic plan(s) ✓ ACO has set explicit, measurable goals for closing known Health Inequities in its patient population
	The ACO has begun operationalizing Health Equity components of its strategic plan(s)[12]	✓ The ACO has implemented change(s) to activity(ies) or operation(s) to intentionally operationalize Health Equity component(s) of its strategic plan(s) ✓ The ACO is regularly reviewing progress with leadership, staff, and providers

At this time, there is no minimum standard for the Strategy activity; responses are "reporting-only" in the LEAP 2024-25 standards. Minimum requirements will be introduced in future ACO Certification application cycles.

[12] Examples of ways ACOs may have begun operationalizing Health Equity goals include: demonstrating leadership commitment; developing internal financial incentives (e.g., performance-based compensation or shared savings distribution methodologies that promote Health Equity); dedicating staffing, funding, or technology (e.g., incorporating use of health equity-related data into the EHR); offering relevant staff and/or provider trainings, and/or improving hiring or retention practices to increase diverse representation in the ACO.

AC-1: Patient Centered Care

The ACO collects and uses information from patients to deliver and improve patient-centered care.

This Assessment Criterion is divided into two requirements: AC-1.1 and AC-1.2.

AC-1.1: The ACO **systematically monitors and assesses** the experience, perspectives, and/or preferences of the patient population served.

Documentation Requirements

The Applicant and/or its Component ACOs satisfy(ies) this requirement through one or more of the following **approaches**: CHECK BOXES, check all that apply across Applicant and/or Component ACOs

- ☐ Regular monitoring of patient experiences or preferences (e.g., online communities, patient focus groups, patient experience survey collection)
- ☐ Systematic data collection on patients' cultural, linguistic, literacy, and similar care-related needs and preferences
- ☐ Robust mechanisms for engaging consumers in governance and/or advisory bodies informing leadership (e.g., active consumer representation on each Governing Body, use of Patient and Family Advisory Councils)

For itself and/or each Component ACO, the Applicant may submit a Primary Source Document as documentation of this approach. If no appropriate Primary Source Document is available, the Applicant may submit an original narrative description.

Primary Source Document

A Primary Source Document must include the following elements, or the Applicant must provide them in Box AC-1.1

- ✓ Short description of the Primary Source Document (including the Component ACO to which it corresponds, if applicable)
- ✓ The frequency of the activity

Examples of possible Primary Source Documents may include, but are not limited to:

- Summaries or analyses of results from periodic patient experience surveys or data collection instruments
- Summaries of feedback received through focus groups or from online communities, or other documentation of these sources (e.g., screenshots or meeting schedules)
- Patient and Family Advisory Council meeting minutes or feedback summaries showing active feedback solicitation, or Governing Body agendas or meeting minutes showing attention to lived experience of consumer representative

Box AC-1.1: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Original Narrative
If submitting an original narrative description in lieu of a Primary Source Document, the narrative must include the following (limit 500 words total): UPLOAD

- ✓ A description of the approach used by ACO leadership for AC-1.1, including scope and scale
- ✓ The frequency with which the ACO conducts the activity

AC-1.2: The information/data gathered via AC-1.1 **informs the ACO's strategy and/or organization-level initiatives** for improving patient experience.

Documentation Requirements

For itself and/or each Component ACO, the Applicant may submit a Primary Source Document **describing one ACO- or system-level initiative** to improve an aspect of patient experience in the past two years. If no appropriate Primary Source Document is available, the Applicant may submit an original narrative description.

Primary Source Document
A Primary Source Document must include the following elements, or the Applicant must provide them in Box AC-1.2:

- ✓ Short description of the Primary Source Document
- ✓ How the need or opportunity was identified from information collected in AC-1.1
- ✓ How the initiative is being measured to gauge impact and/or make improvements

Examples of possible Primary Source Documents may include but are not limited to:

- Overview presentations or written summaries describing the initiative
- Memos or internal communications detailing the initiative

Box AC-1.2: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Original Narrative
If submitting an original narrative description in lieu of a Primary Source Document, the narrative must include the following (limit 500 words total): UPLOAD

- ✓ A description of the ACO- or system-level initiative and its goals
- ✓ A description of how the need or opportunity was identified from information collected in AC-1.1
- ✓ How the initiative is being measured to gauge impact and/or make improvements
- ✓ An estimate of the number of providers, patients, and/or practices engaged in the initiative

AC-2: Culture of Performance Improvement

The ACO fosters a culture of continuous improvement, innovation, and learning to improve the patient experience and value of care delivery.

This Assessment Criterion has one requirement.

AC-2: The ACO's culture of performance improvement is demonstrated by at least two different **approaches**.

Documentation Requirements

The Applicant and/or its Component ACOs satisfy(ies) this requirement through **at least two of the following approaches**: CHECK BOXES, check all that apply across Applicant and/or Component ACOs

- ☐ Periodically convening clinical and/or business leaders from around the ACO to discuss performance improvement goals, opportunities, strategies, and/or activities
- ☐ Leadership commitment to tracking and reviewing performance
- ☐ Internal financial incentives
- ☐ Internal systems or processes to facilitate or encourage innovation and improvement
- ☐ Selection or evaluation of clinical or non-clinical affiliates or partners based on alignment with ACO performance improvement priorities
- ☐ Support for an ACO- or system-wide primary care transformation strategy

For itself and/or each Component ACO, the Applicant may submit a Primary Source Document as documentation for each of the two approaches selected. If no appropriate Primary Source Document is available for one or both approaches selected, the Applicant may submit an original narrative description.

Primary Source Document

A Primary Source Document must include the following elements, or the Applicant must provide them in Box AC-2:

- ✓ Short description of the Primary Source Document
- ✓ Brief explanation of how the approach described contributes to a culture of improvement in the ACO

Examples of possible Primary Source Documents may include but are not limited to:

- Agendas, minutes, or written summaries of internal ACO meetings, organizational management activities, or recruitment strategies aimed at advancing a culture of improvement
- Dashboards or other tools for tracking system or ACO-level quality and financial metrics against ACO goals by leadership, or a narrative describing how the Governing Body(ies) sets strategic performance improvement goals
- Memos, overview presentations, or summaries demonstrating implementation of systems

learning (e.g., Lean) and/or process improvement approaches, or an example of an initiative where frontline staff identified waste, inefficiency, or quality improvement opportunities and were empowered by leadership to test and/or scale proposed solutions
- Scoresheets or written criteria for evaluating potential clinical or non-clinical affiliates or partners (e.g., on factors like use of team-based care, communication and/or data exchange, coordination with community-based services, care transition protocols, cost, quality, or access, etc.)
- Plans or summary documents describing an ACO- or system-wide strategy for primary care transformation based on advanced primary care principles[13], including continuous quality improvement

Box AC-2: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Original Narrative

If submitting an original narrative description in lieu of a Primary Source Document for one or both approaches selected, the narrative(s) must include the following (limit 500 words total): UPLOAD

- ✓ A description of the approach(es) used by ACO leadership
- ✓ Brief explanation of how the approach(es) described contributes to a culture of improvement in the ACO

[13] *Advanced primary care* refers to functions and attributes like comprehensive care, patient-centeredness, coordinated care, accessible services, and a commitment to quality and safety. See: AHRQ. "Defining the PCMH." https://pcmh.ahrq.gov/page/defining-pcmh.

AC-3: Data-Driven Decision-Making and Care Delivery

The ACO is committed to using the best available data and evidence to guide and support improved clinical decision-making.

This Assessment Criterion is divided into two requirements: AC-3.1 and AC-3.2.

> **AC-3.1:** To facilitate learning among providers, decrease provider practice variation, and support provider adherence to evidence-based guidelines, the **ACO adopts processes or tools that make available reliable, current clinical knowledge at the point of care**.

Documentation Requirements

The Applicant and/or its Component ACOs satisfy(ies) this requirement through **at least one of the following approaches**: CHECK BOXES, check all that apply across Applicant and/or Component ACOs

- ☐ Launching an initiative to reduce inefficiency or low-value care, or decrease provider practice variation in the past two years[14]
- ☐ Facilitating or encouraging use of a clinical decision support tool[15]
- ☐ Developing or making available to providers an evidence-based protocol or structured learning opportunity

For itself and/or each Component ACO, the Applicant may submit a Primary Source Document as documentation of this approach. If no appropriate Primary Source Document is available, the Applicant may submit an original narrative description.

Primary Source Document

A Primary Source Document must include the following elements, or the Applicant must provide them in Box AC-3.1:

- ✓ Short description of the Primary Source Document
- ✓ Estimate of the scale of the approach (e.g., prevalence of use or uptake among providers)

Examples of possible Primary Source Documents may include but are not limited to:

- Internal summary materials or presentations describing an initiative to reduce low value care or decrease provider practice variation

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[14] Examples of low-value care include: screenings that are not clinically indicated, certain pre-operative services, potentially unnecessary procedures, imaging services for conditions for which they have little diagnostic value, and inappropriate prescribing. See: Health Policy Commission. “2018 Annual Health Care Cost Trends Report.” February 2019. Available at: https://www.mass.gov/files/documents/2019/02/20/2018%20Cost%20Trends%20Report.pdf

[15] Some commercially available electronic health records include embedded clinical decision support tools. The existence of decision support within electronic health records used by ACO-participating providers is not sufficient to meet the AC-3.1 requirement. To meet the requirement, the ACO must provide strategic guidance or direction to increase provider awareness of decision support tools that align with ACO priorities and/or decrease variations in care delivery among ACO-participating providers.

- Strategy document, memorandum, or internal communication encouraging use of a particular decision support tool or evidence-based protocol among clinicians, or internal summary or dashboard tracking use of a clinical decision support tool
- Event agenda or summary of a structured learning opportunity

Box AC-3.1: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Original Narrative

If submitting an original narrative description in lieu of a Primary Source Document, the narrative must include the following (limit 500 words total): UPLOAD

- ✓ A description of the initiative, tool, protocol, or learning opportunity and the ACO's role in supporting or encouraging its use
- ✓ A description of the scale of the process or reach of the tool (e.g., estimated prevalence of use or uptake among clinicians)
- ✓ Any known quantitative or qualitative outcomes associated with implementation of the process or tool

AC-3.2: The ACO collects and offers providers **actionable data** (e.g., on quality, safety, cost, and/or health outcomes) to guide clinical decision-making, identify and eliminate waste, and enable high-value care delivery.

Documentation Requirements

The Applicant and/or its Component ACOs satisfy(ies) this requirement through **at least one of the following approaches**: CHECK BOXES, check all that apply across Applicant and/or Component ACOs

- ☐ Periodically providing data and/or feedback on cost or quality performance at the individual provider or group level, benchmarked to peers or external standard
- ☐ Offering providers understandable, actionable information on their patients via data analytics (e.g., identifying patients due for mammograms, or diabetic patients in need of HbA1c tests)

For itself and/or each Component ACO, the Applicant may submit a Primary Source Document as documentation of this approach. If no appropriate Primary Source Document is available, the Applicant may submit an original narrative description.

Primary Source Document

A Primary Source Document must include the following elements, or the Applicant must provide them in Box AC-3.2:

- ✓ Short description of the Primary Source Document
- ✓ Estimate of the scale of the approach (e.g., number or percentage of clinicians offered understandable, actionable information on their patients)

Examples of possible Primary Source Documents may include but are not limited to:

- Template for or de-identified example of a cost or quality performance report in use
- De-identified screenshots, memos, or internal communications detailing data analytics available to providers

Box AC-3.2: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Original Narrative

If submitting an original narrative description in lieu of a Primary Source Document, the narrative must include the following (limit 500 words total): UPLOAD

- ✓ A description of the ACO's approach, including the type of data provided
- ✓ How often the data are provided
- ✓ How these activities fit into the ACO's overall performance improvement strategy(ies)

AC-4: Population Health Management Programs

The ACO develops, implements, and refines programs and/or care delivery innovations to coordinate care, manage health conditions, and improve the health of its patient population.

This Assessment Criterion is divided into two requirements: AC-4.1 and AC-4.2.

AC-4.1: The ACO **collects data** to understand the health needs of its patient population and performs appropriate **risk stratification**.

Documentation Requirements

The Applicant and/or its Component ACOs satisfy(ies) this requirement by providing a written narrative describing its approach to collecting and using data to stratify its patient population for inclusion in population health management programs (see AC-4.2). Responses must include: UPLOAD

a. Description of the approach to analyzing data, including source of information (e.g., payer-provided reports, proprietary software from a vendor, internal stratification methodology)
b. Factors on which stratification is based (e.g., emergency department use, functional status, chronic conditions, social factors)
c. Frequency of stratification
d. Any methodological variation by sub-population (e.g., Medicare, Medicaid, commercial)

AC-4.2: The ACO uses the data analysis or risk stratification described in AC-4.1 to design and implement **one or more patient-facing population health management programs** that address areas of need for a defined patient population. The ACO **sets targets for and measures the impact of these programs** to support continuous performance improvement over time.

Documentation Requirements

The Applicant and/or its Component ACOs satisfy(ies) this requirement by completing the Population Health Management Programs and Targets template (see Appendix) to report the following data elements: UPLOAD, using template provided

a. Priority area or program
b. Specific interventions
c. Populations targeted
d. Number of patients served
e. Metrics and targets
f. Progress on metrics, and/or
g. Program change(s) made in past two years based on data gathered or targets missed over the course of implementation
h. Notes or clarifications (optional)

AC-5: Whole-Person Care

The ACO recognizes the importance of non-medical factors to overall health outcomes and cost of care and seeks to integrate behavioral health and health-related social supports into its care delivery models.

This Assessment Criterion is divided into two requirements: AC-5.1 and AC-5.2.

AC-5.1: The ACO is **advancing the integration of behavioral health care** into primary care settings, with respect to workforce, administration, clinical operations, and/or funding. The ACO also **sets and measures progress on discrete goals** for further increasing integration over time.

Documentation Requirements

The Applicant satisfies this requirement by completing the Behavioral Health Integration Progress (BHI) and Targets template (see Appendix) to report: UPLOAD, using template provided

a. BHI Priority Area[16]
b. Goal(s) for the Priority Area
c. Actual Performance in Previous Measurement Period, if applicable
d. Current Target
e. Time Period for Previous Measurement and Current Target
f. Type of ACO Support Provided

AC-5.2: The ACO is also advancing efforts to **understand and address its patients' health-related social needs** through screening and referral relationships with community-based and/or social service organizations. The ACO also sets and **measures progress on discrete goals** for improving the effectiveness of these processes.

Documentation Requirements

The Applicant may submit a Primary Source Document as documentation of these processes. If no appropriate Primary Source Document is available, the Applicant may submit an original narrative description.

Note: If the Applicant's HRSN screening process is embedded in the Applicant's Population Health Management Program(s) described in AC-4.2, the Applicant may provide the information required for AC-5.2 in the Population Health Management Programs and Targets template

[16] Behavioral health integration priorities may include, but are not limited to, activities like supporting co-location of providers, incorporating behavioral health providers onto care teams, facilitating information-sharing, implementing of behavioral health screening and referral processes, or supporting evidence-based behavioral health care. Include any area that the ACO is investing in or otherwise supporting. The scale of these efforts and investments may vary and need not apply to every practice participating in the ACO.

submitted in AC-4.2. In that case, the Applicant must indicate in Box AC-5.2 that it has exercised this option, and provide additional information in Box AC-5.2 or by uploading a brief narrative on progress toward or plans for use of bi-directional methods or platforms to refer patients to community services and facilitate communication between the ACO, primary care provider, and community-based service provider.

Primary Source Document

A Primary Source Document must include the following elements, or the Applicant must provide them in Box AC-5.2:

- ✓ Short description of the Primary Source Document
- ✓ Estimate of the scale of the screening processes

Examples of possible Primary Source Documents may include but are not limited to:

- Examples (e.g., screenshots) of HRSN screening response summaries or results dashboards
- Memos, overview presentations, or summaries detailing the ACO's approach to HRSN screening

Box AC-5.2 (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Original Narrative

If submitting an original narrative description in lieu of a Primary Source Document, the narrative must include the following (limit 500 words total): UPLOAD

- ✓ Description of ACO's approach to HRSN screening, including tools used
- ✓ Progress on or plans for use of bi-directional methods or platforms to refer patients to community services and facilitate communication between the ACO, primary care provider, and community-based service provider
- ✓ Metrics tracked
- ✓ Current performance
- ✓ Performance targets

Supplemental Information

Applicants must provide complete responses to all of the Supplemental Information questions in order to receive HPC ACO Certification. If the Applicant has multiple Component ACOs, unless otherwise noted, please provide a response that best describes the overall characteristics or approach across the Applicant and all of its Component ACOs. In the questions below, the HPC uses "the ACO" to signify each risk contract-holding entity included in the application (i.e., each Component ACO and those Applicant organizations that themselves hold risk contracts).

For each set of Supplemental Information questions, Applicants will have the option to upload one or more additional documents to further explain or supplement a response.

SI-1: Facilitating High-Value Care Delivery

Questions:

1. The HPC is interested in understanding the innovations and care delivery changes made possible by value-based payment and the ACO model. Considering all the experience the ACO has had participating in risk contracts, what has been the most important innovation or change to care delivery that you have been able to accomplish that would not have been possible under purely fee-for-service contracts? TEXT BOX

2. In which of the following areas have the ACO's own performance targets been the most difficult to achieve? Check as many as apply, considering all Component ACOs. Provide a brief narrative describing more specifically the ACO's performance in each area selected, why performance targets have been difficult to achieve, and any ongoing efforts to improve performance in this area. CHECK BOXES, check all that apply
   - ☐ Quality (e.g., preventive, mental health, chronic care, or specialty care measures) SHORT TEXT BOX
   - ☐ Cost or cost trend SHORT TEXT BOX
   - ☐ Efficiency (e.g., readmission rates) SHORT TEXT BOX
   - ☐ Patient experience (e.g., CAHPS results) SHORT TEXT BOX
   - ☐ Clinician process factors (e.g., adherence to clinical protocols) SHORT TEXT BOX
   - ☐ Health equity (e.g., inequities reduction within measures) SHORT TEXT BOX
   - ☐ Other SHORT TEXT BOX

3. Which of the following, if any, are strategies the ACO is pursuing to deliver higher-value care? For any response, please provide 3-5 sentences summarizing the ACO's actions. CHECK BOXES, check all that apply
   - ☐ Increasing the proportion of total dollars at risk for provider performance SHORT TEXT BOX
   - ☐ Incorporating specialty providers into ACO initiatives and/or incentives SHORT TEXT BOX
   - ☐ Keeping care within the ACO's network of providers SHORT TEXT BOX
   - ☐ Shifting to greater use of mid-level clinical staff SHORT TEXT BOX

- ☐ Launching innovative models of care delivery SHORT TEXT BOX
- ☐ Using technology (e.g., remote monitoring, app-based tools, or asynchronous visit or communication opportunities) to manage care outside of clinical settings SHORT TEXT BOX
- ☐ Identifying and reducing low-value services SHORT TEXT BOX
- ☐ Investing in "upstream" interventions to address social determinants of health SHORT TEXT BOX
- ☐ Transparent reporting of performance data at the provider level SHORT TEXT BOX
- ☐ Other SHORT TEXT BOX

SI-2: Medicare Advantage

Questions:

1. How is performance under the ACO's Medicare Advantage and/or Senior Care Options risk contract(s) managed, relative to other risk contracts held by the ACO? RADIO BUTTON
   - ☐ Managed by the same body responsible for other commercial or public risk contracts as part of an integrated system-wide strategy
   - ☐ Managed by the same body responsible for commercial or public risk contracts, but not integrated into a system-wide strategy
   - ☐ Managed separately, not integrated into a system-wide strategy
   - ☐ Managed separately, but executing system-wide strategy
   - ☐ N/A – no Medicare Advantage or Senior Care Options risk contracts

2. Considering the approaches identified in this application for the Applicant and/or Component ACOs, which of the following are also applied to the Medicare Advantage and/or Senior Care Options risk population? CHECK BOXES, check all that apply
   - ☐ Patient-centered care strategies
   - ☐ Elements supporting a culture of performance improvement
   - ☐ Supports for data-driven decision-making
   - ☐ Population health management programs and strategies
   - ☐ Behavioral health integration supports
   - ☐ Health-related social needs supports
   - ☐ N/A – no Medicare Advantage or Senior Care Options risk contracts

Part 3: Application for Certification: Affidavit of Truthfulness

The Primary Application Contact or another authorized representative of the Applicant is required to electronically sign and confirm the following statements upon submission of an application for ACO Certification. Additionally, the undersigned understands and acknowledges that the HPC requires Applicants that have received ACO Certification to notify the HPC of any significant changes to the information in the application during the Certification term that make it and/or its Component ACOs no longer able to meet the HPC's Certification criteria.

I, the undersigned, certify that:

1. The information submitted to the HPC for ACO Certification is complete, accurate and true.

2. I am duly authorized to submit this application for HPC ACO Certification on behalf of the Applicant.

Signed on the _____ day of ______________, 20____ under the pains and penalties of perjury.

Name: ______________________________________

Title: ______________________________________

E-Signature: ______________________________________

CONFIDENTIALITY AND USE OF INFORMATION SUBMITTED BY ACOs

Through the ACO Certification program, the HPC seeks to promote greater transparency and continuous improvement of the Massachusetts health care system. To support its application for ACO Certification, the Applicant must submit certain information and documents to the HPC. Some of this information may be publicly available, while other information and documents may be of a clinical, financial, strategic, or operational nature that is non-public.

Information Sharing with the Public

At public meetings and in publications, the HPC will discuss and report on certified ACOs using aggregate or non-attributed information submitted for Certification. In addition, the HPC may report on specific certified ACOs using publicly available information and documents, including those listed in Table 4 that are submitted to the HPC for ACO Certification.

The HPC will not disclose, without the consent of the Applicant, non-public information and documents submitted for ACO Certification that are clinical, financial, strategic, or operational in nature, at the individual ACO level (see Table 5 below). The ACO Certification application will provide the Applicant the opportunity to give consent to the HPC to disclose the information listed in Table 5. The HPC will continue to highlight novel approaches and care delivery models, and otherwise promote shared learning through public reporting of the information listed in Table 5, using both aggregate or non-attributed information and individual ACO information for which it has received consent.

Table 4: Information for Public Reporting

Identifying Information
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 street address
Applicant city
Applicant state
Applicant zip code
Applicant public contact first name
Applicant public contact last name
Applicant public contact prefix
Applicant public contact title
Applicant public contact phone number
Applicant public contact email
Primary application contact first name
Primary application contact last name
Primary application contact title
Primary application contact phone number
Primary application contact email address

PR-1: Governance
Organizational chart(s) of the Governance Structure(s) of the Applicant (and Component ACOs as applicable), including Governing Body, executive committees (including a brief description of the responsibilities of any executive committees), and executive management
PR-2: Risk Contract Information
Name(s) of payer(s) with which Applicant and/or Component ACOs have risk contracts
Year that each risk contract began and expires
Years of risk experience with the payer
Number of attributed patients per risk contract
Whether or not each risk contract is upside-only or includes downside risk

Table 5: Information for Public Reporting If the Applicant Consents

PR-2: Risk Contract Information
Risk contract product types, maximum amount of risk (up- and downside) for which the Applicant and/or its Component ACO was/is responsible under each contract, payment methodology, and description of quality incentives in the payment model
AC-1: Patient-Centered Care
Summaries, developed by the HPC, of ACO activities to monitor patient experience and ACO strategies or initiatives to improve aspects of the patient experience
AC-2: Culture of Performance Improvement
Descriptions, developed by the HPC, of activities or processes the ACO has in place to foster a culture of performance improvement
AC-3: Data-Driven Decision-Making and Care Delivery
Description, developed by the HPC, of initiatives, tools, or protocols used to make information available to providers; description, developed by the HPC, of data feedback or analytics approaches
AC-4: Population Health Management Programs
Description, developed by the HPC, of approach to stratifying patient population and of Population Health Management programs
AC-5: Whole-Person Care
Description, developed by the HPC, of priority areas and goals for behavioral health integration
Description, developed by the HPC, of HRSN screening processes
Health Equity Requirement
Summaries of health equity activities and commitments
SI-1: Facilitating High-Value Care Delivery
Summaries of ACO innovations, performance improvement efforts, and strategies to deliver higher-value care
SI-2: Medicare Advantage
Overview of ACO Medicare Advantage contracts performance management

APPENDIX I: Application Templates

The risk contract information requested in **PR-2** must be uploaded to the submission platform using a template that will be provided.

HPC ACO Certification
Applicant Overview Template PR-2: Risk Contracts

Applicant:	

Component ACO Holding Contract (if applicable)	Name of payer *Add rows as necessary*	Product	Fully-insured or self-insured?	Number of years risk experience with this payer	Year current contract began; year current contract expires	Number of attributed patients/covered lives	Financial Risk Terms					Payment methodology	Description of quality incentives in the payment model (incl. health equity incentives)
							Upside only or upside and downside risk?	Max shared savings rate, if applicable	Max shared loss rate, if applicable	Cap on savings payments, as PMPM or % of budget, if applicable	Cap on shared loss amounts, as PMPM or % of budget, if applicable		
DEF ACO	*Medicare*	*ACO REACH*	*Fully-insured*	*8*	*2023; 2026*	*20,000*	*Upside and downside risk*	*100%*	*100%*	*50% or $20 PMPM*	*50% or $20 PMPM*	*FFS payments reconciled against budget*	*Quality score affects spending benchmark (higher performance reduces standard benchmark discount)*
												Prospective capitation	
												Partial prospective capitation (e.g. for primary care)	

Population Health Management Programs information requested in **AC-4** must be uploaded using a template that will be provided.

HPC ACO Certification
Applicant Overview Template 4.2: Population Health Management Programs and Targets

	Program Characteristics				Program Goals, Metrics, and Targets					Program Evolution
Component ACO (if applicable)	Program/ Priority Area	Specific Intervention(s)	Population Targeted	Number of Patients Served	Program Goal(s) / Metric(s)	Actual Performance in Recent Measurement Period	Most Recent Measurement Period	Current Target	Measurement Period for Current Target	Major Programmatic Changes Made in Past Two Years Based on Data Gathered or Targets Missed (if applicable)
	"ED Frequent Flyer" Care Integration Program	*Care coordinators embedded in ED to share info with ED clinicians and assist with discharge and transfer*	*Top 2% of patients by cost or utilization*	*850*	*Reduction in emergency department visits*	*1% reduction in ED visits relative to CY2021 baseline*	*CY2022*	*5% reduction in ED visits relative to CY2021 baseline*	*CY2023*	*Have added a social worker to the care model in CY2023 to faciltate connections to non-medical services*

Behavioral Health Integration information required **AC-5** must be uploaded using a template that will be provided.

HPC ACO Certification
Applicant Overview Template 5.1 : Behavioral Health Integration Targets and Progress

Brief overview of Applicant's behavioral health integration strategy (max. 150 words)

Component ACO (if applicable)	Priority Area	Types of Support Provided by the ACO	Behavioral Health Integration Goal(s) / Metric(s)	Target for Most Recent Measurement Period	Actual Performance in Recent Measurement Period	Most Recent Measurement Period	Current Target	Measurement Period for Current Target
	Co-location	*Financial (to desgn office space) and infrastructure (shared EHR platform)*	*Proportion of sites with a behavioral health provider on-site*	*15% of primary care practice sites have a PsyD on location*	*18% of primary care practice sites have a PsyD on location*	*CY2022*	*20% of primary care practice sites have a PsyD on location*	*CY2023*
	Information-sharing across settings	*Technical assistance to install new IT system*						

The Health Equity Requirement document must be uploaded using a template that will be provided.

HPC ACO Certification
Health Equity Requirement

This document tracks ACO progress on three discrete activities or competencies: using data to develop interventions to improve Health Equity; engaging patients in the development of such interventions; and making ACO-wide strategic commitments to Health Equity. For each Activitiy, please select a status from the dropdown menu that best reflects each Component ACO's current approach. Status options within each category represent a continuum of potential progress for ACOs. For each Status selected by Component ACO, please then provide short descriptions or examples elaborating on both progress made in the past two years and plans for progress in the next two years, as applicable.

Data-Driven Interventions

Activity	Component ACO	Status	Short description or example to illustrate progress in the past two years, if applicable	Short description of plans or commitments for progress in the next two years
The ACO **uses race, ethnicity, language, and/or disability (RELD) and sexual orientation, gender identity, and sex (SOGIS) data** to inform and aid its quality improvement, care delivery, and/or population health management processes in closing inequities.	Component A	INEQUITIES MONITORING ONLY: ACO is generating and using stratified metrics to identify and monitor Health Inequities		
	Component B	INTERVENTION(S) DESIGNED/IMPLEMENTED: ACO is using stratified metrics to inform design and implementation of interventions to close identified Health Inequities		
	Component C	ACO has not taken steps in this area		

Patient Engagement

Activity	Component ACO	Status	Short description or example to illustrate progress in the past two years, if applicable	Short description of plans or commitments for progress in the next two years
To inform design and implementation of care delivery interventions and/or population health management programs with an equity focus, the ACO **meaningfully engages with patients experiencing the targeted Health Inequity**.	Component A	ACO has INFORMED patients about design and implementation		
	Component B	ACO has not engaged patients in design and implementation		
	Component C	N/A		

Strategy

Activity	Component ACO	Status	Short description or example to illustrate progress in the past two years, if applicable	Short description of plans or commitments for progress in the next two years
The ACO has **articulated a vision for advancing Health Equity** in its strategic plan(s), has **set explicit goals** for advancing Health Equity across its risk population(s), and is **using ACO operational infrastructure** (including, but not limited to incentives, technology, training/education) to achieve Health Equity goals articulated in the strategic plan.	Component A	The ACO has begun operationalizing Health Equity components of its strategic plan(s)		
	Component B	ACO has incorporated Health Equity in strategic plan(s) and set explicit goals		
	Component C	ACO has not taken steps in this area		

APPENDIX II: Sample Application Responses

Box AC-1.1: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Component ACO A engages Vendor XYZ to conduct patient experience surveys. Surveys are conducted on a rolling basis and are emailed to patients following primary care visits. Document 1 is an example of an internal memo reviewed by the Governing Body and quality improvement staff that summarizes recent survey results. These memos are produced twice a year and identify opportunities for improving patient experiences in participating practices.

Component ACO B relies on a Patient and Family Advisory Council (PFAC) to surface patient experience issues and considerations for the ACO's Governing Body. The PFAC consists of 12 patients and meets on a quarterly basis. ACO staff attend the meetings to solicit ideas and feedback on ACO initiatives, and rely on a feedback loop to inform PFAC members of how input from previous meetings has been used. Document 2 is a copy of meeting minutes from a recent PFAC meeting in which PFAC members discussed issues with access at ACO-participating practices.

Box AC-1.2: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Through the patient experience surveys administered by Vendor XYZ, Component ACO A identified an opportunity to improve language access for patients receiving certain health care services at participating practices. Document 3 is a slide deck reviewed at a meeting of the Governing Body that describes an initiative implemented in 2022 to embed Spanish language interpreters into six ACO practice sites. Quarterly updates on implementation and progress in decreasing the number of language-related access barriers identified in patient surveys are shared with the Governing Body.

Based on the access issues identified by the PFAC, in 2023 Component ACO B piloted expanded hours to include more early morning and evening appointment opportunities in three large ACO-participating practice sites. Document 4 is a slide deck outlining these changes and early results of the initiative. ACO staff will be attending an upcoming PFAC meeting to apprise PFAC members of progress and solicit feedback on next steps.

Box AC-2: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Component ACO A convenes practice managers from ACO-participating sites on a quarterly basis to discuss measurable goals set by the ACO. These meetings represent key opportunities for identifying performance improvement opportunities. Document 5 is a copy of meeting

minutes from a quarterly review meeting where progress made towards goals were discussed with clinical and business leaders from around the ACO.

Component ACO A has also implemented a patient-centered medical home (PCMH) model in support of a primary care transformation strategy for all ACO-participating primary care practices. Document 6 is a slide deck that summarizes the goals of the ACO's primary care transformation strategy, as well as recent progress on practices achieving PCMH accreditation.

Component ACO B has developed a methodology for distributing shared savings under risk contracts that reinforces the ACO's quality and cost performance improvement strategy. Savings are distributed based on practice-level performance on factors that include quality, patient experience, and cost trend. Document 7 is a one-page overview describing how shared savings are distributed to ACO-participating practices.

Component ACO B also has an internal performance improvement process through which staff or providers at any department or practice site in the ACO can propose new projects or ideas using a systematized form. A dedicated steering committee that includes representation from senior leadership of the ACO meets monthly to review, approve, and prioritize projects using a scoring sheet that numerically rates projects based on the benefit to the ACO and level of resource utilization required. Document 8 is a slide deck from a recent meeting of the steering committee showing how a proposed project was considered and scored.

Box AC-3.1: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Component ACO A facilitates use of clinical decision support tools by building best practice alerts into the electronic health record (EHR) and educating providers on their use. Practices participating in the Component ACO A have implemented the health system's EHR, so all ACO-participating providers have access to the alerts. Document 9 is an example of a newsletter shared with participating practices monthly to update providers on newly available alerts, as well as other changes made to existing alerts in the EHR.

Component ACO B launched a series of structured learning opportunities in 2023 to encourage evidence-based care while providing clinicians with reference resources to updated evidence-based protocols and best practices. Through these meetings—which are held in person as well as recorded and shared online—subject matter experts provide up-to-date guidance on the treatment of high-prevalence chronic conditions, including asthma, diabetes, and hypertension. Roughly 90% of ACO-participating providers have attended at least one session in 2023. Document 10 is an example of a slide deck presented at a recent session.

Box AC-3.2: Brief description of Primary Source Document(s) (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Both Component ACO A and Component ACO B provide participating practices with data reporting and analytics on cost and quality performance at the practice and provider levels. Performance dashboards are distributed to all ACO-participating primary care providers on a monthly basis. Documents 11 and 12 are blinded examples of dashboards distributed by Component ACO A and Component ACO B, respectively.

Box AC-5.2 (Max. 150 words per document uploaded) LONG TEXT BOX and UPLOAD

Component ACO A and Component ACO B have each set measurable goals for improving HRSN screening and referral processes. Document X is a slide deck reviewed at a joint meeting of the Component ACOs' Governing Bodies that summarizes all-payer HRSN screening, referral, and follow-up rates at the practice level and at the ACO level. These summaries are produced quarterly and identify opportunities for improving HRSN screening and referral processes in participating practices.