November 18, 2020

Dear Health Policy Commission,

Below are comments from the Merrimack Valley ACO. We are an ACO that formed recently (2017) in order to participate in the EOHHS contract as a Model A partnership plan so we are not as far along in ACO evolution as other organizations in the state may be. Some of the activities you anticipate in these criteria may also require a level of funding to which we may not have access.

1. Do the proposed 2022-2023 assessment criteria align with the strategic priorities of ACOs and reflect reasonable expectations for ACO capabilities in important operational areas? If not, how should they be modified?

   Response: I think generally, yes, you are capturing aspects of high performing ACOs, but in certain areas the expectations are a high hurdle for a new, smaller ACO that is comprised of independent community providers. In particular, I think the longstanding lack of investment by all payors and specifically the lack of investment in Behavioral Health reimbursement, has limited the capacity for independent community providers to achieve ideal BH integration into primary care. Dedicated new resources are required, especially for small independent primary care practices. In our case, the Greater Lawrence Family Health Center has added some BH capabilities but has had trouble recruiting and retaining these positions. Our Medicaid ACO does not have funding available for hiring psychiatric clinicians. We are trying to determine how to better assist members to connect with Optum (AllWays' Health Partners' network) outpatient BH clinicians via telehealth, but that is not in place yet.

   With respect to the use of race/ethnicity data and socioeconomic status, this is an area of opportunity statewide and locally, as evidenced by the dearth related to COVID-19 diagnosis by race and ethnicity. Race/ethnicity data are patient self-reported and guidelines to ensure that they are captured accurately and thoroughly have not been well established. We have not used it to stratify patients but have begun to use it to compare for equity of programs across our membership. We are doing screening for social determinants of health and using positive screening results to refer members for needed services, including the flexible services program that MassHealth funds for housing and nutrition supports. Our risk stratification is usually based on clinical conditions and diagnoses and claims, not on race/ethnicity.

   On specific assessment criteria: #1 – If MHQP includes it in their patient experience surveys they do for the Mass Health contract, we will then have this ability to stratify results based on race/ethnicity or socioeconomic factors; we will however, be using our PFAC to work on patient experience across our whole population. #3 - in working with independent primary care practices, we cannot directly monitor their use of EHR decision support, and we do have a variety of EHR systems in place. #2 – we would not seek to require disclosure of internal compensation arrangements within independent community practices to the ACO. #4 – I think there is overlap here with #5 in terms of screening. Our SDOH screening is most applicable for both but seems to belong in #5 better. Although we are investing in an SDOH referrals

platform, it is surprising to me that you would be requiring that level of investment in #5 and we have not yet solved for sustaining that investment.

2. Do the proposed documentation requirements options for the assessment criteria provide sufficient opportunities for ACOs to demonstrate adherence with the letter and spirit of the standards? If not, how should they be modified?

   Response: I think generally speaking, providing a variety of options of how to satisfy the spirit of the standards works well. I think ACO's are challenged by dynamics that vary by region, population and provider mix. Each ACO needs to demonstrate success on certain specific outcomes and must judge on that basis foremost. It has been shown that it is difficult to generate an ROI for example, on care management, a key population health program. I think the incentives and judging built into risk contracts is enough and the HPC would ideally remain focused on process and programs.

3. Do the proposed 2022-2023 supplemental questions categories reflect the topics of greatest importance? If not, how should they be modified? Which of the proposed questions are the most important in each category?

   Response: Health equity is an important topic, but I think we need to level set a bit about how this applies to a Medicaid ACO for example, serving an underprivileged population, where our mission and everything we do is focused on improving member health outcomes equally across our population. I think innovation in care delivery is a great topic to learn more about and I think question 2 in that section seems reasonable and telehealth, SUD supports and palliative care could all be incorporated into that format. Similarly, I think asking about strategies to control TME growth is fine, but you could just ask an open-ended question about what strategies we employ, with examples if you'd like, but don't need all the specific questions.

4. What changes, if any, would your ACO need to make to meet the requirements related to stratifying information by race, ethnicity, or socio-economic status in the proposed patient-centered care and population health management programs assessment criteria? Would it be valuable for the HPC to offer technical assistance to ACOs on these requirements? What would make your ACO more likely to participate in such technical assistance if it were offered?

   Response: Mass Health would have to make MHQP add these questions to its surveys. We could try to add them to other surveys done by GLFHC and AllWays Health Partners. We are always interested in technical assistance, particularly if available at no cost and on a short-term basis.

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

   Response: I have given my perspective which represents a less experienced, smaller ACO, partnered with a safety net hospital and federally qualified health center and a few small, independent primary care practices to serve the Medicaid enrollee population, and have expressed my concerns that some of the criteria would be

difficult to achieve. Some of the initiatives suggested would require a surplus on risk contracts to reinvest or additional funding to implement them, which could be a barrier.

6. Does the proposed 2022-2023 HPC ACO certification program appropriately balance the need for a rigorous certification program with the provider administrative burden that may be associated with certification? If not, what modifications would improve it?

   Response: I think continuing to partner with other state agencies asking for similar information is helpful. I think being open to ACOs providing information on things they are already doing that fit within a category lessens the burden. I don't think you should impose new burdens on reporting performance on anything that is not already included in a risk contract and should not be judging on outcomes. I think overall your staff have proved very helpful as we move through the certification process which is great.

Thank you for the opportunity to submit comments on these proposed new standards. I am happy to answer any questions.

Andrea Sullivan
CEO, Merrimack Valley ACO