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Health Policy Commission
50 Milk Street
8th Floor
Boston, MA 02109

Re: Proposed 2019 Accountable Care Organization (ACO) Certification Standards

Dear Commissioners:

Thank you for the opportunity to comment on the proposed updates to the HPC's ACO Certification program. As former chair of HPC's Care Delivery and Payment System Transformation Committee, I am thrilled that the ACO Certification program is continuing successfully and that a health equity lens is being applied. I am submitting some comments as an individual who continues to care about health policy and child health. They are mainly observational in nature.

With regard to Risk Contract Performance, I applaud the use of the Massachusetts Aligned Measure Set. A significant contributor to physician burnout is the high administrative burden of practice; adopting a single set of quality metrics across all payers for a practice would help to reduce this burden and permit focusing attention on improving significant quality markers. This does not mean that the current designated measures are all the best or most important quality metrics in health care. Indeed, there are very few that apply to pediatric populations and none relating to oral health, and it is possible that some of the menu measures should move up to become core measures. However, there is a process in place to decide and agree on what should be included (or excluded) in the measure sets, and to me that is the best path for ongoing measure inclusion or exclusion.

Concerning "Patient/Consumer Representation" on ACO governance, I suggest that the criteria be both tightened and expanded. The current wording "…having at least one patient or consumer advocate within the governance structure…" does not specify that the advocate must be a patient of that ACO. I recommend stating explicitly that the patient, or parent or consumer advocate be someone who (or whose family member) receives care from the ACO. Furthermore, my experience is that a single representative of a minority group may feel intimidated within a governing body. I respectfully suggest that the requirement be for two or more patient representatives within the governance structure. Finally, the requirements specify that ACO describe the "reporting relationship" of the patient and family advisory committee, but not what authority that committee might have or whether the governing bodies must respond to committee recommendations. Perhaps this requirement could be tightened. And "a statement appearing on a website describing how the Component ACO acts as a patient-centered organization" hardly seems adequate documentation of patient involvement in governance.

I strongly support the requirements spelled out in section 4 “Population Health Management Programs,” and endorse stratification by functional status and by socioeconomic status or racial/ ethnic subgroups in order to monitor disparities in both care and outcomes.

With regard to section 5 “Cross-continuum Care”, please consider including oral health. I would also contend that “other arrangements with ….BH providers” are inadequate for an entity to qualify as a bona fide ACO. The brain is part of the body and its care should be treated as such. Special attention should be paid to adequacy of behavioral and developmental services for children within the ACO.

Re: “Proposed 2019 Supplemental Questions, Section 1: Adding to the Evidence Base”

“Providing High-value Care.” Consider adding a question about what barriers exist to providing high-quality, affordable care.

“Behavioral Health Integration into Primary Care.” Suggest this wording: “How does the ACO *encourage* access…”. Also, what measures are taken to assure age-appropriate and need-appropriate BH services? (e.g. SUD, autism spectrum disorder, adolescent depression, etc.)

“Advanced Health Information Technology-enabled Care Coordination.”
In addition to facilitating communication “among ACO Participants” with “non-ACO Participant providers”, how does the ACO facilitate interoperable communication with non-ACO *non-participant* providers? It could be something as simple as receiving a treatment or immunization record from a retail -based clinic or as complex as a care plan from a school or other institution. Considerations include care coordination, reduction in duplicative care, but also privacy.

“Coding.” The question about number of staff to support coding confuses me. Coding staff infrastructure is a large administrative cost to health care systems. I cannot tell whether you are encouraging more or less coding staffing. The goal should be coding simplification and elimination of non-value-added services, while achieving a better understanding of risk stratification of the ACO population.

“Market Functioning.” Balancing access and service adequacy with cost containment has always been a thorny issue. “Leakage” is not always a bad thing, especially if the optimal service (e.g. pediatric specific) does not exist within the ACO network or if it is available more conveniently or less expensively elsewhere. There must be safeguards for patients.

“Community Partnerships to Address Social Determinants of Health.” Thank you for focusing on social determinants and highlighting early childhood development.

The Proposed ACO Distinction Program has promise. It is not clear to me whether the Performance Reporting requires improvement in all 4 of the domains listed. Also, if HPC selects one measure for each domain, is it the same measure for every ACO or are the measures ACO-specific?

Finally: Re "Questions for Public Comment"

Re #9 and #10 regarding Distinction program; measures for cost, quality, and access and evaluation of improvements in health equity:

As ACO's are generally non-profit organizations with a mandate to provide community benefits or community-building activities, and as most include hospitals that are required under the ACA to perform community health needs assessments, it seems appropriate that the Distinction designation reflect an improvement or attempted improvement in community health. This would dovetail nicely with the MA Attorney General's updated Community Benefit Guidelines. I would propose that an ACO seeking the Distinction designation be required to assess one or more key issues affecting the health of their service population and attempt to address them using root cause analysis. Once a major contributor is identified, the ACO should commit to partner with the community to work toward remediation. A few limited illustrative examples include:

- High rate of childhood asthma: evaluate possible contributing causes such as substandard housing, high vermin populations, excessive smoking rates, or poor air quality. Potential remediation could include improved housing standards, vermin extermination, regulation of tobacco sales and provision of intensive cessation services, or introduction of electric (non-polluting) buses.

- High lead levels: undertake evaluation of potential sources (e.g. housing, vehicle emissions, water pipes) and partner with utilities or housing regulators to correct them.

- High rates of obesity: examine access to healthy food and/or exercise as well as food sources for children through schools and during weekends and school vacations. Perhaps partner with vendors of healthy food and/or build safe recreational spaces in the community.

- High rates of accidental or intentional injury, or high suicide rates: examine access to weapons, or rates of domestic violence, or other hazards within a community and analyze racial and ethnic inequities. Partner with law enforcement, faith communities and local business and nonprofit organizations to look for solutions – for example creation of a 24/7 youth center with behavioral health counseling included.

- High or inappropriate ED usage: examine adequacy of and access to primary care as well as possible factors contributing to increased local morbidity. Increase penetration of primary care within the community; evaluate transportation adequacy and insurance coverage penetration; look at schools and workplaces as potential care sites, etc.

- High rates or school or work absenteeism: evaluate whether chronic illness or disability is contributing; monitor patient population for functional outcomes. Address the underlying causes.

What I hope this community focused requirement might accomplish is to tighten connections between the ACO and its service community, identify major causes of morbidity within that community, put resources where they might accomplish the most good, and ultimately improve population health (while learning what approaches work well and which do not.) It might also encourage thinking "outside the box" of usual health care strategies. The ACO should also partner with the MA Department of Public Health in order to avoid duplication of effort. I would exclude addressing opioid use from this Distinction requirement because it is pervasive across all communities and already being addressed.

All of my comments are offered with the intention of clarifying certain provisions and stimulating conversation. I firmly believe that the MA ACO Certification program will improve care and can serve as a model for the country.

Sincerely,

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former Commissioner, MA Health Policy Commission