American Academy of Pediatrics
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The Massachusetts Chapter

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To Whom it May Concern:

The Massachusetts Chapter of the American Academy of Pediatrics (MCAAP), representing 1,700 pediatricians in the Commonwealth, appreciates the opportunity to comment on the 2019 Health Policy Commission (HPC) proposed accreditation standards for ACOs in the Commonwealth. MCAAP believes that, while there has been substantial growth in Medicaid ACOs, the needs of the pediatric population have not adequately addressed. Over 40% of MassHealth recipients are children and youth, yet the health and behavioral health needs of this vulnerable population are virtually absent from the ACO assessment criteria.

We have generally organized our comments by the sections of the HPC proposal.

The Assessment Criteria section lists five criteria domains. We have no comments on the Governance Structure domain. Herein we provide comments on the four remaining domains. We list the domain first in italics and our domain specific comments below.

Patient / Consumer Representation: *The ACO governance structure is designed to serve the needs of its patient population, including having at least one patient or consumer advocate within the governance structure and having a patient and family advisory committee.*

To provide adequate representation of the needs of children, adolescents, and their families, both parents and young people should be included on the patient and family advisory committee, which should have regular input into the governance decisions and administration of the ACO. In place of "at least one patient or consumer advocate within the governance structure," we recommend including **two** or more patients or family members of patients from the ACO's patient population.

Performance Improvement Activities: *The ACO Governing Body regularly assesses the access to and quality of care provided by the ACO, in measure domains of access, efficiency, process, outcomes, patient safety, and patient experiences of care, for the ACO overall and for* ***key subpopulations*** *(i.e. medically or socially high needs individuals, vulnerable populations), including measuring any racial or ethnic disparities in care. The ACO has clear mechanisms for implementing strategies to improve its performance and supporting provider adherence to evidence-based guidelines.*

The assessments for access to and quality of care provided by should call out children as a key sub-population and address whole child health. Key issues for children and youth, such as immunizations, healthy weight management, socio-emotional development, developmental screening (now part of the 2019 Medicaid core measurement set), and mental health should be reflected in the metrics in addition to encounter-based outputs like preventive visits.

Population Health Management Programs: *The ACO routinely stratifies its entire patient population and uses the results to implement programs targeted at improving health outcomes for its highest need patients. At least one program addresses behavioral health and at least one program addresses social determinants of health to reduce health disparities within the ACO population.*

We recognize that children and youth account for a relatively small proportion of overall health expenditures, including Medicaid expenditures – and pediatric care has only a few opportunities for substantial short-term savings. On the other hand, children and youth include high need patients, and appropriate care and prevention for pediatric populations can strengthen the foundation for a healthy life, leading to improved health across the life course. There are a multitude of studies which demonstrate that childhood health impacts health and wellbeing across the life course and that childhood is where pathophysiology leading to disease in adulthood begins. Childhood is also the time when health disparities develop, not only for major childhood illnesses like asthma, but also for chronic diseases of adulthood such as cardiovascular disease and diabetes.

Because of the long reach of childhood experience, addressing social determinants of health and development in childhood is critically important. Poverty is one of the strongest social determinants of health. Children have the highest rates of poverty among all age groups. Thus, services through Medicaid have particular importance to improving the health of young people and to decreasing the well-established health disparities that exist in the Commonwealth across generations.

Because children and youth are one of the most diverse subpopulations in the Commonwealth, especially with respect to culture, race/ethnicity, and language, it is critical that Medicaid ACOs deliver highest quality care that is culturally appropriate and sensitive to the diverse needs of families in Massachusetts. Children and families should have easy access to developmentally and culturally appropriate care.

Furthermore, “highest need” should be defined so as to include those at highest need within the pediatric age ranges. Highest need should be defined not only by high medical need (e.g., childhood cancer, sickle cell, chromosomal disorders, children and youth with special health care needs), but also those living with high social needs (e.g. homelessness, poverty, food insecurity) who face the greatest challenges to healthy childhood development.

Cross-continuum Care: *To coordinate care and services across the care continuum, the ACO collaborates with providers outside the ACO as necessary, including: Hospitals**,** Specialists, including any sub-specialties**,** Long-term services and supports (LTSS) (including both facility-based and community-based services and providers)**,** Behavioral health providers (BHPs) (both mental health and substance use disorder providers). Providers and facilities within the ACO collaborate to coordinate care, including following upon tests and referrals across care rendered within the ACO.*

Children with rare conditions and with medical complexity need access to qualified pediatric **subspecialists**, and networks should assure having such subspecialists available when needed in such circumstances. The rarity of some conditions and the small number of qualified specialists may mean that some ACOs will not have the full array of needed services. In these cases, ACOs should have clear agreements with subspecialists outside the network to provide these services. Accessing specialized pediatric care should not engender excessive logistical or financial burdens for the family or primary care practitioner.

Fewer pediatric than adult patients need **LTSS**; nonetheless, a sizeable population of children and youth in Massachusetts do need such services. Each ACO should collaborate with LTSS providers that have experience and competence in pediatric care. Children and youth with special health care needs (CYSHCN) must have access to pediatric-certified home health nurses and therapists. Currently, agencies in parts of the State may have one or no pediatric nurse, with no contingency for illness or time off, with similar problems with respect to respiratory therapists.

Behavioral health providers partnering with ACOs should be able to address child and adolescent mental/behavioral health concerns. The State relies on MassHealth's Children's Behavioral Health Initiative (CBHI) to help children and youth with diagnosed mental health disorders get services outside the primary care setting. Unfortunately, CBHI does not provide services that lead to mental and behavioral integration in primary care, which we see as a best practice.

Many important health services for children and youth take place in non-traditional settings though non-traditional providers, including school-based health centers, schools (nurses) more broadly, preschool and after school programs, and camps. ACOs should support effective use of these services and include coordination of care with non-traditional providers as part of the care continuum for children and should work with those settings and encourage their high-value use.

In addition to the Assessment criteria, the HPC's Request for Public Comment included several supplemental questions. MCAAP has several comments relative to these supplemental questions. The MCAAP believes ACOs must develop new methods to manage compensation for populations such as children, where cost savings of direct care are likely to be minimal, but investment is important to improve long term population health. Furthermore, ACO risk coding must be developed with all populations in mind and take into special consideration the different risk coding requirements for child health. Risk coding for children should include linkage to parental food and housing insecurity. For example, an infant born to a food or housing insecure risk-identified parent should be immediately flagged as also having those high-risk indicators. Some ACOs use "past year" data that often excludes the social determinants and health determinants of children under a year of age.

Finally, children depend for much of their care and development on adults, especially parents and teachers. Schools and preschools are critical partners in pediatric care. ACOs should aim to impact child health and development throughout childhood, and outcome measures should assess such progress (school readiness, reading levels, high school graduation). Furthermore, community partners can be essential in addressing SDOH and outcomes should reflect this--reduction in food insecurity, increased economic mobility. ACOs can also be asked what they are doing to systematically address in policy, practice and partnerships, the root causes of the hardships noted above.

The MCAAP appreciates the thought and time the HPC is putting into the development of the 2019 ACO certification standards. We hope these comments will help the HPC and the Commonwealth support our youngest citizens.

Sincerely,

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President, Massachusetts Chapter of the American Academy of Pediatrics