

American Academy of Pediatrics



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Comments of the Massachusetts Chapter of the American Academy of Pediatrics to the Massachusetts Health Policy Commission ACO Certification Standards and Oral Health

We thank you for the opportunity to submit written comments regarding the proposed ACO certification standards on behalf of the Massachusetts Chapter of the American Academy of Pediatrics. As pediatricians, pediatric dentists, and other healthcare providers, we are invested in the health and wellbeing of children and adolescents.

We urge the Commission to integrate oral health and dental care as a component of the care provided by ACOs. Oral health is critical to overall health. Childhood caries (cavities) is the number one chronic disease affecting children in the United States, and is five times more common than asthma.¹ Dental pain and related problems are responsible for school absenteeism and malnutrition, both of which impact educational achievement and have lifelong effects on wellbeing.² This has significant individual and societal implications, considering that most oral disease is preventable and prevention is highly-cost effective.

Pediatricians have an important role to play in ensuring the oral health of children, just as dental providers also have an important role in the overall health of children. ACOs provide a way to correct an important missed opportunity in primary care, as children see medical providers earlier and more regularly than they see dentists due to both well-child and sick care visits. Both pediatricians and dental providers profoundly understand the need to move away from episodic, acute care to care that focuses on prevention and wellness. Dental care is increasingly being recognized as an integral part of primary care. Just as we have come to understand the value of integrating behavioral health as part of patient-centered care, we now strongly urge the integration of oral health and dental care into the Health Policy Commission's ACO standards.

We recommend that dental services be included in the structure of ACOs. The cross-continuum networks as described in Criteria 9 and 10 should incorporate dental providers, including pediatric dentists. As with other providers currently included in the proposed standards, ACOs should demonstrate and assess the effectiveness of ongoing collaborations with dental providers. Additionally, there is a need to ensure robust oral health provider network adequacy, with a sufficient number and type of oral health providers to meet patient demand.

¹ Benjamin, R. M. (2010). Oral Health: The Silent Epidemic. *Public Health Reports*, 125(2), 158–159.

² Jackson S.L., Vann W.F., Kotch J.B., Pahel B.T., Lee J.Y. (2011). Impact of poor oral health on children's school attendance and performance. *American Journal of Public Health*. 101(10):1900–6.

ACOs should also include systems to ensure appropriate payment methodologies that incentivize primary care providers to better integrate oral health into routine care. This includes adequate reimbursement to allow for oral health risk assessments, oral health evaluations, application of fluoride varnish, patient education, and other necessary and routine oral health care in the primary care setting. Similarly, there should be incentives in place for care innovations in the dental care setting. The ACO should have systems in place to provide direct and indirect support to practices that are committed to transforming to a patient-centered medical home, including technical assistance and rewards for practices that achieve medical home recognition. This would incentivize providers to integrate medical and dental care at a high level while at the same time increasing the likelihood of cost savings.

ACOs should be required to demonstrate an ability to coordinate care for complex and high-risk patients, including pediatric patients. Community linkages, through the use of Community Health Workers for example, will help support care coordination and delivery of primary and specialty care to all populations, in particular children with complex conditions. ACOs should also interface with all health-related operations in the Commonwealth, including all Title V programs, early intervention programs, Head Start offices, WIC, and public education entities to ensure that children experience optimal outcomes.

We also recommend that there be a pediatric risk-adjustment methodology in place to ensure appropriate payment for the delivery of care to children with special health care needs, including dental care. There is significant additional effort to involve family, community, and educational resources in pediatric care coordination and management and pediatric practices should be appropriately compensated for this.

We applaud the inclusion of a Patient & Family Advisory Council to guide ACO leadership. ACO leadership, however, including governance, quality, and clinical committees, must have adequate representation of clinical professionals from the oral health disciplines. Concerning Criterion 4, we urge that both dental providers as well as pediatricians be included in the ACO governance structure to ensure that oral health and dental care voices are not lost. It is imperative that ACO governance not be controlled solely by adult medical providers. This would help ensure that resources are adequately devoted to the unique needs of children in ACOs, notably oral health needs, where the conversation might otherwise be dominated by care for adults.

Regarding Criterion 6, quality committees should be required to consider oral health quality outcomes. Quality improvement metrics that relate specifically to children's health, including children's oral health, should be developed with strong input from the pediatric medical and dental provider communities. Thanks to the Affordable Care Act, since May of 2015 all commercial insurers have been required to reimburse for up to four pediatric fluoride varnishes per year applied in the primary care setting. We strongly suggest these be included as a financing-dependent quality metric or at the very least, as a reporting metric.

To ensure that quality improvement becomes a valued part of all providers in an ACO, there must be systems in place to allow for the sharing of performance data among all members of the care team, including dental providers. This will optimally include interoperable health information technology and electronic health records systems. Although we recognize that this is an intimidating task considering the historical separation among primary care and oral

health providers, we believe that it is both surmountable and necessary to ensure optimal care coordination and an exciting opportunity for Massachusetts to be a leader in integrated care. At the very least, ACOs should initially establish systems and protocols for structured referrals between primary care and dentistry, and encourage providers to invest in infrastructure.

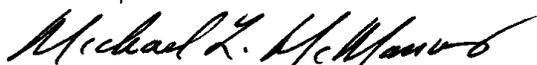
In Criterion 8, which requires targeted interventions for improving health outcomes, oral health should also be included as a program focus. This is particularly important for the pediatric population, where caries continue to be the most common chronic disease among children.

We believe that oral health is an integral part of overall health and primary care. The care delivery system must be reformed in a way that incentivizes all providers to pay closer attention to oral health. ACOs present a significant opportunity to make this shift and improve coordination and collaboration between medical and dental homes. The Massachusetts Chapter of the American Academy of Pediatrics firmly believes that including dental care in ACO standards is a good way to help ensure that children's oral health receives the attention it deserves, and can help begin to integrate the two fields.

Sincerely,



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