



January 29, 2016

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

Submitted via email to HPC-Certification@state.ma.us

RE: Public comment on proposed ACO certification standards

Dear Ms. Harrison:

Attached please find responses to the Request for Public Comment you released regarding accountable care organizations, submitted on behalf of the Boston Public Health Commission (BPHC). BPHC is the health department for the city of Boston, serving a diverse population of over 625,000 residents. In addition to providing public health services, BPHC operates the largest emergency medical service in the state, provides residential and outpatient substance abuse services and operates New England's largest homeless shelter.

We deeply appreciate the opportunity to provide comments and hope that our responses will be useful as you look for opportunities to incorporate prevention and public health into the delivery of clinical services. If you require additional information, please feel free to contact Lisa Conley, Director of Intergovernmental Relations at (617) 534-2288 or lconley@bphc.org.

Thank you for your time and attention.

Sincerely,

A handwritten signature in black ink, appearing to be "Huy Q. Nguyen". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Huy Q. Nguyen, MD

Interim Executive Director & Medical Director

Mandatory Criteria			
Domain	#	Criterion	BPHC Comment
Legal and governance structures	3.	The ACO governance structure includes a patient or consumer representative. The ACO has a process for ensuring patient representative(s) can meaningfully participate in the ACO governance structure.	We strongly believe that consumers should be given the opportunity to play an active role in ACO governance. Specifically, we recommend that HPC adopt a requirement that, similar to community health centers, ACOs dedicate a certain percentage of their voting board seats to consumers and not have just one representative.
	4.	The ACO governance structure provides for meaningful participation of primary care, addiction, mental health (including outpatient), and specialist providers.	Participation of dental care providers should also be included in the ACO governance structure. Poor oral health has been associated with an increased risk for heart disease and stroke, complications of diabetes and HIV disease, low birth weight, and premature infant births, which ultimately lead to more costly medical interventions. Incorporating oral health into the ACO governance structure could have significant consumer benefits through improved overall health and reduced costs through a focus on preventive care.
Risk stratification and population specific interventions	7.	<p>The ACO has approaches for risk stratification of its patient population based on criteria including, at minimum:</p> <ul style="list-style-type: none"> - Behavioral health conditions - High cost/high utilization - Number and type of chronic conditions - Social determinants of health (SDH) <p>The approach also <i>may</i> include:</p> <ul style="list-style-type: none"> - Functional status, activities of daily living (ADLs), instrumental activities of daily living (IADLs) - Health literacy 	We support this criterion since stratifying by these categories (especially SDH) would inform population-specific health interventions and aid in reducing health inequities. SDH should include race, ethnicity, language spoken at home, and highest level of education in addition to other known social determinants of health. Rules should incentivize the systematic collection of gender identity and sexual orientation to enable stratification by these known SDH. This information should be made publicly available to allow stakeholders to determine how well ACO members across various health profiles are being served. It would also enhance opportunities for collaboration between community-based public health service providers and ACOs.
		Using data from health assessments and risk stratification or other patient information, the ACO	We support this criterion and feel that part of the requirement should be for ACOs to describe how these programs address the

	8.	<p>implements one or more programs targeted at improving health outcomes for its patient population. At least one of these programs addresses mental health, addiction, and/or social determinants of health.</p> <p>ACO annually evaluates the population health programs in terms of patient experience, quality outcomes, and financial performance.</p>	<p>specific needs of their patient population. Along with using tools to measure patient satisfaction (surveys and focus groups), ACOs should document patient enrollment/attrition (turnover), institutional cultural competence, patient complaints and patient outcomes.</p>
<p>Cross continuum network: access to BH & LTSS providers</p>	9.	<p>ACO demonstrates and assesses effectiveness of ongoing collaborations with and referrals to:</p> <ul style="list-style-type: none"> - Hospitals - Specialists - Post-acute care providers (i.e., SNFs, LTACs) - Behavioral health providers (both mental health and substance use disorders) - Long-term services and supports (LTSS) providers (i.e., home health, adult day health, PCA, etc.) - Community/social service organizations (i.e., food pantry, transportation, shelters, schools, etc.) 	<p>We support this requirement and recommend that ACOs first conduct an evaluation of the needs and assets of a community to identify potential organizational partners. We recommend that HPC add local municipal officials, including the local health department, as a potential collaborator.</p> <p>In order to more effectively integrate primary care with community-based preventive services, we must acknowledge that many of the community-based services and public health activities that improve population health are not currently funded through the traditional medical care system. Instead, these programs and services rely on a mixture of public funds and private grants. Many of these community-based and public health services have been scaled back or eliminated due to budget pressures in the public sector. If we hope to create a system where clinical providers are able to refer their patients to participate in community prevention programs, we must also ensure that these programs will have a reliable source of funding. This could be achieved either by requiring ACOs to dedicate a portion of their per capita payments to population-based services or by creating an alternative mechanism, through the creation of a trust fund, for example, to provide a more reliable stream</p>

			of funding for community-based health services.
Analytic Capacity	13.	ACO regularly performs cost, utilization and quality analyses, including regular trending and forecasting of performance against budget and quality measure targets, and works with practices and providers within the ACO to meet goals and targets. Analysis could be completed by a vendor or in-house. ACO disseminates reports to providers, in aggregate and at the practice level, and makes practice-level results on quality performance available to all participating providers within the ACO.	<p>Performance targets should include eliminating gaps in quality measure results for at-risk sub-populations in addition to meeting performance targets for the overall ACO population.</p> <p>Furthermore, performance and quality measures should include tracking of under-utilization. HPC can work with ACOs and payers to monitor and analyze claims data annually to make sure individuals with high risk factors are not being denied care.</p>
	N/A	We recommend the inclusion of a new criterion focused on quality measures related to preventive health.	<p>Specifically, we believe that providers should be assessed based on the following federal ACO quality measures:</p> <ul style="list-style-type: none"> • Influenza Immunization: Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February); • Pneumococcal Vaccination: Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine; • Mammography Screening: Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months; • Colorectal Cancer Screening: Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening; • Cholesterol Management for Patients with Cardiovascular Conditions: <ul style="list-style-type: none"> ○ The percentage of members 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary

		<p>interventions (PCI) of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year:</p> <ul style="list-style-type: none">▪ LDL-C screening▪ LDL-C control (<100 mg/dL); <ul style="list-style-type: none">• Adult Weight Screening and Follow-up: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.<ul style="list-style-type: none">o Parameters:<ul style="list-style-type: none">o Age 65 and older BMI _ 30 or < 22;o Age 18-64 BMI _ 25 or < 18.5;• Blood Pressure Measurement: Proportion of adults who had blood pressure screened in past 2 years• Tobacco Use Assessment and Tobacco Cessation Intervention: Percentage of patients who were queried about tobacco use. Percentage of patients identified as tobacco users who received cessation intervention; and• Depression Screening: Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow up plan documented. <p>In addition to these, we recommend the inclusion of a measure specifically related to alcohol misuse:</p> <ul style="list-style-type: none">• Screening, brief intervention and referral for treatment for alcohol and drug misuse: Percentage of patients aged 18 years and older screened for alcohol misuse and follow up plan documented.
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			<p>Alcohol screening has been determined by the US Preventive Services Task Force and other expert panels as effective, evidence-based preventive care.</p> <p>We also recommend that HPC include measures for diabetes and asthma screening, since these are common, costly chronic diseases that benefit from close management. We suggest additional cancer screening measures to include cervical and oral cancers. We would also like to see measures incorporated to screen patients for food and housing insecurity, exposure to violence (including domestic violence) and amount of daily physical activity.</p>
<p>Patient and family experience</p>	<p>14.</p>	<p>The ACO conducts an annual survey (using any evidence-based instrument) or uses the results from an accepted statewide survey to evaluate patient and family experiences on access, communication, coordination, whole person care/self-management support, and deploys plans to improve on those results.</p>	<p>ACOs should be required to publish a patients' bill of rights and employ an ombudsman to triage and respond to patient complaints. Furthermore, patient satisfaction surveys should be required both as a quality measure as well as a way of engaging consumers on the question of whether the new system is working for them.</p> <p>ACOs should be required to have a written non-discrimination policy in place before being certified by the state. ACOs, provided that they have openings for new patients, should be required to accept all patients who wish to join the ACO unless there are age and/or gender restrictions based on the patient population served by the provider (i.e., pediatricians, obstetricians). If an ACO wishes to deny entry of a patient into an ACO there should be a mechanism for the ACO to report this denial to the state for tracking purposes.</p> <p>We are concerned that individuals with or in recovery from a mental health or substance use disorder (MH/SUD) may be</p>

			at particular risk if an ACO is able to avoid or otherwise deny care to those with more complex health needs. HPC should consider instituting special protections for ACO members who report or are diagnosed with MH/SUD, such as monitoring this group as a population to ensure that they are receiving appropriate and accessible treatment.
Community health	15.	ACO describes steps it is taking to advance or invest in the population health of one or more communities where it has at least 100 enrollees through a collaborative, integrative, multi-organization approach that acknowledges and accounts for the social determinants of health.	We support this requirement, but suggest that these steps be taken in all communities where the ACO serves significant numbers of people that suffer from poor health outcomes. We also believe that HPC should be more prescriptive regarding the investments that ACOs are required to make in population health, (e.g., a certain percentage of ACO payments or some other measure of ACO size and capacity). Otherwise, this will be left open for interpretation and will not result in new investments.

Reporting Only Criteria

Domain	#	Criterion	BPHC Comment
Care coordination	23.	The ACO has a process to track tests and referrals across specialty and facility-based care both within and outside of the ACO.	In addition to specialty and facility-based care, ACOs should be required to demonstrate an ability to refer their patients to community-based services and activities that promote health and to support these services and activities. Building this capacity will not only create vital linkages for patients, but will also help providers feel more engaged in promoting wellness by giving them greater resources to offer their patients. We believe that certain services, such as home visits for asthma patients, nutrition counseling for obese patients and tobacco cessation services for tobacco users, do not fall into the traditional categories of services that are required, but will yield significant health benefits and cost savings

			if used consistently and systematically. We urge you to broaden the scope of health services offered through ACOs to include evidence-based preventive care that will reduce the burden of chronic disease and help to control health care spending and to require ACOs to contract with local health departments or other community-based groups that provide these services.
	24.	<p>The ACO demonstrates a process for identifying preferred providers, with specific emphasis to increase use of providers in the patient’s community, as appropriate, specifically for:</p> <ul style="list-style-type: none"> – oncology – orthopedics – pediatrics – obstetrics 	<p>Oral health care must be included in ACO care coordination efforts. This could include having primary care providers and pediatricians conduct oral exams and risk screenings, apply fluoride varnish, and make referrals to dental providers. Furthermore, a part of the care coordination criteria should relate to an ACO’s ability to manage care for high risk patients and hard-to-reach populations. This is an area in which community health workers could be leveraged through outreach and education/disease management programs. We also recommend that these criteria (#23-26) be re-classified as “mandatory criteria” as opposed to “reporting only criteria.”</p>
Peer support	27.	<p>The ACO provides patients and family members access to peer support programs, particularly to assist patients with chronic conditions, complex care needs, and behavioral health needs. The ACO also provides training to peers as needed to support them in performing their role effectively.</p>	<p>We support this criterion and recommend that this be included under the “mandatory criteria.”</p>
ACO population demographics and preferences	31.	<p>The ACO assesses the needs and preferences of its patient population with regard to race, ethnicity, gender identity, sexual preference, language, culture, literacy, social needs (food, transportation, housing, etc.) and other characteristics and develops plan(s) to meet those needs. This includes provision of</p>	<p>We strongly support this criterion since comprehensive data collection can improve quality of care through an assessment of a specific population’s needs and targeted interventions to address those needs. This is such a critical component that we feel this criterion should be moved to the “mandatory criteria” section.</p>

		interpretation/translation services and materials printed in languages representing the patient population (5% rule).	
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