

January 29, 2016

Chairman Stuart Altman
Executive Director David Seltz
Health Policy Commission
50 Milk St., 8th Floor
Boston, MA 02109

Re: Comments on Proposed ACO Certification Standards

Dear Chairman Altman and Mr. Seltz:

We are excited at the opportunities in the evolving health care financing and delivery landscape – including the certification of ACOs - to focus our collective attention on how to most effectively keep people healthy and prevent the onset of expensive medical conditions. We believe that ACOs in Massachusetts can be a powerful force to promote health, reduce costs, promote equity, and lead the nation. ACOs have a unique ability to provide necessary medical services, as well as to provide care coordination, patient support, and wellness services to address the health needs of members. ACOs also have an important role to play in address the underlying social determinants of health which drive health outcomes and contribute to significant inequities in health outcomes across race, ethnicity, and income.

Thank you for the opportunity to provide comments on the HPC's proposed certification standards for ACOs. We are grateful to the Health Policy Commission for developing a thoughtful and innovative framework for the certification of ACOs in Massachusetts. We would like to highlight several key areas that we believe are essential to the ability of ACOs to effectively address population health, as well as to contribute to eliminating health inequities.

1. Population Health Programs and Partnerships

We appreciate the strong focus in the proposed standards on promoting population health and addressing social determinants of health. **Criteria 8 and 15** lay a strong foundation for the role that ACOs can play in addressing population health. In order to ensure that these programs are effectively targeted, they must be well defined and related to identified risk factors in the member population.

Recommendation: As part of **criteria 8 and 15**, we recommend that ACOs describe how their population health programs address specific risk factors and social determinants of health identified through screening and data collection.

In order to appropriately target population health interventions, uncover and address health disparities, and improve how ACOs deliver care, outcomes and other quality indicators should be stratified by social determinants of health indicators

Recommendation: We recommend for **critterion 8** that the required one or more programs resulting from health assessments and risk stratification be targeted to improve health outcomes for patient populations experiencing disparities in outcomes related to the designated conditions (e.g. mental health, addiction, and/or social determinants of health). Additionally, for **critterion 8** we recommend adding disparities in health outcomes to the list of aspects of population health programs that should drive annual ACO evaluations of its programs.

In order to effectively address the impact of social determinants of health – such as violence, housing insecurity, or unemployment - on a member population, ACOs must partner with other community resources, including community-based service providers, legal and social services advocates, public health agencies, and community action agencies.

Recommendation: These partnerships are required in **critterion 9**, but they should be described in more detail. We recommend that ACOs describe how community partnerships are specifically related to needs identified by screening and data collection.

Recommendation: We also recommended that ACOs demonstrate an understanding of community needs and assets in relation to key identified social determinants of health as part of **critterion 9**. This could come through an assessment conducted by the ACO or through an existing community health needs assessment.

Through partnerships with community resources, ACOs should be able to refer individual members to needed services (e.g., nutrition counseling or community-based diabetes prevention programs). Additionally, we recommend that ACO partnerships focus on addressing social determinants of health at the community-wide or geographic level within areas of concentrated need (e.g., addressing lack of access to healthy foods in food deserts).

Recommendation: In order to achieve this goal, we recommend that to meet **critterion 9**, ACOs demonstrate at least one partnership with a community resource that has expertise in community-wide change, such as a public health department, community action agency, or similar organization.

Criterion 15 requires that ACOs invest in population health in one or more communities where it has at least 100 members, but this requirement should be broadened to achieve meaningful population impact.

Recommendation: To effectively impact health and costs, ACOs should address population health – directly or through partnerships - not just in one community, but in all communities where they serve significant numbers of members that suffer from poor health outcomes.

Criterion 15 should reflect this, emphasizing that partnerships will be a vital tool for ACOs to achieve this goal.

2. Data Collection

Data collection forms the backbone of an ACO’s ability to effectively manage the health of its member population and to meaningfully intervene to address risk factors that lead to poor health outcomes. Data collection should include key demographic information about members, including race and ethnicity, primary language, sexual orientation and gender identity, disability status, and age. Additionally, we strongly recommend that ACOs use screening tools to identify social determinants of health that impact their members, including housing insecurity, food insecurity, exposure to violence, unemployment or underemployment, transportation barriers, and related issues. Screening for this information will allow the ACO to understand key barriers to health and how those barriers are distributed across its member population.

Recommendation: In order to accomplish these goals, we recommend that **criterion 31**, regarding assessment of member needs, be mandatory. Having a comprehensive set of sociodemographic data for an ACO’s patient population is necessary to effectively accomplish a number of other criteria.

Recommendation: We also recommend that additional detail about screening for social determinants of health be included in **criterion 7**, including examples of factors that ACOs should consider, including housing insecurity, food insecurity, exposure to violence, unemployment or underemployment, transportation barriers, and others. We also recommend a requirement for reporting on health outcomes stratified by social determinants of health.

3. Risk Adjustment and Social Determinants of Health

It is crucial that ACOs employ effective risk adjustment methodologies to ensure that sufficient resources are available to serve the highest need and highest risk members, as well as to eliminate incentives to limit needed care for these members. Risk adjustment should take into account socioeconomic status as well as other social determinants of health. In order to reduce incentives to deny or limit medically necessary care, the HPC should encourage payer contracts with ACOs to use risk adjustment measures under alternative payment arrangements that include adjustments for social, cultural, and economic factors, so that resources are available to provide services for people at high risk for poor health outcomes.

4. Community Health Workers and Care Coordination

Community health workers (CHWs) are frontline staff who are trained to work with low-income, underserved patients with the goal of bridging communication, cultural, and other barriers to accessing care. Additionally, CHWs serve as a link and resource to address the non-clinical challenges affecting health status. As part of integrated care teams, CHWs have been shown to provide cost-effective services that increase quality of care and reduce disparities. In order to provide member-centered care, ACO payment methodologies must promote care teams that provide medical care and wraparound services to meet a member's health needs. Evidence has demonstrated the effectiveness of CHWs as part of complex care and high risk care teams, particularly for linguistic, ethnic/racial minority and other underserved populations.

Recommendation: We recommend that CHWs be referenced in list of provider types in **criteria 9**, in their capacity as care coordinators, offering cultural, communication linkages across clinical and community services, and as support for at risk and complex patients to navigate the health care system.

Care coordination is vital to managing an individual's care, reducing fragmentation and improving outcomes, and should be a core component of all ACOs.

Recommendation: We recommend that the care coordination criteria (**criteria 23-26**) be amended to add a criterion that ACOs must also demonstrate an ability to coordinate care for high risk and complex patients and to provide outreach services to hard-to-reach populations, such as through utilizing community health workers. ACOs should further educate members on care coordination and care planning, including group visits and chronic disease self-management programs. The care coordination criteria should additionally be moved from reporting-only to mandatory.

CHWs should also be included as part of any plan to link clinical settings with community based programs and services to help patients address barriers related to social determinants of health (including housing, transportation, language, literacy challenges).

In addition to providing services to individuals, CHWs – whether employed by ACOs, contracted provider organizations, or community partnerships – play an important role in addressing community-wide population health challenges. CHW core competencies include community assessment and capacity building, and CHWs can play an important role engaging ACO members most impacted by detrimental social determinants of health.

Recommendation: ACOs should show how CHWs are engaged in the population health interventions required by **criteria 8, 15, and 31**.

5. Integration of Behavioral Health Services

ACOs should integrate mental health and substance use disorder services with primary care, which can include co-located models, formal partnerships with community-based behavioral health providers, and/or the federal Health Homes opportunity. ACOs should also emphasize prevention and early interventions with children and their families. We fully support the inclusion of **critterion 27** addressing peer support programs and recommend that this criterion be made mandatory in order to ensure access to services that help individuals manage their conditions successfully.

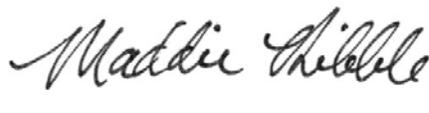
In conclusion, we'd like to thank Health Policy Commission board members and staff for your leadership and attention to addressing population health, prevention, and the social determinants of health. The proposed standards provide a strong framework for how ACOs can effectively address these goals in Massachusetts.

We are ready to collaborate with the Health Policy Commission, consumers, and providers to achieve our common goals.

Sincerely,



Rebekah Gewirtz
Executive Director



Maddie Ribble
Director of Public Policy