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Dr. Stuart Altman, Commission Chair
Health Policy Commission
50 Milk Street, 8th Floor
Boston, Massachusetts 02109

Mr. David Seltz, Executive Director
Health Policy Commission
50 Milk Street, 8th Floor
Boston, Massachusetts 02109

Dear Chairman Altman and Director Seltz,

I am writing to you on behalf of the Massachusetts Society of Optometrists (MSO), which has a membership of over seven hundred licensed optometrists, representing the largest group of primary eye care providers in the Commonwealth. Optometrists currently render care in a variety of practice settings from standalone independent office clinics to community health centers and urban hospitals. As care delivery is shifting through the adoption of alternative payment methodologies (APMs) and implementation of new health care delivery models, such as Accountable Care Organizations (ACOs), the MSO respectfully urges the Health Policy Commission (HPC) to embrace and incorporate the high value services delivered through independent, cost effective, community-based providers, such as optometrists.

As an initial matter, the MSO recommends that the HPC develop guidance for ACOs that lays out processes for health care providers to seek inclusion in an ACO as a provider or supplier. Further, the MSO encourages the HPC to require its ACOs to actively procure the services of different provider types when opening up opportunities to providers to become a part of an ACO. The inclusion of a broad variety of providers in a health care delivery model helps to lower costs while increasing access. By providing ACOs with a range of recommended “on-ramps” for different provider types, the HPC will be contributing tools needed to reach health care cost containment objectives. As well, the “on-ramp” should be open to all providers of a given service regardless of geographic region, when the ACO is seeking to build its provider base and

networks. Embracing the services of some providers and not others will adversely impact competition and drive up costs for the ACO.

Similarly, the MSO recommends that the HPC work to eliminate barriers to care and prevent disadvantaged marketplace competition by recognizing and addressing the issues caused by contractual carve-outs of *certain* claims to third-party administrators (TPAs).¹ As in the behavioral health realm, eye care services *provided by optometrists* are frequently carved out to a third party claims administrator that requires its own contract with different coverage rules and often grossly disproportionate fee disparities. Oddly, when the *same* eye care services are provided by a *different* provider type under the same insurance policy, such services are not required to be carved out to a TPA. As has been discussed in some of the HPC Advisory Council meetings and commission hearings, carving out services creates barriers to integration and coordination as well as fee disparities that are directly at odds with the goals and principles upon which ACOs are founded. The HPC should require its ACOs to eliminate contractual arrangements that perpetuate carve-outs for some providers and not others. In the alternative, if the HPC permits ACOs to accept carve-out arrangements with a third party, *all* providers of the same services (as defined by CPT and ICD-10) should be subject to the carve-out to minimize an anti-competitive healthcare marketplace.

Regarding the HPC's proposed ACO Certification Standards, the MSO has a few specific recommendations. The HPC has the opportunity now to implement a series of policies and requirements of ACOs that prevent negative impacts on competition through amendments to the HPC's current proposed ACO Certification Standards. All of the MSO's recommendations ask the HPC to require that ACOs adopt policies and practices known to contain costs, enhance competition and provide for broad patient access (i.e. require transparency of provider reimbursement rates, eliminate unwarranted provider reimbursement disparities, etc.). To that end, the MSO offers the following recommendations:

Mandatory Criteria Recommendations

- **Criterion #4: Require ACOs to account for all provider types and establish a provider advisory board.** The ACO governance structure must provide for meaningful participation of representatives of each provider type delivering care for the ACO. Limiting the governance structure to the specified primary care, addiction, mental health (including outpatient), and "specialist" providers does not sufficiently acknowledge representation of the many other provider types that deliver care on behalf of the ACO. To ensure that ACOs maintain meaningful participation of different provider types in the ACO structure, it is necessary for the HPC to require that ACOs account for the whole

¹ Insurers are more and more frequently "carving out" specific services provided by one provider type and *not* carving out those same services when provided by a different provider type.

range of different provider types. The MSO recommends that the HPC require ACOs to report the number of its different provider types, by license, on an annual basis. In addition, the MSO recommends that all provider license-types have some form of input to governance decisions. For instance, if the ACO does not have all provider types represented on the governing board, ACO should at the very least establish a provider advisory board that meets on a quarterly basis to provide feedback to the ACOs on its care delivery coordination, outcomes, opportunities for greater utilization of services at lower costs and other issues of concern to the provider community.

- **Criterion #6: Reduce disparities and ensure broad access to positive health outcomes.** The ACO Quality Committee should regularly review policies that could adversely impact clinical health outcomes, result in unnecessary referrals or contribute to a delay in patient care and recommend or require changes to address the same. Additionally, the HPC should require that ACO Quality Committees work to implement policies to remove provider payment disparities that are not tied to quality of care. The ACO Quality Committee should also establish systems for evaluating the relative quality of care received by patients from different providers, rendering the same services. With that data, and to be consistent with the non-discrimination provisions of §2706 of the Accountable Care Act (Public Law 111-148), the ACO Quality Committee would be able to ensure that there is no difference in APM reimbursements for *any* provider rendering the same services, absent quality of care differences. Finally, the HPC should require ACO Quality Committees to develop written guidance and policies that promote and require, inclusion of providers' full scope of services as defined by statute. All too often providers face arbitrary contractual limitations on the types of services certain provider license-types can render within a given care delivery framework. This limiting, but commonplace practice creates barriers to access for patients, reduces patient choice and drives health care costs up. The ACO Quality Committee should work to ensure that services can be rendered by any of its high-quality providers, provided such service is within the provider's scope of practice.
- **Criterion #9: Require ACOs to include a broad variety of providers to deliver community-based non-emergency and preventative care.** To further the HPC's mission, it should require ACOs to embrace cost-effective, local care in all practice modes for its patient population. In addition to demonstrating and assessing the effectiveness of ongoing collaborations with and referrals to ACO-providers, ACO's must ensure that patients have options to obtain community-based non-emergency and preventative care. By enlisting "allied health providers" or other types of non-MD licensed health care providers, such as local optometrists, ACOs can help to prevent unnecessary emergency room visits for non-emergency care. Further, the ACO must not

be permitted to discriminate with respect to participation in the ACO based solely on an individual provider's license type.²

- **Criterion #11. Eliminate reimbursement disparities in budget-based contracts for Medicaid patients.** By the end of ACO Certification year 2, ACO's should be required to establish budgets based on the lowest available reimbursement rates for Medicaid services to prospectively eliminate unwarranted price variation for providers providing the same services in the Medicaid (MassHealth) system. This encourages systemic utilization of the most efficient, high-value providers to render certain services and should work to help efficiently achieve cost savings for ACOs.
- **Criterion #12. Require ACOs to report the PCMH participation levels of all provider types.** All types of health care providers, not only "primary care providers", will be participating in NCQA and HPC Patient-Centered Medical Homes (PCMHs). As such, it is prudent for the HPC to require that ACOs report on the level of participation for all of its provider-types. This broader level of reporting will provide the HPC with a better picture of the participation and may provide data and insight as to new opportunities for incentivizing greater participation on a go-forward basis.
- **Criterion #13. Require that ACO cost, utilization and quality analyses be made available to the public.** If ACOs will be required to perform such analyses, it would be valuable to make these reports publicly available to consumers to help inform health care decision-making. This information, if made available to the public, could help to stimulate competition and lower costs between and among ACOs.

Market and Patient Protection Criteria

- **Criterion #18. Establish a mechanism for the HPC to receive notices of complaints concerning an ACO's potential or actual statutory or regulatory violation.** In addition to an ACO's attestation of compliance with all federal and state antitrust laws, the HPC should be notified of other complaints of an ACO's, or any of its subcontractors' or third party administrators', potential or actual violation(s) of other statutes or regulations. In order to effectuate this reporting, the HPC should create a mechanism for consumer, patient, and provider reporting of regulatory or statutory complaints concerning an ACO or its subcontractors' or third party administrators' practices. Complaints concerning an ACO should be filed directly with the HPC and complaints concerning one of the ACO's subcontractors should be filed with both the HPC and the ACO. As the certifying entity, the HPC should consider any negative outcomes or unresolved matters when the ACO applies for recertification.

² This requirement is consistent with Mass. General Laws c. 176D, Section 3A and the federal non-discrimination provisions of §2706 of the Accountable Care Act (Public Law 111-148).

- **Criterion #19. Establish a mechanism for the HPC to receive aggregate reports on patient grievances concerning ACOs.** The HPC should require and create a mechanism for the ACO or the Office of Patient Protection to provide an aggregate report of patient complaints on a quarterly or annual basis. This information should be deemed relevant to the HPC when it considers the ACO's application for recertification.

Reporting Only Criteria

- **Criterion #23. Mandate that the ACO track tests and referrals.** At present, this criterion only requires the ACO to have a process to track tests and referrals, however, the ACO should be required to not only track tests and referrals, but also to analyze that data. The MSO recommends that the HPC move this reporting only criterion to the mandatory criteria for ACOs because this data could be extremely valuable in identifying costly trends that are problematic or contribute to unwarranted expenditures. If the HPC determines that the ACO does not have the capacity to analyze the data, perhaps the HPC requires that the data be reported to the Center for Health Information Analysis for evaluation.
- **Criterion #30. Report a methodology for the distribution of funds to providers that does not discriminate based on provider license-type.** The MSO strongly supports the HPC's proposed criterion that requires ACOs to include a description of the fund distribution methodology and notice of the same to providers. The MSO recommends that the HPC take this one step further in requiring that the methodology not perpetuate unwarranted reimbursement disparities based solely on provider license-type. The HPC has the ability at this time to ensure that future ACOs reimburse based on quality of care for the service provided. By requiring that the ACO's provide evidence of a fund distribution methodology that does not reimburse different amounts for the same services, the HPC will be ensuring that ACOs have the tools to succeed as new health care delivery systems in this era where cost containment is imperative.

Thank you for considering the aforementioned recommendations, which the MSO respectfully submits as part of its mission to partner with the Commonwealth in further enhancing transparent and value-driven health care delivery. Please feel free to contact me with any questions.

Sincerely,



Rich Lawless
Executive Director