



January 29, 2016

Health Policy Commission
50 Milk St., 8th floor
Boston, MA 02109

RE: Proposed HPC ACO Certification Framework

On behalf of Health Care For All (HCFA) and Health Law Advocates (HLA), thank you for the opportunity to offer our comments on the Health Policy Commission's proposed Accountable Care Organization Certification Standards. The Health Policy Commission (HPC) has an opportunity to promote approaches to payment reform that fundamentally transform the way care is delivered. ACOs should deliver high quality, high value care that treats the individual as a whole person. ACOs should ensure coordination of care, improved communication, member support and empowerment, and ready access to health care providers, services and community-based resources and supports. We offer the following recommendations for the HPC to consider as it moves forward with developing and implementing standards of certification for ACOs.

Member Engagement at Multiple Levels

Ensuring delivery of care that meets the needs of members and their families requires meaningful systematic engagement of members and families at both the individual and governance levels.¹

- *In organizational design and governance and policy making:* Members are formally integrated as advisors in design and governance of policies and procedures.
- *In direct health care:* Members (and/or their family member or caregivers) should understand their own role in the care process and be confident in taking on that role.

Ensure consumer representation and input in ACO governance bodies and advisory councils

Individual patients and consumers are the heart of the care system, and must be valued as members of the design and governance teams for the delivery system reform structures. Bringing the perspectives of patients and families directly into the planning, delivery, and evaluation of health care, and thereby improving its quality and safety, is what patient- and family-centered care is all about. When consumers

¹ For a thorough definition of meaningful engagement and what it entails, please refer to the framework described in Carman, K.L., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., Sweeney, J. (2013). Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies. *Health Affairs* 32(2): 223-231.; See also Millenson, M.L. (2015) Building Patient-Centeredness in the Real World: The Engaged Patient and the Accountable Care Organization. Health Quality Advisors, available at: <http://www.nationalpartnership.org/research-library/health-care/building-patient-centeredness-in-the-real-world.pdf>; HCFA can also provide the following: HCFA's Principles to Achieve Meaningful Patient and Family Engagement in Care and Multidimensional Framework for Patient and Family (P&F) Engagement in Health and Health Care: A Model for Massachusetts (2015).

and families, providers, and health care administrators work in partnership, the quality and safety of health care rise, costs decrease, and provider and consumer satisfaction increase.²

The HPC has an opportunity to accelerate progress toward patient-centered care delivery by requiring that ACO design and governance teams include independent consumers among their members. We urge the HPC to ensure meaningful involvement of members and consumer advocates in the following ways:

- Sufficient representation on the ACO's Governance Board. We recommend that criterion #3 be amended so that the ACO governance board contains more than one patient and/or consumer advocate representative in order to ensure sufficient representation. Having multiple consumer advocates and patient representatives on a governance board will ensure more sufficient representation of the ACO's member population and avoid isolating the representative. ACO governing boards should also include representatives from community-based organizations, including those concerned with public health. In addition, ACOs should ensure consumer advocate and member representation on the governance board reflects the diverse member population it serves.
- Representatives are *meaningfully engaged* in decision-making. We also recommend that the HPC provide more detailed documentation requirements on how to ensure that participation and engagement is meaningful under criterion #3, and support the existing documentation requirements described. All representatives on the governance entity (including consumer advocate and member representatives) must have an equal seat and say at the table and an opportunity to share their perspectives and influence decisions as they are being made, including equal voting rights.
- ACOs should form Member Advisory Councils. We strongly support requiring ACOs to have a Patient and Family Advisory Council or similar committee under criterion #5. These councils should address issues related to the ACO's quality, member experience, and affordability goals from the member perspective, including continuous quality improvement. This can be one overarching council to look at care across the practice and/or subcommittees or smaller councils for particular areas. We also recommend that the HPC provide more specific documentation requirements for this criterion. Specifically, councils should:
 - Have membership that currently receives care at the ACO. Membership should reflect the populations/community served by ACO (including representation across age, race, ethnicity and languages).
 - Hold meetings at least quarterly, with agendas developed in collaboration with the group, and distributed in advance of the meeting.
 - Regularly share member satisfaction/complaints and other relevant data.
 - Have a documented "feedback loop" in which recommendations are carried up to the leadership of the ACO. Appropriate follow-up should be then demonstrated to the governance entity to ensure accountability.
 - Develop and implement written policies and procedures that include, at a minimum, purposes and goals, membership eligibility, officers, orientation and continuing education, and roles and responsibilities of members.

² Institute for Patient- and Family-Centered Care. (2014). *Advancing the Practice of Patient- And Family-Centered Care: How To Get Started*. Bethesda, MD.

- Have a named staff member responsible for managing the work of the Council and integrating the work of the Advisory Council in other ACO Committees.
- Write an annual public report on their work.
- Develop and implement a plan to regularly communicate with members, including a process to receive direct input and recommendations from members and communicate back to members regarding any responses or actions taken.
- All representatives receive orientation and onboarding support to facilitate their successful participation, as well as ongoing opportunities to connect with peers in other ACOs. Successful partnerships with consumer advocate and member representatives on ACO governing boards and Advisory Councils require a greater level of ACO support, including providing orientation and onboarding support. We recommend that criteria #3 and #5 be amended to require ACOs to describe in their certification applications an orientation and onboarding process for consumer advocate and member representatives on governance boards, other internal multi-stakeholder entities, and Advisory Councils. We encourage the HPC to offer guidance and assistance to ACOs with respect to developing onboarding and orientation processes. The HPC should also facilitate an ongoing process to allow all consumer representatives on these boards to learn from each other, share best practices, and interact with experts on issues related to ACOs.³

It is also essential to ensure adequate support for ACOs and other stakeholders to help them effectively integrate consumer advocates and members and families into the work of the board. Non-profit consumer groups could be engaged to manage this process. We urge the HPC to work with ACOs in the application phase to determine how the ACO will:

- Communicate the important role consumer advocates and member representatives play in governance and decision-making;
- Create an expectation that consumer advocate and member input will be valued, respected and incorporated in ACO operations; and
- Provide training and resources to support effective collaboration with consumer advocate and member representatives.

Finally, it is important for ACOs to monitor and continuously assess the degree to which consumer advocate and member representatives are being meaningfully engaged and whether changes being made through the ACO are actually improving member care experiences and outcomes. This information should be part of the HPC's evaluation of ACOs. We encourage the HPC to work with ACOs and consumers to determine the most appropriate ways to track and share this information.

Example:

- Each CCO in the Oregon Medicaid program must have a governing body that includes at least two members of the community at large to ensure that the CCO's decision-making is consistent with the values of the members of the community, as well as at least one member of the CCO's Community Advisory Council.⁴ The Community Advisory Council that each CCO is required to maintain must include representatives of the community and each county government served

³ See Community Catalyst Meaningful Consumer Engagement: A Toolkit for Plans, Provider Groups and Communities, available at: <http://www.communitycatalyst.org/resources/tools/meaningful-consumer-engagement>.

⁴ ORS 414.625(o).

by the CCO but consumer/member representatives must constitute the majority of the membership.⁵

Promote patient-centered quality measures

ACOs must be accountable first and foremost to their members, and quality measures must reflect this goal. Specifically, holding ACOs accountable for improved member health and experience of care will require quality measures that are focused on outcomes and member-reported data. We support criterion #14, which requires ACOs to conduct an annual survey to evaluate patient and family experiences and deploy plans to improve on those results. While patient experience measures are an important first step, ACOs should also prioritize the inclusion of patient-reported outcomes measures (PROMs). These kinds of high impact quality measures, which are meaningful to both consumers and providers, will help ACOs drive quality improvement and increase value.

Examples of validated PROMs include the Patient Reported Outcomes Measurement Information System (PROMIS), the Patient Health Questionnaire-9 (PHQ-9), Hip disability and Osteoarthritis Outcome Score (HOOS), Knee injury and Osteoarthritis Outcome Score (KOOS), and other tools endorsed by the Substance Abuse and Mental Health Services Administration (SAMHSA).⁶

Maximization of the potential for PROMs and patient experience measures to improve care delivery and health outcomes likely requires evolving our electronic health information infrastructure such that it supports collection and use of PROMs and other high-value measures. We support interoperability so that data can be transmitted between providers in real time and integrated into their work flow and care delivery.

Example:

- Blue Cross Blue Shield of MA has incorporated PROMS for mental health, orthopedics, oncology and cardiology as a complementary measure set for both its Alternative Quality Contract (AQC) and PPO payment reform models. Beginning with contracts in 2016, these measures will be used alongside the core quality measure set. Unlike the core quality measure set, where payment is based on performance, however, payment for the PROMs and other measures in the complementary measure set will be based on adoption and use to improve patient care. Since the BCBSMA introduction of PROMs in 2014 as a voluntary component of the AQC program, the reception from providers has been very positive. While introduction of PROMs into routine practice requires significant adaptation of both work flow and culture, providers have conveyed the significant clinical value in having the PROMS data and the usefulness of being able to monitor patients' progress over time using these measures.
- In California, the Intensive Outpatient Care Program (IOCP), which is funded by the Center for Medicare and Medicaid Innovation, collects functional health status information and uses other standard survey instruments to screen for depression and to measure the patient's ability to engage in improving their health. Patients are screened again following treatment to ensure that their condition has improved.⁷

⁵ ORS 414.627(1).

⁶ See SAMHSA-HRSA Center for Integrated Health Solutions. (2015). *Screening Tools*. Retrieved from <http://www.integration.samhsa.gov/clinical-practice/screening-tools>

⁷ Hopkins, D. and Huff, J. E. (April 2015). *Pacific Business Group on Health Action Brief on Patient-Reported Outcomes*.

Promote member engagement and activation in care

Member satisfaction and engagement/activation measures must also be included among the quality indicators under criterion #14. Numerous studies have shown that individuals who are more actively involved in their health care experience better health outcomes and incur lower costs.⁸ Many health care organizations are employing strategies to better engage individuals, such as educating them about their conditions and involving them more fully in their care.⁹ Such engagement allows individuals and providers to be full partners in care, improving outcomes and lowering cost.¹⁰

Examples of approaches to achieve member engagement in direct care include:

- *Using shared decision making.* In this approach, members and providers together consider the member's condition, treatment options, the medical evidence behind the treatment options, the benefits and risks of treatment, and members' preferences, and then arrive at and execute a treatment plan. Shared decision making often includes the use of decision aids.
- *Using trained health coaches, certified peer specialists and community health workers.* These coaches provide members with knowledge and awareness of their treatment options, help them to sort out their treatment preferences, and encourage them to communicate those preferences to their health care providers.¹¹ Certified Peer Specialists and community health workers are additionally helpful, as discussed in greater detail in subsequent sections.¹²
- *Helping members become "activated."* Members who have the skills, ability, and willingness to manage their own health and health care experience better health outcomes at lower costs compared to less activated members. The "Patient Activation Measure" is a validated survey that scores the degree to which someone sees himself or herself as a manager of his or her health and care. Interventions that tailor support to the individual's level of activation and that build skills and confidence are effective in increasing patient activation.¹³
- *Provide patients with access to all their medical records, including behavioral health records.* Patient portals, which provide members with access to their medical information as well as a means to communicate with their providers, have been shown to increase patient engagement. In

⁸ Hibbard, J. H., Greene, J., Sacks, R., et al. (2013). When Seeing the Same Physician, Highly Activated Patients Have Better Care Experiences Than Less Activated Patients. *Health Affairs*, 32(7): 1295–1305; Hibbard, J.H., Greene, J. (2013). What the Evidence Shows about Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs. *Health Affairs* 32(2): 207-14; Hibbard, J. H., Greene, J., & Overton, V. (2013). Patients with lower activation associated with higher costs. *Health Affairs*, 32(2): 216–222.

⁹ "Health Policy Brief: Patient Engagement," *Health Affairs*, February 14, 2013; Shortell, SM, et al., (2015). An Early Assessment of Accountable Care Organizations' Efforts to Engage Patients and Their Families. *Medical Care Research and Review*, 72(5) 580-604.

¹⁰ Carman, K. L., Dardess, P., Maurer, M., Sofaer, S., Adams, K., Bechtel, C., and Sweeney, J. (2013). Patient and Family Engagement: A Framework for Understanding the Elements and Developing Interventions and Policies. *Health Affairs* 32(2): 223-31.

¹¹ Veroff, D., Marr, A., and Wennberg, D.E., (2013). Enhanced Support for Shared Decision Making Reduced Costs of Care for Patients with Preference-Sensitive Conditions. *Health Affairs* 32(2): 285-93.

¹² See, e.g., Keif, et al., (2014). Peer Recovery Support for Individuals With Substance Use Disorders: Assessing the Evidence. *Psychiatric Services*. 65(7): 853 (lower relapse rates); Gidugu, et al. (2015). Individual Peer Support: A Qualitative Study of Mechanisms of Its Effectiveness. *Community Mental Health Journal*. 51(4): 445-52. (as an adjunct to traditional mental health services); see also National Coalition for Mental Health Recovery (2014). *Peer Support: Why It Works*. Retrieved from <http://www.ncmhr.org/downloads/References-on-why-peer-support-works-4.16.2014.pdf>

¹³ Hibbard, J. H., Greene, J. (2013). What the Evidence Shows about Patient Activation: Better Health Outcomes and Care Experiences; Fewer Data on Costs. *Health Affairs* 32(2): 207-14.

addition, opening up behavioral health records to members decreases provider stigma by requiring providers to describe behaviors in non-judgmental terms.¹⁴

- *Helping increase “patient confidence.”* Health confidence measures the individuals’ level of knowledge, skills, and self-efficacy about taking an active role in their health care and managing their health conditions. Its assessment can result in immediate provider action and lead directly to improved patient engagement. If an individual’s health confidence is low, motivational interviewing can be used to help the individual to reflect on personal strengths, identify behavioral goals and develop a support plan.¹⁵

ACOs should be required to measure and publicly report on these activities and engagement/activation measures in a way that is understandable by members. Meaningfully engaging members as partners in care and delivering member-centered care that meets the needs of members and families is the best way to encourage members to stay within the ACO when seeking care.

Consumer Protections

ACOs must be built upon a strong foundation of robust consumer protections that ensure member rights are safeguarded and that access to care is not impeded. As new models of care and payment are developed and providers take on increased risk, reward, and responsibility, it is important that the HPC ensures that the evolution and application of consumer protections are keeping pace. The HPC should prioritize the inclusion of a broad array of consumer protections as outlined in this section, as well as areas discussed in other sections such as payment design features, heightened quality reporting requirements, consumer-friendly notice and transparency requirements, emphasis on member outreach and education, and adequate protections concerning enrollment, attribution, and data sharing.

Increased levels of risk for losses coupled with influence over utilization management shift the balance of incentives enhancing the potential for ACOs to stint on care. While quality criteria and quality measurement may help control this risk, the limitless combinations of potential stinting are unlikely to be adequately covered by a finite set of measures. The HPC must therefore work to monitor and ensure that members get all the care they need and that ongoing care is not interrupted. Safeguards against under-service and member selection should be incorporated at a number of different levels that include payment design features that impact an ACO’s or a provider’s behavior and additional safeguards layered on top of a program’s internal incentive structure to further minimize the risks of under-service and member selection.¹⁶

Monitor and track underutilization

One way to safeguard against potential incentives to deny or limit care, especially for members with high risk factors or multiple health conditions, is for under-service and underutilization to be tracked and monitored through both concurrent and retrospective methodologies. Under-service refers to the

¹⁴ Kahn, et al., (2014). Let’s Show Patients Their Mental Health Records. *Journal of the American Medical Association*. 311(13):1291.

¹⁵ Wasson, J., and Coleman, E. (2014). Health Confidence: A Simple, Essential Measure for Patient Engagement and Better Practice. *Family Practice Management*. 21(5): 8-12.

¹⁶ See Connecticut Healthcare Innovation Steering Committee. (June 2015). *Connecticut State Innovation Model (SIM) Report of the Equity and Access Council on Safeguarding Against Under-Service and Patient Selection in the Context of Shared Savings Payment Arrangements*. Hartford, CT: Connecticut Healthcare Innovation Steering Committee.

systematic or repeated failure of a provider to offer medically necessary services in order to maximize savings or avoid financial losses associated with value-based payment arrangements.¹⁷

ACOs should be required to establish internal monitoring mechanisms, which should be part of ACO agreements with participating provider groups and individual providers. Specifically, ACOs should establish performance standards, monitor for inappropriate practices including under-service and member selection, hold providers accountable, and report publically on the information gathered through internal monitoring. This could be a separate criterion or included under criterion #13 (analytic capacity).

As a second layer of safeguards, the HPC should work with payers and ACOs to conduct retrospective monitoring and analysis of claims data on an annual basis. Changes in utilization could serve to identify stinting on care and the risk profile of an ACO over time could suggest avoidance of high-risk members. At a minimum, under-service should be monitored by assessing utilization, total cost of care, cost of care by service type and health outcomes over time to identify patterns of variation. In addition, there should be population-specific analyses for populations identified as at particular risk (i.e. characterized by certain clinical conditions and/or socioeconomic factors), which could include monitoring variations in utilization of different interventions by diagnosis. When potential under-service is flagged via monitoring claims data, additional follow-up should be performed to assess the root cause of the variation to evaluate whether repeated or systematic under-service and/or member selection is likely to have occurred.

Additional methods of identifying problems related to underutilization include soliciting member feedback through survey-generated measures and capturing member feedback through member advocacy services such as an ombudsperson center, both of which are discussed in greater detail in other sections of these comments. The HPC should conduct surveys of members who disenroll from ACOs to uncover systemic issues with an ACO or its care.

Examples:

- Oregon Medicaid's Collaborative Care Organizations (CCOs) are required to establish mechanisms to monitor and protect against underutilization of services and inappropriate denials, provide access to qualified advocates such as peer wellness specialists or personal health navigators, as well as develop a complaint, grievance, and appeals resolution process.¹⁸
- New Jersey has determined that collecting and analyzing patient and consumer feedback is the best mechanism to detect and remediate any potential improper limitations in care. An ACO must demonstrate its capability to collect quality data which includes patient access and utilization of services measures and have in place at the management level a quality committee responsible for receiving and addressing patient complaints and conducting ongoing monitoring to ensure access to care and prevent inappropriate provider self-referrals, reductions in care, or limitations on services.¹⁹ In an ACO's gainsharing plan, the ACO must describe how it will provide members with a clear process to make complaints or speak up regarding a possible improper provider self-referral, or reduction or limitation of services.²⁰ Appropriate disciplinary actions should be taken against providers/practices found to have improperly reduced care,

¹⁷ Id. at 2.

¹⁸ OAR 410-141-3015(13).

¹⁹ N.J.A.C. 10:79A-1.5(c)(8).

²⁰ N.J.A.C. 10:79A-1.6(d)(5).

limited services, or engaged in inappropriate self-referral which may include withholding gainshare savings or excluding a practice from the ACO.²¹ The number, types, and resolution process of such complaints at the provider/practice level must be reported annually to the New Jersey Department of Human Services and the public.²² As a part of the ACO certification process, participating providers are further required to submit an affirmative acknowledgement that the provider shall not organize their care delivery to reduce access to care or increase costs, shall be responsible for medically appropriate treatment and referral decisions, shall document the basis for such decisions, and shall not limit treatment and referrals to providers both within and without the ACO if medically indicated.²³

Ensure robust appeals and grievances procedures

Because an individual's treating physician may have a direct financial relationship with the ACO and its participating providers, ACO grievance and appeals processes should be robust and designed to address this unusual context. We support requiring that ACOs must attest to compliance with HPC's Office of Patient Protection (OPP) guidance regarding a process to review and address patient grievances and provide notice to patients under criterion #19.²⁴ We urge that such processes be at least as consumer-protective as current OPP regulations that require carriers to administer appeals and grievance processes. Specifically, the deadlines for members should be at least as generous as current OPP regulations given the special challenges involved in appeals in the provider risk-bearing context. Also, continued benefits and expedited reviews should be mandated for both internal and external reviews. These protections should be clearly available to all members in ACOs.

Providers who stand to share in ACO savings should be required to provide members with a description of all possible treatment options and the provider's basis for deciding on the recommended treatment. Members who are concerned about a provider's decision should have access to a process to seek a second opinion, outside of the ACO network, that does not incur additional cost sharing.

In addition, the OPP's guidance/regulations for ACO grievance procedures should include the following requirements:

- ACOs should have an internal level of appeal and opportunity for further appeal via external review, both of which may be expedited when necessary and requested by the member or her representative.
- All levels of appeal should be decided by independent and qualified clinical professionals.
- To allow for clear communication to members about their right to receive notice and to appeal, OPP should clarify what triggering events give rise to an appealable action, for both internal and external appeals. Examples of ACO situations that could constitute an appealable action include but are not limited to:
 - Referral or second opinion denied/refused by provider
 - Denial of a prescription medication
 - Refusal to do surgery/specific treatment

²¹ N.J.A.C. 10:79A-1.6(d)(5)(iv).

²² N.J.A.C. 10:79A-1.6(d)(5).

²³ N.J.A.C. 10:79A-1.5(c)(4)(ii).

²⁴ The Office of Patient Protection is also under a statutory obligation pursuant to M.G.L. c. 176O § 24 to establish by regulation an external review process for the review of grievances submitted by or on behalf of patients of risk-bearing provider organizations.

- Member choices not reflected in treatment plan or member disagrees with treatment plan
- Testing/assessment insufficient, inadequate or omitted
- OPP should specify the noticing requirements that ACOs must abide by to inform members of the right to appeal, which should be at least as consumer protective as existing OPP appeals notice requirements. The mechanism for filing complaints should include the use of online feedback forms as well as hard copy documents.
- OPP should require ACOs to provide members with reasonable assistance in filing appeals, which includes assistance from qualified community health workers, peer wellness specialists or personal health navigators; free interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capabilities; and reasonable accommodation or modifications as required by any disability of the member.
- ACOs should provide full transparency and access to information for members facing under-service and denials of care. Reporting requirements should be rigorous enough to monitor the implementation of the ACO appeals and grievances process and the impact on members, including reporting the number and types of internal and external grievances and appeals to OPP.

Furthermore, OPP should serve as a single source of information and accountability for under-service through an ombuds program model. The ombuds office can play a key role as a one-stop source of information related to under-service and member selection for members and providers and should report any systemic issues to ACO advisory bodies.

Examples:

- The Oregon Health Authority is charged with adopting by regulation safeguards for members enrolled in CCOs that protect against underutilization of services and inappropriate denials of services.²⁵ In its certification application, each CCO must describe its planned or established mechanisms for a complaint, grievance, and appeals resolution process, and how it will make such a process known and accessible to members.²⁶ Each CCO must further have an approved process and written procedures for a member's right to appeal and a member's right to file a grievance for any matter other than an appeal.²⁷
- Oregon's CCO model includes the right for patients to be able to receive, upon request from the provider organization, summaries of the provider organization's data regarding appeals and accessibility of services.²⁸ CCOs must also maintain detailed yearly logs of all appeals and grievances for seven calendar years. In addition, CCOs must review and report to the Oregon Health Authority complaints relating to racial or ethnic background, gender, religion, sexual orientation, socioeconomic status, culturally or linguistically appropriate service requests, disability status and other identity factors for consideration in improving services for health equity.²⁹
- CCOs must provide members with any reasonable assistance in taking procedural steps related to filing grievances, appeals or hearing requests, which includes assistance from qualified community health workers, qualified peer wellness specialists or personal health navigators; free

²⁵ ORS 414.635.

²⁶ OAR 410-141-3015.

²⁷ OAR 410-141-0000.; OAR 410-141-3260.; OAR 410-141-3261.; OAR 410-141-3262.; OAR 410-141-3263.

²⁸ ORS 414.651(8).

²⁹ OAR 410-141-3260(13); OAR 410-141-3260(17).

interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capabilities; and reasonable accommodation or modifications as required by any disability of the member.³⁰

- In New Jersey, ACOs must provide a clear and easy way for patients or consumers to make complaints or speak up regarding a possible improper provider self-referral, or reduction or limitation of services by a participating ACO member. The mechanism for collecting complaints may include the use of online feedback forms, hard copy documents, and/or a telephone “hotline.”³¹ In addition, ACOs must report annually to the state and the public on the number of complaints received at a provider/practice level, the types of complaints received, and the resolutions implemented. ACOs must also provide for internal monitoring and take appropriate disciplinary actions against individual providers that improperly reduce care or limit services. Reporting to the state includes notification of a material concern involving patient safety within three business days.³²

Protect member choice of providers

While alternative payment methods are an opportunity to improve care while reducing cost, there are risks that ACOs utilizing these new payment methodologies could restrict access to member choice of providers through additional network limitations. Individuals, particularly those with disabilities or chronic needs, benefit from continuity of care from both primary and specialty care providers who know them and their medical needs. Providers joining and leaving ACOs can disrupt relationships and hurt care. Member choice is also important to allow members to seek very specialized services that might not exist in an ACO, to participate in clinical trials, and to obtain very personalized care such as reproductive health or mental health services. Moreover, payment reform will not be successful with the public if perceived as an attempt to limit choice of providers.

Network adequacy and continuity of care

The HPC should ensure that members have access to care across the continuum, which includes reasonable access to a sufficient number of primary care and specialty care physicians, facilities, and other providers through minimum member/provider ratios, as well as benefits delivered in a timely fashion within a reasonable distance that takes into account travel time and access to public transportation. The HPC should also take into account the specific needs of certain populations, including children and youth with special health care needs. These requirements could be added to criterion # 9 (collaboration with a continuum of providers and organizations) or included as separate criteria. We further recommend that criterion #9 be amended to require that ACOs either include in their networks, or effectively collaborate with and promote access to, the providers and organizations listed as well as additional types of providers including oral health providers and community health workers, as discussed in greater detail in subsequent sections.

As part of the network adequacy determination, the HPC should ensure that all ACOs have policies on how consumers may access providers outside of the ACO network. This could be added to criterion # 9 or included as separate criteria. For example, single-case out-of-network agreements should be permitted where an individual is in a course of treatment with a provider; where network providers do not have the same level of expertise, specialization, or cultural and/or linguistic appropriateness as the

³⁰ OAR 410-141-3260(7).

³¹ NJAC 10:79A-1.6(d)(5).

³² NJAC 10:79A-1.6(d)(5); NJAC 10:79A-1.7(c).

requested out-of-network provider; or if a network provider is not readily available or is otherwise geographically or temporally inaccessible. For members in ACOs, getting care from a provider outside the ACO could work similarly to getting care out-of-network from a PPO plan. The provider will still be subject to the ACO's payment and coordination requirements, ensuring that members maintain continuity of care and do not face additional barriers in accessing appropriate care.

In addition, the HPC should ensure that ACOs have protections to ensure continuity of care when a provider leaves an ACO network. This includes notification to the member in advance of the change and the option to continue seeking treatment from the provider via an out-of-network arrangement. Continuity of care, particularly for specialty and behavioral health services, is key to ensuring positive health outcomes and long-term recovery.³³ It has been said that the "best fence is a good pasture." Good ACOs will succeed in keeping members within their system because of the benefits of coordinated care.

Attribution methodologies

The HPC should work with payers and providers to ensure that attribution methods adhere to the goals of care continuity and access and involve member choice to the maximum extent feasible. Members should be able, though not required, to designate their PCP. Members should also be able to designate a non-primary care provider as their PCP for the purposes of attribution. In the event that the chosen provider's panel is closed, the member can either select a different provider or be attributed retrospectively based on the member's historical choices. Members who do not pick a primary care provider through attestation should be assigned based on their recent care-seeking behavior. In determining retrospective attribution, the methodology should not only look at PCP claims but also claims from other providers, as well as non-claims-based factors such as geographical proximity, language and cultural competency, in order to determine the most appropriate assignment. However, allowing for direct member choice is always preferable to retrospective attribution.

Members should receive adequate notice about the right to choose or change providers and ACOs. Members who have been attributed to a provider should receive notice of the attribution and their right to change providers at any time. When individuals select a provider they should know if they are choosing a provider who is participating in an ACO. At the time of selection they should have information about any advantages for the member of selecting an ACO provider. It should be made clear to the member if the provider has a financial incentive to refer in-network, and members should be notified of their right to go out of network and of any potential benefits to staying in the ACO network. All notices should be provided in a manner that is accessible and understandable. We recommend that the HPC include additional criteria to ensure these protections.

Examples:

- Oregon CCOs must ensure that members have a choice of providers within the CCO's network, and applicants to the CCO program must describe how they will work to develop the

³³ Ruttenberg, M. (2014). Choices and Continuity of Care as Significant Issues for Equality in Mental Health Care. *J. Health & Biomedical L*, 10(201); Kluft, R. et al. (2000). Treating the Traumatized Patient and Victim of Violence. *Psychiatric Aspects of Violence: Issues in Prevention and Treatment* ("Continuity of care is an important aspect of long-term treatment, and the object constancy and reliability of the therapist may be one of the most important factors in treatment success."); see also The National Council on Disability. (2013). *Medicaid Managed Care for People with Disabilities*. Retrieved from <http://www.ncd.gov/publications/2013/20130315/20130315Ch3> (emphasizes the need to protect continuity of care when designing health care systems).

partnerships necessary to allow for patient choice in medical, mental health and substance use disorder services, and dental care, and to facilitate access to community social and support services.³⁴

- In New York, ACOs must provide access to care providers that are not part of the ACO.
- Former and prospective members of One Care in Massachusetts often cite the provider network as a primary reason for disenrolling, or not enrolling in the first place. While individuals recognize the benefits of integrated care, the prospect of losing established relationships with behavioral health professionals and other medical providers forms a barrier to participation. Some members experience an inadequate network in their area with no One Care provider located within 45 minutes or more from their home. Other members wait excessive periods of time for a culturally or linguistically appropriate provider, including behavioral health providers that speak their native language. Plans have addressed the issue through provider outreach and offering Letters of Agreement to a member's current physician. Some providers remain reluctant to participate, however, even as MassHealth continues education and outreach efforts.

Comprehensive data collection and risk stratification

Comprehensive data collection

Collecting data on key sociodemographic factors is a critical first step for effectively managing the health of an ACO's patient population, addressing risk factors that lead to poor health outcomes, and appropriately targeting intervention points and strategies.

We strongly support criterion #31 that ACOs should assess 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 develop plan(s) to meet those needs. We recommend, however, that this criterion be moved from the category of reporting-only to mandatory so that ACOs understand key barriers to health and how those barriers are distributed across its member population. In addition, having a comprehensive set of sociodemographic data for the ACO's patient population is necessary to effectively accomplish a number of criteria, including #7 (risk stratification), #8 (targeted population health programs), #9 (ongoing collaborations & referrals with organizations and providers), and #15 (community health programs). Under criterion #31, the provision of interpretation/translation services and materials printed in languages representing the patient population should also be made mandatory as a key strategy to address health disparities and promote health equity.

Risk stratification

To achieve more equitable health care outcomes, it is crucial that ACOs incorporate disparity reduction goals into overall quality improvement goals and adopt tools that support disparities measurement and interventions. Outcomes and other quality indicators should be stratified by social determinants of health indicators in order to appropriately target population health interventions, uncover and address health disparities, and improve how ACOs deliver care.

We therefore strongly support criterion #7, which requires ACOs to have approaches for risk stratification of its patient population based on criteria that includes social determinants of health,

³⁴ OAR 410-141-3015(15).

which could include factors such as homelessness or unstable housing, age, primary language, race and ethnicity, geography, gender identity and sexual orientation. We also think it's important to stratify data based on functional status, activities of daily living, instrumental activities of daily living, and health literacy, as specified as optional in the criteria. Once collected, we think this information should be made available publically. Reporting this data will allow the HPC and the public to assess how well ACOs are serving the entire spectrum of ACO members. As more risk stratification tools are developed and tested over time, ultimately ACOs should use a standardized methodology for risk stratification in order to be able to make meaningful comparisons across ACOs.

This data should be used to target programs at improving health outcomes for its patient population, addressing mental health, addiction, and/or social determinants of health, as called for in criterion #8. As part of this criterion, ACOs should describe how programs address the specific identified needs of social determinants of health for their population. The standards should also require the program to be of sufficient size to address the documented needs.

Additionally, the HPC should require ACOs to use the new consensus metrics, developed by the National Quality Forum (NQF), to assess cultural competency and language services.³⁵ Implementing these measures is critical to address provider biases, poor patient-provider communication, and poor health literacy. Collection and reporting of data on these measures also will help create a long-term agenda for improving health care quality for vulnerable populations and others adversely affected by disparities.

Public reporting and consumer outreach & education

Promote transparency and accountability through public reporting

Public reporting can improve both health care performance and value. We strongly recommend that ACOs be required to publicly report quality and cost information at the provider level, as well as at the ACO level. Providing transparent information on cost and quality performance at the individual provider level as well as the ACO level will help members to make informed decisions with respect to choice of provider and care setting. Providing transparent cost and quality information may also help members to understand the potential benefits that an ACO can provide. ACOs are best equipped to provide more specific information about how care will be better coordinated in their specific integrated systems. We recommend that ACOs be required to publicly report quality and cost information at the provider level, as well as at the ACO level.

The HPC should work with ACOs to publicly report on an annual basis the following information: the names of HPC certified ACO; the number of lives attributed to each ACO; the financial structure of ACOs and participating providers, including surplus or deficit margins; ACO leadership structures; and provider incentives in ACOs. The HPC should further work in conjunction with the Office of Patient Protection to publicly report on an annual basis the number and types of internal and external grievances and complaints filed with the ACO and if and how they have been resolved.

³⁵ National Quality Forum. (Aug. 2012). *Healthcare Disparities and Cultural Competency Consensus Standards*. Retrieved from http://www.qualityforum.org/projects/Healthcare_Disparities_and_Cultural_Competency.aspx

Consumer friendly education and outreach

We recommend adding criteria to ensure that all individuals receiving care, or eligible to receive care, through an ACO be fully informed about what this means for them and how to protect themselves if necessary. ACOs should educate their members on what an ACO is, the benefits of care under the ACO, and the responsibilities and rights that accompany receiving care from an ACO, including the right to receive care from a provider outside of the ACO, the right to file a grievance or complaint with the ACO, and how to go about taking these actions. Additional information should include a description of financial incentives for ACO providers and the ACO as a whole, including incentives to manage the total cost of care and improve quality, definitions of under-service and member selection, and how the ACO is monitoring for under-service.

In the context of value-based care delivery, individuals should also be informed about the nature of their role in achieving the goals of payment reform as well as their own health goals. This should include information about how to work collaboratively with one's provider, how to evaluate if one is receiving appropriate care, and what to do if one is concerned about the extent or type of care that has been ordered.

Information on ACOs should be provided in ways that are accessible and understandable to all members. While these messages should be tailored as appropriate to provide information relevant to specific groups (e.g. enrollees in different ACO models), the core elements should be consistent in order to promote shared understanding across populations, promote continuity of information as individuals' insurance or health status changes, and give providers standard guidance about engaging members that aligns with what members are being told. Information should be made available both in advance of receiving care (e.g. at the time of enrollment) and at the point of care (e.g. in writing in the provider office). To help ensure that this information is effectively shared and communicated, written materials should include taglines in at least 18 languages and large print that inform members of written translation services in all prevalent (500 or 5 percent of potentially attributed individuals) languages, as well as oral assistance for all members with limited English proficiency and assistance for people who are deaf and need American Sign Language.

The HPC should also encourage ACOs to work collaboratively with community-based organizations (CBOs), including those that represent communities of color and/or non-English speaking beneficiaries, around education and outreach. Members are more likely to trust CBOs and local community groups, which will in turn create more buy-in from the member perspective to join/stay in the ACO.

Finally, we recommend that the HPC convene a work group, in collaboration with MassHealth, to advise them on the content to be contained in the core messages described above, and also on the appropriate media and means through which messages should be disseminated. This work group should recommend specific language to be incorporated in member communications. The work group should be composed predominately of members, consumer advocates, and providers. It should also include representatives of payers and state government agencies, and individuals with experience and expertise in communications, including communications with populations believed to be at particular risk of under-service or otherwise difficult to engage.

Data sharing

Offering members electronic access to their medical records and other health information may help them understand the importance of and minimize concerns regarding data sharing. According to a

national survey by the National Partnership for Women & Families, online access appears to be a catalyst for transparency and understanding that helps individuals trust their records, and perhaps better understand how data-sharing across providers contributes to well-coordinated care.³⁶ Offering individuals real-time, electronic access to their complete health information will not only enhance patient engagement, but may strengthen trust and alleviate concerns regarding data sharing, thereby minimizing the number of members who opt-out.

The HPC should add criteria to require ACOs to describe their ability to provide members access to their own electronic health records and related clinical knowledge needed to make informed choices about their care, including electronic health information in non-English languages. A 2014 survey found that individuals with online access to health information in their providers' EHRs overwhelmingly use this capability: 86 percent log on at least once a year, and 55 percent log on three or more times per year.³⁷

The data from this survey clearly show that online access has a positive impact on a wide range of activities that are essential to improved health outcomes and better care, including knowledge of health and the ability to communicate with providers. More frequent online access has an even more dramatic impact. Individuals who used online access three or more times per year reported a markedly greater impact (20 percentage points higher) across these domains of care. Even more significantly, the more often individuals access their health information online, the more they report that it motivates them to do something to improve their health – 71 percent, compared with 39 percent who used online access less frequently.³⁸ This ability to access personal health information has profound implications for engaging members and improving health status.

Access to Services and Care Delivery

Incorporate oral health services

As one of the founding tenets of ACOs is the coordinated health care of whole persons, ACOs must include the opportunity to improve the oral health of their members. To this end, oral health should be included within the scope of ACO services, helping eliminate the arbitrary separation of care based on body part. The savings accrued through increased focus on oral health prevention can be shared throughout the ACO. The evidence on both improvements in quality of life and cost savings through dental care is striking: poor dental health is at epidemic proportions, and untreated dental disease is costly and extremely preventable.

Although largely preventable, dental caries and periodontal disease continue to be among the most common chronic diseases in the US, resulting in millions of hours of missed school and work days annually.³⁹ Untreated dental disease is also costly. Between 2008 and 2011, MassHealth paid over \$11 million for emergency department visits for dental conditions in adults. Individuals who go to the emergency department for dental care generally receive short-term symptomatic relief without treating

³⁶ National Partnership for Women & Families. (2014). *Engaging Patients and Families: How Consumers Value and Trust Health IT*. Washington, D.C.: National Partnership for Women & Families. Retrieved from <http://www.nationalpartnership.org/research-library/health-care/HIT/engaging-patients-and-families.pdf>

³⁷ Id.

³⁸ Id.

³⁹ Centers for Disease Control and Prevention, National Center for Chronic Disease Prevention and Health Promotion, (2002). *Fact Sheet: "Preventing Dental Cavities."*

the underlying condition. Unsurprisingly, in 2011 repeat visits represented nearly 30% of ED use for dental conditions in Massachusetts.⁴⁰

Dental care is cost-effective and benefits overall health, though it is often unaffordable to many even with full medical coverage. Dental services are the second-highest out-of-pocket health expense after prescription drugs; 42% of adults with oral problems did not see a dentist because they did not have insurance or could not afford the out-of-pocket payments.⁴¹ Unfortunately, skipping needed dental care has negative health implications; poor oral health can negatively impact treatment for cancer, coronary vascular disease, kidney disease, joint replacement, and more, and there is increasing evidence to suggest that the provision of dental care actually lowers overall health care costs.

A number of health insurance companies have piloted medical-dental integration, with remarkable results. Cigna estimates that every dollar spent on preventive dental care could save \$8 to \$50 in restorative and emergency treatments.⁴² According to UnitedHealthcare, even those who are noncompliant with medical care but who receive dental care realize significant savings on overall health care costs.⁴³ United Concordia also found annual medical cost savings ranging from \$1,090 annually for members with coronary heart disease to \$5,681 annually for stroke patients that underwent periodontal treatment and maintenance.⁴⁴ Hospitalizations were also at least 21% lower among patients with chronic disease who underwent dental treatment versus patients with chronic disease without dental intervention.⁴⁵

Through ACOs, there is a significant opportunity to both address the unmet health needs of the Commonwealth while leading in oral health payment reform nationally.

Examples:

- One Care members report the availability of dental care is a significant incentive for enrolling in the program, with 48% of voluntary enrollees describing getting better dental benefits as a primary reason for joining One Care.⁴⁶
- Oregon's Coordinated Care Organizations (CCOs) have a global Medicaid budget and are responsible for coordinating all care, including physical, medical, behavioral, and dental, for

⁴⁰ Division of Health Care Finance and Policy. (2012). *Massachusetts' Emergency Departments and Preventable Adult Oral Health Conditions: Utilization, Impact and Missed Opportunities (2008-2011)*. Boston, MA: Center for Health Information and Analysis.

⁴¹ Government Accountability Office. (2013). *Dental Services: Information on Coverage, Payments and Fee Variation*. Retrieved from <http://www.gao.gov/assets/660/657454.pdf>

⁴² Cigna. (2010). *Improved health and lower medical costs: why good dental care is important [white paper]*. Retrieved from http://www.cigna.com/assets/docs/life-wall-library/Whygooddentalcareisimportant_whitepaper.pdf

⁴³ UnitedHealthcare, Optum, (2013). *Medical Dental Integration Study*. United HealthCare Services, Inc. Retrieved from http://www.uhc.com/content/dam/uhsdotcom/en/Private%20Label%20Administrators/100-12683%20Bridge2Health_Study_Dental_Final.pdf

⁴⁴ Jeffcoat, M.K., Jeffcoat, R.L., Gladkowski, P.A., Bramson, J.B., Blum, J.J. (2014). Impact of Periodontal Therapy on General Health: Evidence from Insurance Data for Five Systemic Conditions, *American Journal of Preventive Medicine*, 47: 174-182.

⁴⁵ Ibid.

⁴⁶ Henry, A., Fishman, J., Gettens, J., Goody, M. and Alsentzer, D. (2015). *Findings from One Care Member Experience Survey: The One Care Early Indicators Project*. Retrieved from <http://www.mass.gov/eohhs/docs/masshealth/onecare/eip-survey-2-report.pdf>

people enrolled in Medicaid or dually eligible for Medicare and Medicaid.⁴⁷ CCOs are specifically required to have formal contractual relationships with dental care organizations in their region. Dental care services are capitated under the current Medicaid managed care program and are part of a CCO's global budget.⁴⁸

- New Jersey ACO gainsharing plans submitted to the Department of Human Services will be evaluated in part on whether a gainsharing plan provides funding for improved access to dental services for high-risk individuals likely to inappropriately access an emergency department and general hospital for untreated dental conditions.⁴⁹
- Hennepin Health in Minnesota is an ACO with advanced integration of dental care, including shared risk and incentives based on performance and outcomes. Recognizing potential cost savings by reducing hospital admissions for dental emergencies, Hennepin Health also created an ED diversion program that connects patients to local dentists.⁵⁰

Incentives for Primary Care and Dental Providers to Integrate Care

As overall health includes oral health, we recommend that oral health be included as a component of routine primary care. Incorporating dental services into ACOs may need to be phased in, but creating opportunities to increase the profile of oral health within the primary care system and decrease overall costs can begin in the early phases of implementation.

ACOs should offer incentives, including adequate reimbursement, for primary care settings to incorporate oral health into routine care. This approach capitalizes on PCP access to individuals as well as primary care's expertise in care coordination and prevention education, and will help ACOs achieve cost-savings.

The Health Resource and Service Administration (HRSA) has identified five core oral health clinical domains and competencies to be incorporated into primary care education and practice:⁵¹

- Risk assessment
- Oral Health Evaluation
- Preventive Intervention (including fluoride varnish)
- Communication and Education
- Interprofessional Collaborative Practice (including structured referrals and, ideally, establishing a dental home)

There should also be appropriate incentives for dental providers to join ACOs, which would in turn help ensure network adequacy and create a new culture of integrated, collaborative care. ACOs should also encourage dental care delivery innovations to help close patient care gaps including medical screenings done in the dental setting and novel integration models such as co-location or virtual

⁴⁷ Robert Wood Johnson Foundation. (2012.) *Medicaid's Pivotal Role in Leading Oregon's Health Care Transformation*. Retrieved from <http://www.rwjf.org/en/library/articles-and-news/2012/04/medicaids-pivotal-role-in-leading-oregons-health-care-transformation.html>

⁴⁸ Vujicic, M and Nasseh, K. (2013). *Accountable Care Organizations Present Key Opportunities for Dental Profession [research brief]*. American Dental Association and the Health Policy Resources Center. Retrieved from http://www.ada.org/~media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0413_2.ashx

⁴⁹ N.J.A.C. 10:79A-1.6(a)(1)(v).

⁵⁰ Edwards, J.N. (2013). Health Care Payment and Delivery Reform in Minnesota Medicaid. *The Commonwealth Fund*. 12:1667.

⁵¹ Health Resources and Services Administration. (2014). *Integration of Oral Health and Primary Care Practices [report]*. Retrieved from <http://www.hrsa.gov/publichealth/clinical/oralhealth/primarycare/integrationoforalhealth.pdf>

integration. New innovations should be developed with the needs of relevant patient populations in mind.

To successfully integrate oral health care, some level of culture change as well as appropriate education and training will be required. ACOs should offer training, resources, and incentives for providers to invest in education and training around oral health integration. In addition, changes to front desk practices can be beneficial to support individuals in establishing a dental home.

Examples:

- Many Patient Centered Medical Homes stress oral health as part of primary care. Other projects integrating oral care into the primary care setting are currently being piloted across the country. In Massachusetts, the Dorchester House Multi Service Center in Boston implemented a medical-dental integration project focused on preventing and treating oral disease in children 0-5 years old. This project included oral health screening, risk assessment, and fluoride varnish application during the PCP visit and connected patients with a timely dental appointment at the Dorchester House Dental clinic.

Dental providers should be included in cross-continuum networks

The cross-continuum networks as described in the proposed criteria #9 and #10 should include dental providers. To overcome the current separation between the medical and dental fields, it is important that ACOs assess the effectiveness of ongoing collaborations and referrals to and from dental providers. Processes should be in place to assess the effectiveness of ongoing collaborations and referrals, which are particularly important for care coordination. As with any other specialty, ACOs should set targets for dental access, and ensure an appropriate breadth and capacity of dental services available, including specialty dental care such as pediatric, periodontic, endodontic, and others.

ACO governance and clinical committees should have representation from oral health clinicians

Dental providers, including dental specialty providers serving diverse populations, should be represented in the ACO governance structure as described under criterion #4. Oral health practitioners, particularly those that serve vulnerable populations, represent an important voice to help ACOs ensure adequate resource allocation to populations commonly left out of the dental care system.

ACO quality committees should address oral health quality and have representation from oral health clinicians

The HPC should work in collaboration with MassHealth to establish a committee or workgroup to identify clinical quality and health outcome measures and decrease disparities in oral health through new delivery system models. In addition, criterion #6 should be amended to require that ACO quality committees have representation from oral health clinicians and be required to consider oral health quality outcomes, including those of special populations, when developing metrics. Metric development should also receive substantial feedback from the oral health provider community. Although payment arrangements may vary among ACOs, it is important that payment be tied to targeted quality metrics so dental providers are properly incentivized to meet quality measures. Establishing these measures will create incentives for dentistry to start thinking about value-based care and help spur innovations in dental care delivery.

Example:

- As part of its CCO legislation, Oregon established a nine-member Metrics and Scoring Committee, charged with identifying objective outcome and quality measures and benchmarks,

including outcome and quality measures for ambulatory care, inpatient care, chemical dependency and mental health treatment, oral health care and all other health services provided by CCOs. The Dental Quality Metrics Workgroup identified five metrics to be implemented, the first, *Sealants on permanent molars for children*, was implemented in July 2015.

- Since May 2015, the Affordable Care Act has required that all commercial insurers reimburse for up to four pediatric fluoride varnish applications per year done in the primary care setting. This could be included as a financing-dependent quality metric for ACOs.

Data sharing and technology integration

Similarly important is ensuring that ACOs set goals for communication and/or data-exchange for all providers. Agreements with dental providers should include specific standards for access and requirements for clinical data sharing. ACOs should encourage providers to invest in infrastructure, including interoperable electronic health records systems. At a minimum, structured referral networks between primary care and dental providers should be established at the ACO level and be bi-directional in nature. This will allow PCPs and dental providers to share important information related to member care and notify providers when a referred appointment has been scheduled. Smart investments in health information technology will greatly help improve care coordination and integrated care.

Population health programs should also include oral health as a program focus

Certain populations, including those with special needs, pregnant women, and children, among others, have high oral health needs. Including oral health as a program focus under criterion #8 would help focus attention on the significant unmet oral health needs of specific populations.

Improving the oral health status of Massachusetts residents will require rethinking the financing of dental care. Although the inclusion of dental is new territory for commercial ACOs, including dental in the ACO structure is a clear opportunity to save money and establish Massachusetts as a leader in the effort to advance whole-person, integrated health care.

Promote care coordination and management

Care coordination should be a core component of all ACOs and is vital to managing an individual's care, reducing fragmentation and improving outcomes. We recommend that all of the care coordination criteria (#23-26), including our following recommendations, be moved from reporting-only to mandatory.

Complex and high-risk members in particular need and will benefit from care management and coordination the most, and attention to these populations will result in the best potential for costs savings and improved health outcomes.⁵² We therefore recommend that the care coordination 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.

As individualized care plans and team-based care are core elements of effective care coordination, we urge the HPC to also emphasize care planning in ACO requirements. ACOs should be encouraged to

⁵² Chawla, R., Colombo, C. et al. (2014). Medical homes and cost and utilization among high-risk patients, *The American Journal of Managed Care*, 20(3), e61-71; Gawande, A. (2011, January 24). The hot spotters: Can we lower medical costs by giving the neediest patients better care? *The New Yorker*, pp. 41-51.

use *shared care plans*, which are jointly maintained and updated by members, family caregivers with member consent, and members of their care team.⁵³ Care management should include the provision of services to create and implement thorough and appropriate treatment plans, including wellness, recovery, and transportation to recommended medical, social, and physical activities, peer assistance, exercise support, food delivery and equipment. ACOs should be required to document in the certification application how they are pursuing a team-based approach to care.

As part of effective care management, ACOs should additionally be required to demonstrate an ability to effectively involve members in care transitions to improve the continuity and quality of care across settings, with case manager follow up; demonstrate an ability to engage and activate members at home to improve self-management, through methods such as home visits or telemedicine; and utilize shared decision-making tools and processes through robust program requirements and quality measures. ACOs should further demonstrate that they have mechanisms in place to conduct member outreach and education on the necessity and benefits of care coordination and chronic disease self-management programs.

Examples:

- Massachusetts community health centers have achieved strong results using these types of services for diabetes patients. The Commonwealth Care Alliance (CCA), an ACO-like provider in Massachusetts, has also succeeded at using a team-based, consumer-directed care approach for individuals with complex medical and behavioral health needs, resulting in improved health and better self-management of chronic illness. Model legislation and other resources on shared decision-making are available from the Informed Medical Decisions Foundation.⁵⁴
- One Care, another ACO-like model for individuals with disabilities, provides examples of successful care coordination resulting in significant improvements in the well-being of participants. The Interdisciplinary Care Team (ICT) ensures that a member's non-medical needs are addressed meeting a continuum of care in the home and the community that supports medical treatments. Assistance with maintaining the home environment, connecting individuals to day habilitation programs, and peer support services have directly reduced emergency room visits and hospitalizations in specific cases.
- CCOs in Oregon must ensure that each member has a stable relationship with a care team that is responsible for providing their primary and preventive care and for comprehensive care management in all settings. The care team must be identified for each member and is responsible for the flow of information with other providers and for conducting patient follow-up. Additionally, Oregon CCOs are explicitly directed to prioritize working with members who have high health care needs, multiple chronic conditions, mental illness, or substance use disorders using individualized care plans to address the needs of each member. CCOs are to ensure that individual members are involved with the process of developing their own individualized care plans and must be able to describe how plans reflect the member or caregiver's preferences and goals.⁵⁵

⁵³ See Consumer Partnership for eHealth. (2013). *Care Plans 2.0: Consumer Principles for Health and Care Planning in an Electronic Environment*. Washington, D.C.: National Partnership for Women & Families. Retrieved from <http://www.nationalpartnership.org/research-library/health-care/HIT/consumer-principles-for-1.pdf>.

⁵⁴ See Informed Medical Decisions Foundation. (2015). *Shared Decision Making Policy*. Boston, MA: Informed Medical Decisions Foundation. Retrieved from <http://www.informedmedicaldecisions.org/shared-decision-making-policy/>

⁵⁵ OAR 410-141-3015(16); OAR 410-141-3014(19); OAR 410-141-3015(17).

Promote the integration of mental health, substance use disorder and behavioral health services with primary care services

We believe that ACOs and other accountable care models should fully integrate mental health and substance use disorder services (referred to henceforth as behavioral health) with primary care services. Many consumers with behavioral health needs face barriers to accessing primary care, including provider stigmatization of persons with mental health diagnoses. At the same time, primary care settings have become the gateway to the behavioral health system, and primary care providers need support and resources to screen and treat individuals with behavioral and other health care needs. There may be more than one model for integrating behavioral and physical health services, including co-located models employed by the ACO or by a partner behavioral health agency and formal partnerships between ACOs and community-based behavioral health providers.

We view integrated health care as a coordinated system that combines medical, behavioral, and oral health services to address the whole person, not just one aspect of his or her condition(s). In this model, with the consent of the member, medical and behavioral health providers partner to coordinate the prevention, diagnosis, treatment, and follow-up of both behavioral and physical conditions; and consumers, behavioral health professionals, peers and family partners are key members of the team. However, physical health care providers may not provide the same quality of care to persons with psychiatric diagnoses as to those without mental health histories.⁵⁶ Therefore, it should be up to the individual enrollee whether and to what extent psychiatric information is shared among his or her physical health care providers. Members will be able to share such information with providers who inspire trust, a necessary element of any health care relationship.

Community-Based Behavioral Health Providers

We believe that the HPC should promote strong clinical partnerships between ACOs and community-based behavioral health care providers. We appreciate that criteria #9 and #10 identify particular providers to address the continuum of services, including behavioral health and LTSS. We believe that the HPC should further encourage ACOs to leverage existing community-based expertise in these areas.

Community-based behavioral health providers have an important role in the integration of physical and behavioral health services for a number of reasons:

- Established roots in the community and existing connections to community-based supports and services, including partnerships with non-medical community resources, translate into improved patient experiences through care coordination.
- Community-based providers can leverage existing partnerships with other providers such as hospitals, community health centers, locally-based physician practices, community action agencies and others.
- Community-based providers have a broad perspective of the health care delivery system and the key role that community services can play in addressing social determinants of health such as housing stability and food security.
- Community-based providers are well-positioned to devote the time and effort to locate and engage members with complex needs, to work with them in their homes and communities, and

⁵⁶ Fendell, S. (2014). The Unintended Results of Payment Reform and Electronic Medical Records, *Journal of Health & Biomedical Law*. 10: 173-200.

to access services and coordinate care with primary care, behavioral health, and other services and supports on a local level.

- Consumers value long-term, trusting relationships with community-based behavioral health providers. Utilizing community-based providers ensures greater continuity of care for patients who already access services in the community. In addition, these established relationships may increase acceptance of primary care services.
- Community-based behavioral health provider organizations deliver care in lower cost community settings.

Structural safeguards – such as requiring ACO governance boards to include community-based behavioral health provider representation – should also be put into place to ensure that these providers are appropriately utilized and that community expertise is preserved.

Recovery Model and Peer Supports

ACOs should approach behavioral health care using the recovery model of care and behavioral health care coordination should include facilitation of socio-economic improvements, such as housing, employment, and access to social supports, that impact recovery.⁵⁷ We fully support the inclusion of criterion #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.

Behavioral health integration requires access to services that help consumers manage their conditions successfully. As such, ACOs should partner with organizations to deliver recovery coaching and peer supports and services provided by peer support workers, certified peer specialists, recovery learning communities, and licensed alcohol and drug counselors. Peer supports provide a unique and important role in the delivery of behavioral health care and can enhance the care that is provided in integrated settings.

Peer support services are delivered by individuals who have common life experiences with the people they are serving. Studies have shown that the use of peers may reduce costs and improve health outcomes, including decreased hospitalizations; improved quality of life; and reduction of the number of major life problems.⁵⁸ Peers also play an important role in increasing access as they have the potential to reach individuals who may not otherwise receive care, especially behavioral health care, and are viewed as more credible by some individuals. The use of peers may also reduce the overall need for behavioral health services over time.

Behavioral Health Services for Children and Youth

Children and youth have specialized needs that are not adequately addressed in a system built for adults. Accountable care models should emphasize prevention and early interventions with children and their families; children also require providers to consult with more “collateral contacts,” such as parents, teachers, and other service providers. ACOs should also focus on prevention and early intervention, with the goal of reducing the need for children and youth to engage in more intensive behavioral health services.

⁵⁷ See SAMHSA materials on Recovery and Recovery Support, available at: <http://www.samhsa.gov/recovery>

⁵⁸ National Coalition for Mental Health Recovery (2014). *Peer Support: Why It Works*. Retrieved from <http://www.ncmhr.org/downloads/References-on-why-peer-support-works-4.16.2014.pdf>

Care coordination is key for behavioral health integration, especially for youth. Quality and performance metrics that are specific to children's behavioral health are essential, especially for children's behavioral health services. Although there is as yet no set of well-developed and validated measures, the Massachusetts Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration grant project awarded in 2010 offers key care coordination measures, including:

- Needs assessment for care coordination;
- Care planning and communication;
- Facilitating care transitions between inpatient and ambulatory settings;
- Connecting with community resources and schools; and
- Transitioning to adult behavioral health care.⁵⁹

We also support comments submitted by the Children's Mental Health Campaign, which provide more detail about ensuring ACOs meet children's behavioral health needs.

Examples:

- With the One Care program, co-located services have resulted in increased recognition of behavioral health needs previously undetected by primary care physicians. It allows for a broader reach to underserved populations that are less likely to seek care from mental health specialists and improves access to services.
- Under statutory requirements, Oregon CCOs are responsible for coordinating the delivery of physical health care, mental health and chemical dependency services, oral health care and covered long-term care services. CCOs must provide fully integrated person-centered care and services designed to offer choice, independence, and dignity across the delivery system. It is further required that the governing board of each CCO include a mental health or chemical dependency treatment provider to ensure the interests of mental health and chemical dependency providers and patients are represented in the decision-making process.⁶⁰
- In New Jersey Medicaid ACOs, the organization's gainsharing plan to be approved by the Department of Human Services will be partly evaluated on whether or not the ACO provides funding for interdisciplinary collaboration between behavioral health and primary care providers for patients with complex care needs likely to inappropriately access emergency department services and general hospital services for preventable conditions.⁶¹
- Twenty-two states provide reimbursement for peer support through their Medicaid programs. Today, MassHealth reimburses for Family Support and Training as part of the Children's Behavioral Health Initiative (CBHI), which provides linkages to community resources and a one-to-one relationship between a Family Partner and a parent or caregiver to help improve the capacity of the parent/caregiver and support youth in the community.⁶²

⁵⁹ Massachusetts CHIPRA Demonstration Grant Measure Development Background and Status. Retrieved from <http://community.nichq.org/sites/default/files/4.%20Measure%20Development%20Workgroup%20Information.pdf>.

⁶⁰ ORS 414.625(1)(e); 410-141-3015(12); ORS 414.625(2)(o)(C)(ii).

⁶¹ N.J.A.C. 10:79A-1.6(a)(1)(iv).

⁶² Executive Office of Health and Human Services. (2012). *Family Support and Training Performance Specifications*. Boston, MA: Executive Office of Health and Human Services. Retrieved from <http://www.mass.gov/eohhs/docs/masshealth/cbhi/ps-family-support-and-training-ps.pdf>.

- The Kaiser Family Foundation compiled a review of behavioral health integration efforts in several states that run the continuum from focus on universal screening and providing care navigators to co-location, health homes, and systems-level integration.⁶³

Ensure access to member-centered long-term services and supports (LTSS)

We believe that people with disabilities and chronic conditions and seniors should have choice, control and access to a full array of quality services, including LTSS, that assure optimal outcomes, such as independence, health and quality of life. We also believe that this portion of our health care delivery system is among the most fragmented and poised for improvement. Massachusetts has made great strides in shifting utilization and spending of long-term services and supports (LTSS) from institutional settings to the community. Preliminary 2015 numbers show that the percent of MassHealth spending on community-based LTSS has risen to 65%, as compared to institutional settings.⁶⁴ Even so, many people still need to put together a patchwork of services to get what they need, and the pieces of their care quilt rarely focus on shared care planning. Importantly, LTSS services must be member-driven and controlled. As such, we request that each member in need of LTSS have access to an independent, conflict-free LTSS coordinator to assess the member's needs and develop a consumer-centered care plan. With the development of accountable care models, the Commonwealth has the opportunity to value person-centered LTSS for members, and to break down life-threatening barriers to care transitions.

We support criteria #9 and #10, which requires ACOs to collaborate with providers across the care continuum, including community-based LTSS and community and social service organizations. Inclusion of LTSS should be based on transparent, documented readiness of ACO entities and community-based LTSS provider organizations. The HPC should look to lessons illustrated by the One Care experience, both from a financing and service delivery point of view. One Care offers evidence about how integrated LTSS can work, and provides direct experience for the development of quality metrics to evaluate these services. All ACOs should be required to create a detailed timeline for integrating community-based LTSS into their system, with consultation from LTSS providers, members who need LTSS and advocates. As with behavioral and oral health, community-based LTSS providers have an important role in the integration of physical, oral and behavioral health services and LTSS.

ACOs must look beyond the medical model of LTSS to address everyday needs that keep people in the community as well as overarching social determinants of health. A 2013 survey conducted by the DPH and University of Massachusetts Medical School found that 85% of respondents with disabilities reported finding affordable housing as a significant health-related need.⁶⁵ Community-based LTSS providers can help members connect to social services for help with non-medical needs that contribute to the overall health, wellbeing and security of members.

⁶³ Nardone, M., Snyder, S., Paradise, J. (2014). *Integrating Physical and Behavioral Healthcare: Promising Medical Models*. Kaiser Family Foundation. Retrieved from <http://kff.org/report-section/integrating-physical-and-behavioral-health-care-promising-medicare-models-issue-brief/>.

⁶⁴ Manatt Health Solutions. (Dec. 2015). *MassHealth Matters II Long-Term Services and Supports (LTSS): Opportunities for MassHealth*. Blue Cross Foundation. Retrieved from http://bluecrossfoundation.org/sites/default/files/download/publication/Manatt_MMPI_ChartPack_FINAL_v05.pdf.

⁶⁵ Massachusetts Department of Public Health. (2013). *Health Needs Assessment of People with Disabilities in Massachusetts, 2013*. UMass Center for Health Policy and Research. Retrieved from http://commed.umassmed.edu/sites/default/files/8504_Health%20Needs%20Assessment%20PWD%20EHS%20Apr%2001-16-2014_0.pdf.

Examples:

- While Medicaid-funded long-term care services are excluded from Oregon's CCO budget, CCOs are required to promote shared accountability with providers of LTSS services for cost, performance and incentives through contractual agreements.
- One Care offers an Independent LTSS Coordinator as part of the member's care team, if the member chooses. The LTSS Coordinators are from community-based organizations independent from health plans.

Ensure adequate access to and appropriate standards for pediatric services

Children have distinct health care needs. The HPC's criteria should ensure that ACOs establish access and quality standards specific to pediatric primary care, behavioral health, oral health, and specialty providers. An ACO established to serve adults will not necessarily have relevant pediatric expertise and capabilities, especially for children and youth with complex conditions.

A major difference between the adult and pediatric populations is the role of the family in the care and health of children. For pediatric patients, the role of the family and home environment can be particularly relevant. As such, there is likely a role for home visiting, which is not a traditional service provided by institutional providers. Strong partnerships with community-based organizations that do provide these services are essential. There are many models for home-based services currently offered to children and families through the Massachusetts Home Visiting Initiative, Children's Behavioral Health Initiative, as well as pilots such as Boston Children's Hospital's Community Asthma Initiative.⁶⁶ These services not only target medical and behavioral health issues, but also bring to light other factors, such as home environment, that are important to the health of children.

Examples:

- Recognizing that children may also receive care in the school setting, Vermont has made Medicaid ACOs responsible for spending on services administered through the department of education as well as spending on care in traditional medical settings.
- Oregon CCOs are encouraged to partner with the Oregon Early Learning Council, the Youth Development Council, school health providers, and others in conducting its Community Health Assessment and subsequent Community Health Improvement Plan. CCOs will be further required, to the extent practicable, to base the Community Health Improvement Plan on research including adverse childhood experiences; evaluate the adequacy of the existing school-based health center network to meet pediatric and adolescent health care needs and make recommendations to improve that system; improve the integration of all services provided to meet the needs of children, adolescents, and families; and address primary care, behavioral and oral health, promotion of health and prevention, and early intervention in the treatment of children and adolescents.⁶⁷

⁶⁶ MA Department of Public Health. (2015). *Massachusetts Home Visiting Initiative*. Executive Office of Health and Human Services. Retrieved from <http://www.mass.gov/eohhs/gov/departments/dph/programs/family-health/home-visiting/the-massachusetts-home-visiting-initiative.html>; MA Department of Public Health. (2015). *Children's Behavioral Health Initiative*. Executive Office of Health and Human Services. Retrieved from <http://www.mass.gov/eohhs/gov/commissions-and-initiatives/cbhi/>; Boston Children's Hospital. (2015). *Community Asthma Initiative*. Boston Children's Hospital. Retrieved from <http://www.childrenshospital.org/centers-and-services/community-asthma-initiative-program>.

⁶⁷ 2014 OR regulation Text 35936 proposed changes to OAR 410-141-3145(9).

Population Health and Prevention

Promote linkages with community-based organizations and active coordination with community resources

Given that many populations face significant social, economic, and environmental barriers beyond their immediate health concerns, it is critical that ACOs support their members with education and assistance with accessing the community resources in their area. We therefore support the requirement in criterion #9 that ACOs must demonstrate and assess effectiveness of ongoing collaborations with and referrals to community/social service organizations as well as other specified providers.

Under this criterion, ACOs should be required to demonstrate the effectiveness on such collaborations and referrals in a number of ways. ACOs should first assess community assets and challenges (e.g., high levels of violence, poor access to healthy food) to better understand community needs and target partnerships/interventions. ACOs should also partner with community resources to exchange member information (with member permission). The community e-referral system being established under the state's SIM grant, for example, provides an opportunity for medical practices to serve their members through a broad array of services that contribute to overall health.

ACOs should further partner with community/social service organizations to integrate those services into the physical, behavioral, and oral health care that is already being provided. This can include promotion of community-based wellness programs and activities that integrate community public health interventions that have an emphasis on the social/environmental determinants of health and include member education and outreach provided by community health workers. Community-based programs can enhance practices' understanding of members' local resources and socio-cultural preferences, gain trust of members and families, and serve as a referral service for much-needed support.

Example:

- Oregon CCOs are required to demonstrate partnerships necessary to allow for access to and coordination with social and support services, including culturally-specific community-based organizations, community-based mental health services, Medicaid-funded long-term care services, and mental health crisis management services.

Support and invest in community-level changes in conditions which drive health outcomes

Prevention and public health are critical to lowering health costs and improving quality. We believe it is necessary for an ACO to look beyond its members to address public health needs of the greater population (e.g., the service area or community where the practice is located). By focusing on the underlying social determinants of health at the community-wide or geographic level, ACOs have an opportunity to work towards truly improving health outcomes and advancing health equity.

As part of this model, ACOs should collaborate with external partners to address community-based drivers of poor health. This will ensure that medical practices and public health agencies work together towards improving health at the individual, delivery system, and community levels.

As a first step, ACOs should perform an assessment of community assets and challenges (e.g., high levels of violence, poor access to healthy food), which can be achieved in part through the data collected via criterion # 31, to better understand community needs and target partnerships/interventions. We also strongly support criterion #15, which requires that the ACO

advance or invest in the population health of one or more communities where it has at least 100 enrollees that accounts for the social determinants of health. In order to effectively impact health and costs, we suggest, however, that ACOs should address population health via these initiatives – either directly or through partnerships – in *all* communities where the ACO serves significant numbers of individuals that suffer from poor health outcomes and/or with documented health needs.

As mentioned above, we further support criterion #8, which requires ACOs to target programs at improving health outcomes for its patient population addressing mental health, addiction, and/or social determinants of health. As part of this criterion, ACOs should describe how the programs address the specific identified needs of social determinants of health for their population. The standards should also require the program to be of sufficient size to address the documented needs.

Example:

- Oregon CCOs are required to participate in a community health assessment process in partnership with their local public health authority and other health and social service agencies to develop a shared community health improvement plan. CCOs are also encouraged to utilize community health workers when appropriate. Under their CMS waiver, Oregon has the ability to use Medicaid dollars for health-related flexible services. In fact, CCOs are encouraged to form partnerships with local housing agencies and public health organizations (e.g. those focusing on obesity prevention or tobacco cessation) to help address the social determinants of health.⁶⁸

Utilization of community health workers

ACOs have the opportunity to promote public and community health through strengthening the role of community health workers in connecting people to care resources and promoting overall health. The 2015 DPH study on community health workers identified several strategies to leverage community health worker skills to strengthen access to care, reduce disparities and lower health costs.⁶⁹ These key front line providers are able to reach people where they are – in their communities and homes – outside the clinical setting, providing a bridge between traditionally underserved populations and needed health information, support, care and social services.⁷⁰

We recommend that criterion #9 be amended to require that ACOs utilize community health workers both through partnerships and within care teams to provide care coordination, wrap-around services and outreach to high risk patients, and engage in population health interventions. ACOs should follow evidence-informed guidelines for the ratio of community health workers and practice-based clinical supervisors for Medicaid and commercial populations.

Example:

- Oregon CCOs are required to provide members with assistance in navigating the health care delivery system and accessing community and social support services including the use of health care interpreters, community health workers, peer wellness specialists, and personal health navigators.⁷¹

⁶⁸ OAR 410-141-3015(8).

⁶⁹ MA Department of Public Health. (2015). *Achieving the Triple Aim: Success With Community Health Workers*. Executive Office of Health and Human Services. Retrieved from www.mass.gov/dph/communityhealthworkers

⁷⁰ See Hostetter, M. and Klein, S. (2015). *Integrating Community Health Workers into Care Teams*. The Commonwealth Fund.

⁷¹ OAR 410-141-30f15(21).

Incentives to reduce racial, ethnic and linguistic health disparities, including incentives to provide culturally and linguistically appropriate care

While racial and ethnic disparities in access to care have decreased significantly since the passage of Chapter 58, access to insurance coverage has not fully solved the problem of access to quality health care for racially and ethnically diverse populations in Massachusetts. In fact, disparities in health outcomes, infant mortality, and rates of chronic disease continue to be prevalent. Commonly identified factors related to health disparities include cultural differences in understandings of the causes of illness, language barriers, implicit bias, lack of patient trust in the health care system, lack of health literacy and poor communication by all parties.

While health disparities involve multiple social, economic, and behavioral factors that impact the distribution of disease and health outcomes, the delivery system can play a key role in addressing disparities. In addition to robust data collection as described above, ACOs should be required to train their providers on cultural competence and make efforts to reduce implicit bias among caregivers. At a minimum, ACOs should be required to comply with the Culturally and Linguistically Appropriate Services (CLAS) standards issued by the HHS Office of Minority Health. The purpose of the CLAS standards is to ensure that all people entering the health care system receive equitable and effective care in a culturally and linguistically appropriate manner. The standards are meant to be inclusive of all populations, but are specifically designed to meet the needs of racially, ethnically, and linguistically diverse populations that experience unequal access to health care services.

Example:

- Oregon CCOs have been directed to focus on these issues by developing strategies to ensure health equity (including interpretive services and promotion of cultural competence) and elimination of avoidable gaps in health care quality and outcomes as measured by gender, race, ethnicity, language, disability, sexual orientation, age, mental health and additions status, geography, and other cultural and socioeconomic factors. They are further required to collect and maintain race, ethnicity, and primary language data for all members on an ongoing basis. CCOs are also required to partner with their local public health authority, hospital system, mental health authority, and Aging and People with Disability field office to conduct a shared community health assessment with a focus on health disparities.⁷²

Financial Incentives and Payment Methodologies

Incentive payments

Under alternative payment methodologies (APMs), providers achieve the greatest financial benefit if costs are effectively managed and quality targets are met. The cost benchmark chosen for the population cared for in an ACO using an APM contract can therefore play a fundamental role in determining whether or not an ACO receives a financial reward for adequately controlling costs. A cost benchmark should provide an incentive to reduce medically unnecessary expenditures through better care coordination, utilization management, and achievement of a healthier population, without creating perverse incentives to stint on necessary care or to avoid particularly complex members in order to meet the defined cost targets. An accurate and realistic cost benchmark will also likely incent providers to take on more complex members. Clinically complex members are likely already diagnosed with the illnesses that make them complex, which makes their costs more predictable.

⁷² OAR 410-141-3015(24)(a); OAR 410-141-3015(24)(c); OAR 410-141-3015(8).

Given these considerations, we recommend that the HPC work with payers and ACOs to encourage quality and cost-based payment incentives for ACOs that prioritize patient quality outcomes as the leading component of payment incentives, so that cost savings are not the sole motivation of provider payment reforms. In particular, we suggest that the HPC take into account the following:

- Set cost benchmarks that promote appropriate cost management but not set unattainable targets or incent under-service or member selection.
- Reward providers for improving cost performance year over year, as opposed to achieving a fixed cost benchmark, as this will minimize pressure on historically lower performers to achieve a benchmark that is unattainable. As providers will take some time to retool their practices, it is also probably unrealistic to expect savings in the first year or two of the program.
- Reward improvements in quality, including outcomes, to encourage practices to invest in care. Providing discrete incentive payments that reward quality improvement, irrespective of whether savings are achieved, will serve as a counter-balance against any incentive to inappropriately reduce costs. If quality measures are not included in the payment formula, providers will have little to incentive to work to improve quality.
- Opportunities to earn savings should be correlated with quality performance. Using a sliding scale to increase the share of savings the ACO receives based on quality performance can incent a pattern of continuous performance improvement.
- Measure ACO quality performance via year over year changes, using members who have been continuously attributed to the ACO during the prior year, to ensure that ACOs are not penalized for accepting new members who may be more challenging to care for.
- Only allow ACOs to share in any savings if they meet threshold performance on quality measures and are not found to have engaged in under-service or member selection.
- Ensure that up-front investment funds are allocated to behavioral health, LTSS, oral health, and community-based organization providers, as well as medical providers.
- To reduce the incentive for providers to under-serve, individual providers and provider groups at the sub-ACO level should not be rewarded based on the portion of savings they individually generate. Instead, individual providers and provider groups should earn a share of savings that the ACO generates which is proportional to their own quality performance and the number of attributed lives on their panel. Rewards should return to the ACO level to reflect the broad community responsible for the savings. This will also help shift incentives to improve coordinated and team-based care.⁷³

In order to align incentives, payment levels should be tied to patient outcomes. “Potentially preventable events” (PPEs) is one valuable measure of outcomes that identifies health care encounters that are potentially avoidable and lead to unnecessary services and poor quality of care. PPEs can never be fully eliminated, and their measurement must include risk adjustments that take into account patient severity of disease and burden of illness, as well as socioeconomic factors (see below). ACOs with lower relative adjusted rates of PPEs – such as avoidable hospitalizations, preventable readmissions, preventable complications, or unnecessary emergency room visits – should be rewarded. The rewards will provide incentives for practices to invest in quality-improving changes that lead to improvements in their patients’ health. These measures should be used in conjunction with effective methods for tracking under-treatment, and with patient-reported outcomes measures, as mentioned above.

⁷³ See footnote 1, supra.

The HPC should require ACOs to report and demonstrate how the entity is implementing payment incentives in order to decrease PPEs and improve outcomes. The reporting should also be transparent and made available to the public.

Example:

- Maryland, New York and Texas are examples of states currently implementing policies that tie Medicaid payments to preventable events, while several other states are considering this.⁷⁴

Flexibility in spending

As noted in prior sections, payers should be encouraged and incentivized to pay for coordination, wellness and prevention services that are not traditionally reimbursed, including: care coordination, group visits, home visits, peer support, transportation to and from medical services, culturally-appropriate interpreter services, member education and outreach provided by community health workers and others, shared decision-making, member transitions support, and other health-related flexible services. The payment system should further support teams that can deliver culturally competent, coordinated preventive and primary care that focuses on the individual's physical, behavioral and oral health.

Risk adjustment should take into account socioeconomic status

Costs of care vary substantially among individuals with similar medical conditions but varying social and economic profiles. If these factors are not taken into account, ACOs will face increased risk from caring for vulnerable or disadvantaged members. Payment adjustments must guard against ACO providers shunning high-risk members or limiting care. We can learn from the One Care program, which has faced challenges in financing because payments were not adequately adjusted to account for the needs of the population being served.

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 culturally and linguistically appropriate services for people who are lower income, homeless, have difficulties with English, are from ethnic and/or minority populations, and for persons with physical, mental, intellectual or sensory impairments. This will require extensive preparation, as these measures are just beginning to become available. We understand that MassHealth is working with UMass Medical School to devise appropriate adjustments. Their work should be shared with the broader community concerned about these issues, and the HPC and MassHealth should work in collaboration to prioritize starting on this path now.

In addition to adjusting payments based on socioeconomic status and other sociodemographic factors, payers should also consider making similar appropriate adjustments to some ACO quality metrics used in payment as well. The decision made by NQF last year to endorse adjusting outcomes measures⁷⁵

⁷⁴ Community Catalyst. (2011). *Smart Payment Reforms Can Reduce Costs and Improve Quality: A Short Primer*. Community Catalyst. Retrieved from http://www.communitycatalyst.org/doc-store/publications/Medicaid_Payment_Reform_Savings.pdf

⁷⁵ National Quality Forum. (2014). *Risk Adjustment for Socioeconomic Status or Other Sociodemographic Factors*. Washington, D.C.: National Quality Forum. Retrieved from http://www.qualityforum.org/Publications/2014/08/Risk_Adjustment_for_Socioeconomic_Status_or_Other_Sociodemog

based on these factors reflects the concern that a provider should not be penalized as a poor performer because it serves more vulnerable patients. For example, a recent study found that Medicare readmission rates varied significantly based on their patient population.⁷⁶ The researchers concluded that “Hospitals serving healthier, more socially advantaged patients may not have to devote any resources to achieving a penalty-free readmission rate, whereas hospitals serving sicker, more socially disadvantaged patients may have to devote considerable resources to avoid a penalty.”⁷⁷

However, these adjustments should only be made to measures that implicate patient characteristics, and should not apply to issues solely under the provider’s control (for example, surgical checklists or hand washing). In addition, unadjusted stratified data should be made available for measuring disparities and targeting quality improvement efforts.

As risk adjustment methodologies that include SES are still evolving, payers should also make supplemental payment adjustments to ACOs enrolling disproportionate numbers of high-need and complex patients in the interim.

We appreciate the opportunity to provide you with our ideas of key features of member-centered delivery models. We know that the HPC has a unique opportunity to drive change throughout the health care delivery system, and are excited at the prospect of those changes resulting in enhanced patient care and improved outcomes. We are eager to collaborate with the HPC to dramatically improve health and health care in Massachusetts. Thank you for your consideration.

Sincerely,



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raphic_Factors.aspx; see also studies collected at <http://essentialhospitals.org/institute/sociodemographic-factors-and-socioeconomic-status-ses-affect-health-outcomes/>

⁷⁶ M. Barnett, J. Hsu, J. M. McWilliams. (2015). Patient Characteristics and Differences in Hospital Readmission Rates. *JAMA Intern Med.* 2015;175(11):1803-1812.

⁷⁷ Id.