Joslin Diabetes Center

**Robert A. Gabbay, MD, PhD, FACP**
Chief Medical Officer and Senior Vice President
Associate Professor of Medicine

One Joslin Place
Boston, MA 02215
www.joslin.org

Phone: 617 309 2470
Fax: 617 309 2574
robert.gabbay@joslin.harvard.edu

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HPC-Certification@state.ma.us

On behalf of the Joslin Diabetes Center (Joslin), I submit the following comments regarding proposed ACO certification standards and associated proposed documentation requirements Even though the Joslin is unlikely to submit an ACO application to the Health Policy Commission, as the leading specialty practice in the Commonwealth focused on diabetes, we offer the following suggestions that we believe are worth inclusion in the final ACO standards. We believe that our suggestions may fall under several criteria found in Table 1 but are linking our comments to specific criteria for ease of consideration. Our comments relate to the following issues.

*3. The ACO governance structure includes a patient or consumer representative. The ACO has a process for ensuring patient representative(s) can meaningfully participate in the ACO governance structure.*

**Consumer Grievance Procedures**

Joslin believes that ACO grievance procedures should provide member safeguards that protect against underutilization of services and inappropriate denials of services if better outcomes are available outside the ACO. ACOs should deliver high quality, high value care that ensures coordination of care and ready access to health care providers, services and community-based resources.

Increased risk levels for losses combined with influence over utilization management shift the balance of incentives enhancing the potential for stinting of care by ACOs. Quality criteria and quality measurement will help control this risk.

*4. The ACO governance structure provides for meaningful participation of primary care, addiction, mental health (including outpatient), and specialist providers.*

**Under Treatment and Member Choice of Providers**

We believe that ACO criteria should exclude the possibility of under treatment for people with chronic conditions. ACO criteria should include mechanisms to assess sufficiency of treatment through periodic measurement of quality provided by comparable providers. Members should not be limited to specialists within an ACO if outcome and quality measures demonstrate that better care is provided outside the ACO. As Chair Altman has indicated in the past and Commissioner Berwick stated at the January 20, 2016 meeting, “people should be able to get the care that helps them”. Additionally, individuals, particularly those with chronic conditions and comorbidities, benefit from continuity of care from both primary and specialty care providers who know them and their medical needs. Member choice should allow members to seek specialized services, including better outcomes that might not exist in an ACO.

Members also should have access to care across the health care continuum, including reasonable access to specialty health care team and facilities.
ACOs should have parameters for contracting with specialty providers outside of the ACO when

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necessary. Getting care from a provider outside the ACO could work similarly to getting care out-of-network from a PPO plan. The provider should be subject to the ACO's payment and coordination requirements, including "most favored nation" clauses, ensuring that unequal payments do not occur among specialists within and outside the ACO providing the same services. No stinting of care should occur because of financial risk reasons.

**No Lock-in Period**

We believe members should be allowed to switch ACOs if they desire. The ACO criteria should not include a consumer lock-in period, which we believe will hurt consumers. If better care is available elsewhere, consumers should be able to access it.

*6. The ACO has a quality committee reporting directly to the ACO board, which regularly reviews and sets goals to improve on clinical quality/health outcomes (including behavioral health), patient/family experience measures, and disparities for different types of providers within the entity (PCPs, specialists, hospitals, post-acute care, etc.).*

**Monitor underutilization**

We believe that underutilization should to be tracked and monitored to avoid the provision of optimum services thereby potentially maximizing savings or avoiding financial losses associated with value-based standards. ACOs should have internal monitoring mechanisms linked to participating provider groups and individual providers. We recommend that payment levels be tied to patient outcomes. In this way incentives are provided for PCPs and specialty practices that result in improved quality outcomes and improved health of ACO patients.

*12. The ACO reports to HPC on NCQA and HPC PCMH recognition rates and levels (e.g., II, III) of its participating primary care providers.*

We suggest that this language consider inclusion of specialty care providers in addition to *primary care providers*. I note that last year Joslin was awarded Level III NCQA certification as a Patient Centered Specialty Practice, the only one in the Commonwealth.
Thank you for the opportunity to submit these comments and we are happy to answer any questions pertaining to them.

Sincerely,

Robert A. Gabbay, MD, PhD
Chief Medical Officer and Senior Vice President, Joslin Diabetes Center
Associate Professor of Medicine, Harvard Medical School