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RAISING THE BAR FOR HEALTH

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Health Policy Commission
Attn: Catherine Harrison
50 Milk Street, 8th Floor
Boston, MA 02119

Re: **Comments on Proposed Accountable Care Organization (ACO) Certification Standards**

Dear Commissioners and Staff:

We are pleased to have this opportunity to contribute input on the task before the Health Policy Commission (HPC): establishing the essential features of a high quality ACO that meaningfully serves the health-related needs of a large and diverse set of patient populations in Massachusetts. The HPC's certification standards are a critical opportunity to assure that risk-related data is collected soundly, and that risk adjustment is undertaken equitably to cover both (a) therapeutic care to disease-overburdened disparities populations, and (b) services provided by a range of allied health professionals who are uniquely equipped to promote primary and secondary prevention within these populations. We note that the HPC's Request for Public Comment poses a crucial question – *how prescriptive should the HPC be*? We believe the standards should be specific, prescriptive, and subject to meaningful verification in order to honor the "A" in ACO.

MLPB's mission is to equip healthcare, public health, and human services teams with legal problem-solving strategies that promote health equity for vulnerable people. We do this by integrating a "low dose" of legal advocates into healthcare teams featuring a "high dose" of allied health professionals (e.g., social workers, case managers, community health workers, etc.) who help patients address health-related social needs (e.g., housing insecurity, food insecurity, unlawful denials of disability benefits and services, etc.). We provide our services on a project-based, contract basis, meaning the bulk of our funding comes from healthcare, public health, and human services entities that understand and support our consumer-centered mission.

Our recommendations to the HPC, below, reflect almost 25 years of experience, including participation in multiple randomized controlled trials that *measure* – and in the case of the one such RCT whose findings have been published, *confirm* – how thoughtful, titrated integration of non-traditional workers into the healthcare team can resolve core challenges in healthcare quality and costs. We have a seasoned, mission-driven lens on the opportunities and challenges that lie ahead in revising current healthcare delivery structures to meaningfully and accountably treat The Whole Patient.

Against this backdrop, we urge the HPC to assure that ACOs are accountable to all patients. And we recommend the HPC require accountability measures derived from research and data from (a) the Massachusetts Department of Public Health (DPH) and (b) community-based organizations (CBOs) that reflect and serve the disparities populations living in the communities to be served by an ACO aspiring to certification. Specifically:

The Proposed Conceptual Framework

- We vigorously support the HPC's frame (articulated on page 3 of the Request for Public Comment) that this effort is about "developing a holistic programmatic framework to [support] a movement toward patient-centered accountable care."
- We are particularly committed to strengthening Theme 5 of the framework, "enhancing patient protection to increase patient access to services, especially for vulnerable populations." We believe this value can be realized by the following adjustments and amplifications to three of the proposed certification criteria:

Criterion #7 Achieving thoughtful risk stratification by disparities populations so that global payment standards serve all populations equitably (preventing cherry picking/lemon dropping) is a *sine qua non* for ACO integrity and success by a range of established measures. Building structured collaboration with DPH and CBOs into certification standards limits these risks by requiring formal interconnection with the rest of a statewide health-promoting infrastructure.

> Recommendation: *Risk stratification processes should require thoughtful incorporation of existing MDPH data regarding health disparities and vulnerabilities, and rigorous, structured consultation with CBOs for the region to be served. It is not sufficient to require written explanation of alternative methodologies the ACO may choose; the HPC certification requirements should require that these two crucial data sources and sets of expertise (DPH and CBOs) populate and animate the risk stratification process.*[1]

Criterion #8 We applaud the attention to mental health and addiction services, and the general reference to social determinants of health (SDOH). However, the HPC should be more prescriptive by requiring the ACO to adopt strategies/programming that address the needs of multiple populations confronting major health disparities; this criterion should not be limited to just one program helping one population.

> Recommendation #1: *We recommend an approach that requires certified ACOs either to (a) develop and provide the needed service within its network or (b) link to the service through structured coordination with other providers in the region thereby affirmatively preventing certain disparities populations from falling between the cracks of ACO "islands." This approach could focus on disparities populations of a designated percentage or numeric threshold within the ACO's geographic catchment area.*
> Recommendation #2*: Whether Criterion #8 stays "as is" or is modified in the way we recommend, it will be important to clarify for ACOs seeking HPC certification if and how Criterion #8 is distinct from a traditional community benefits program obligation.*

Criterion #31 This criterion's focus – conducting needs and preferences assessment across disparities populations, including translation/interpretation needs, and developing plans to address them – is deeply linked to the others noted above.

> Recommendation: *This criterion should be mandatory as it forms the essential foundation on which programs and approaches to addressing disparities will be built. Structured collaboration with DPH and CBOs will exponentially advance this effort, which will build upon the data analysis required by Criterion #7.*

With regard to all three criteria, we are strongly recommending that the HPC endorse a more structured role for the DPH and CBOs that serve disparities populations so that (1) population health and equity-advancing approaches will be part of the scaffolding around which newly HPC-certified ACOs build their programs, and (2) DPH's birds-eye view on population health in the Commonwealth can be leveraged to connect the dots for especially vulnerable disparities populations who experience care gaps – related both to biological health and health-related social needs – by virtue of geography, transportation challenges, lack of access to clinical specialists, inaccessibility of interpreters, and much more.

Leveraging ACO Certification to Promote Prevention and Accelerate Elimination of Health Disparities

We support certification standards – and the resulting work of ACOs – that advance the Commonwealth's commitment to reducing and eliminating health disparities. We have largely focused our comments on the risk stratification/adjustment component of ACO certification – which is key to addressing the "Elephant in the Fruit Bowl" as we see it: unregulated cherry-picking and lemon-dropping in the absence of a more prescriptive set of incentives. Health equity is not advanced if certified ACOs merely negotiate for higher rates of payment to serve an at-risk population that actually develops the disease burden at issue. There must

[1] On Wednesday, January 27, 2016, the Massachusetts House of Representatives voted almost unanimously in favor of *An Act to Eliminate Racial and Ethnic Health Disparities in the Commonwealth*. If enacted, this will create a new office to support the MDPH in cross-secretariat efforts to address social determinants of health and advance cost containment and health equity goals articulated in Ch. 224.

be an incentive for ACOs to help that population do better preventively in order to re-balance the tension between "sick care" and "health care."

A familiar, documented example: Premature delivery and low birth weight is costly. It leads to NICU stays and sometimes life-long chronic disease that could be avoided if full gestation and healthy birth weight were reached. Worse, it can lead to infant mortality. Compared with white women, black women experience much higher rates of premature delivery and low birth weight. This is the case even when factoring in socioeconomic status (e.g. income, education level) and behavior (e.g. smoking, engagement with prenatal care). An HPC-certified ACO should be incentivized to assure holistic, responsive primary care, prenatal care and obstetric care to black women across all income levels on whose pregnancies accumulated experiences of racism have an impact at conscious and unconscious levels (as scientific evidence increasingly confirms).

Relatedly, the proposed certification standards – targeting the commercial market – also have a unique and critical role to play in ensuring that the health needs of the "working poor" (who are not eligible for Medicare or Medicaid) are met. Consider a Spanish-speaking lower-income worker with diabetes living in Boston's exurbs (where the state's housing market is pushing more and more lower-income people), who does backbreaking CNA labor at a local nursing home. If she is not Medicaid-eligible, and if the certified ACO serving "Exurbia" does not provide specialized diabetes care, will she have to find her way to – for example – Boston Medical Center in her unreliable car because she falls into an at-risk population that the commercial ACOs are not incentivized to serve? Will she be lemon-dropped to an institution that, while it may have wonderful preventive care programs, is not geographically accessible for her? Might this lead to loss of vision, amputation, and or kidney failure – avoidable health disparity catastrophes but not necessarily a cost catastrophe for an ACO if it has already negotiated a higher global payment to serve the diabetes "at risk" population of Latinas? It is crucial to ensure this population will not be segregated to inaccessible providers, or worse, shut out of the kind of affirmative preventive care that is one of the hallmarks of ACO transformation.

In Massachusetts, ACOs should be structured to ensure thoughtful risk stratification processes, and comprehensive risk adjustment processes that account for: (a) assuring negotiated global payments that to cover downstream "sick care" as needed, and (b) assuring negotiated global payments that cover upstream "healthcare" such as deployment of community health workers (including doulas and *promotoras de salud)* as culturally appropriate allied health professionals to support pre-conception, pre-natal, and neo-natal care to black women, and to support Latina women confronting Type II diabetes to prevent, or control and even reverse their disease.

In closing, these recommendations reflect on a subset of certification standards challenges on which our colleagues at several sister organizations have commented more broadly. We support the complementary comments submitted by **Health Care for All of Massachusetts** and the **Massachusetts Public Health Association** and urge you to incorporate their recommendations as well into the final certification standards.

Respectfully submitted,

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