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PHILLIP KASSEL
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January 29, 2016

RE: Health Policy Commission
Proposed Accountable Care Organization (ACO) Certification Standards
Request for Public Comment

Dear Commissioners:

I am writing on behalf of the Mental Health Legal Advisors Committee (MHLAC), a state agency providing legal representation to persons with psychiatric challenges. The certification criteria for Accountable Care Organizations (ACOs) will have a significant impact on whether ACOs are a new and improved form of health care delivery or a trip back in time to the discredited managed care organizations of the 1990s. The Health Policy Commission (HPC) proposed set of criteria has strengths for which we are grateful, but certain revisions will heighten the potential that ACOs will improve care for all and avoid the pitfalls of older versions of managed care.

We support the HPC recommendations on innovations in health care delivery, including the use of peer services; criteria reflecting recognition of social determinants of care and that public health initiatives are essential. We also approve of criteria requiring sensitivity to demographic factors in care delivery, such as gender preference and language. However, MHLAC hopes that the HPC will strengthen the certification criteria by including within mandatory requirements:

- patient[1] access to and control over electronic health and medical records:
- free and independent second opinions to support patient appeals of care denials;
- transparency of ACO financial incentives to providers;
- protection of patient choice and continuity of care, and
- inclusion of peer services as part of the required ACO network.

MHLAC also suggests other modifications to proposed criteria to ensure that:

- quality measurements reflect outcomes, not just processes or proxies for outcomes:

[1] "Patient" is used interchangeably with "consumer" throughout this document.

- patients have an adequate and meaningful voice in ACO governance, which requires increased consumer representation,[2] representative access to financial and claims data, as well as ACO operating policies;
- ACO cost reduction comes from actual quality improvements, not just service cuts.[3]

Finally, MHLAC suggests further requirements that will:

- broaden the definition of evidence-based care to encourage the use of promising innovative approaches to health;
- require that network tiering place more weight on quality than on cost,
- facilitate health care delivery that promotes recovery and wellness, not just the treatment of illness (like changing #10's requirement that LTSS contracts reflect categorized approach by severity of need),[4] and
- render all submissions for ACO certification available to the public.

More specifically:

1. *Integration of health care without patient access to and control over electronic health and medical records is likely to harm persons with mental health diagnoses*:

HPC states in the introduction to its proposed ACO certification criteria that it is developing a "holistic programmatic framework," that includes enhancing "patient protection, including increasing patient access to services, especially for vulnerable populations." Persons with psychiatric diagnoses are members of a vulnerable population. We suggest changes in criteria governing electronic health records that will ensure progress toward this laudable goal. These criteria control whether electronic records ultimately improve care or result in inferior care.

a. *Patient control over sharing psychiatric information among providers is essential.*

The HPC is aware that persons with mental illness die on average 25 years earlier than persons without mental illness. Inadequate physical health care is likely responsible for this in significant

[2]A single consumer voice is insufficient. See Experiments 17 and 18, Miligram, S., Obedience to Authority: An Experimental View (Harper Perennial Modern Classics 2009), Asch, S.E., *Opinions and social pressure*, 193 Scientific American, 35–35 (1955), and self-categorization theory generally.

[3] Hospital admission rates, for example, do not necessarily indicate quality improvement. In some cases, it may be preferable to treat a condition aggressively to improve outcomes. Likewise, reductions in imaging may merely prolong the period during which a patient must live in pain while providers explore less costly treatment like physical therapy.

[4] LTSS should be provided to maintain wellness, not just treat acute situations. Therefore, LTSS service criteria should not be based on "severity of need." Payment to LTSS should be based on services rendered and their effectiveness on achieving and maintaining recovery and wellness.

part.[5] It is well established that stigma and bias can result, for example, in the attribution of fatigue caused by a cardiac condition to depression or the pain caused by ovarian cancer to an anxiety disorder.[6] In fact, the leading cause of death among men with mental illness is heart disease and for women, cancer.

Delayed diagnosis of conditions like heart disease and cancer due to diagnostic overshadowing contributes to poor physical health care for persons with mental illness.[7] Lifestyle, poverty, and psychiatric medications themselves may contribute to that statistic, but a key culprit is stigma within the medical profession.[8] Where a psychiatric diagnosis appears in an individual's medical

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[5] See, e.g., *See* BARBARAMAUER, NAT'L ASS'N OF STATEMENTAL HEALTH PROGRAM DIRS.MED. DIRS. COUNCIL, MORBIDITY ANDMORTALITY IN PEOPLEWITH SERIOUSMENTAL ILLNESS 4, 6-7, 11-15 (Joe Parks et al. eds.2006). Sixty percent of premature deaths in persons with serious mental illness are due to "natural causes," the front-runner being cardiovascular disease. *Id.* at 4, 11-15. Persons with serious mental illness have lower rates of cardiovascular procedures compared to the general population for these reasons. *Id.* at 7. In one study of patients presenting with chest pain, for example, only 40% of patients with behavioral or mental health diagnosis were referred for coronary angioplasty. *See* Susan Jeffrey, *Psychiatrists Not Immune to Mental Health Bias*, MEDSCAPE (May 21, 2013), http://www.medscape.com/viewarticle/804499#1. In addition, persons with a serious mental illness and a cardiovascular condition receive about half the number of follow-up interventions, such as bypass surgery or cardiac catheterization, following a heart attack than do normal cardiac patients with no serious mental illness. *See* Juliann Garey, *When Doctors Discriminate*, N.Y. TIMES (Aug. 11, 2013), http://www.nytimes.com/2013/08/11/opinion/sunday/when-doctors discriminate.html?pagewanted=all&_r=0.

[6] *See*, Roy R. Reeves et al., *Unrecognized physical illness prompting psychiatric admission*, 22 ANNALS OF CLINICAL PSYCHIATRY 180, 184 (2010), *available at* https://www.aacp.com/pdf%2F0810%2F0810ACP_Reeves.pdf (concluding physical symptoms of patient with mental-illness history are more likely attributed to psychiatric-illness). In one study, approximately 80% of persons brought to a psychiatric research ward had physical illness requiring treatment that had been undiagnosed by their physicians, more than half of which either caused or greatly exacerbated these patients' psychiatric conditions. R. Hall, *Physical Illness Manifesting as Psychiatric Disease*, 37 ARCH. GEN. PSYCHIATRY 989-95 (Sept. 1980). One hundred patients were intensively evaluated for the presence of unrecognized medical illnesses that might have affected their hospitalization. *Id.* Forty-six percent of these patients suffered from physical, medical illnesses previously undiagnosed by their physician and which physical, medical illnesses either directly caused or greatly exacerbated their psychiatric symptoms. *Id.* An additional 34% of patients were found to be suffering from at least one other undiagnosed physical, medical illness requiring treatment though unrelated to their psychiatric symptoms. *Id. See also*, J.E. Tintinalli, et al., *Emergency Medical Evaluation of Psychiatric Patients,* 23 ANN. EMERGENCYMED., ,859, 859-62 (1994). Eighty percent of those "medically cleared" by emergency department for psychiatric hospitalization an illness should have had a physical illness identified. *Id. See also* R.R. Reeves et al., *Inappropriate Psychiatric Admission of Elderly Patients with Unrecognized Delirium*, 103 SOUTHERNMEDICAL JOURNAL, 111–15 (2010) (finding patients in psychiatric rather than medical units less likely to undergo full diagnostic assessment).

[7] S. Kisely, *et al.,* "Cancer-Related Mortality in People With Mental Illness." 70 JAMA PSYCHIATRY 209 (2013) (Although incidence is no higher than in the general population, psychiatric patients are more likely to have metastases at diagnosis and less likely to receive specialized interventions).

[8] *See generally*, Allison L. Smith & Craig S. Cashwell, *Stigma and Mental Illness: Investigating Attitudes of Mental Health and Non-Mental Health Professionals and Trainees,* 49 J. HUMANISTIC COUNSELING, EDUC. AND DEV. 189, 189-202 (2010); A. Llerena et al., *Schizophrenia stigma among medical and nursing undergraduates*, 17 EUR. PSYCHIATRY 298, 298-99 (2002); H. Rao et al., *A Study*

record, diagnostic overshadowing frequently occurs. One study showed that 45% of PCPs are more willing to consider psychosomatic etiology for patients seen in outpatient psychiatry. In addition, study after study shows that a person's psychiatric diagnosis, in and of itself, can result in inferior treatment of diagnosed conditions.[9] For example:

- physicians are less likely to order tests for severe headache or abdominal pain;
- persons with psychiatric diagnoses are less likely to receive adequate care once diagnosed with pancreatic cancer;[10] and
- diabetes care is typically deficient – essential basic tests are often skipped.[11]

HIPPA does not require patient consent to share psychiatric diagnoses, medications, providers, treatments, and evaluations among treating providers.[12] In light of the documented potential that medical treatment might be compromised,[13] patients should have the ability to control release of their psychiatric information to health care providers.[14] The argument that sharing information

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of Stigmatized Attitudes Towards People with Mental Health Problems Among Health Professionals, 16 J. OF PSYCHIATRIC AND MENTAL HEALTH NURSING 279, 279-84 (2009); M. Hugo, *Mental Health Professionals' Attitudes Towards People Who Have Experienced a Mental Health Disorder,* J. OF PSYCHIATRIC AND MENTAL HEALTH NURSING, 419, 419-25 (2001); S. Jeffery, *Psychiatrists Not Immune to Mental Health Bias,* Medscape (May 21, 2013)(report on inferior physical health care delivered to persons with serious mental illness delivered as Abstract NR12-12, American Psychiatric Association's 2013 Annual Meeting) .

[9] Among all physicians who said bias affected treatment, 72% said that emotional problems had a negative effect on treatment. C. Peckham, Medscape Psychiatry Lifestyle Report 2016: Bias and Burnout 2016, Slide 7, available at http://www.medscape.com/features/slideshow/lifestyle/2016/psychiatry.

[10] Casey A. Boyd et al., *The effect of depression on stage at diagnosis, treatment, and survival in pancreatic adenocarcinoma*, 152 SURGERY 403–413 (2012) (national, population-based study shows that pre-existing depression in patients with pancreatic cancer is associated with advanced stage at diagnosis, decreased likelihood of receiving adequate treatment, and poor survival).

[11] *See* Graham Thornicroft et al., *Discrimination in Health Care Against People with Mental Illness,* 19 INT'L REV. PSYCHIATRY 113 (2007). "There is strong evidence that people with a diagnosis of mental illness, for example, have less access to primary health care and also receive inferior care for diabetes and heart attacks. . . ." (*citations omitted*). *Id.* at 118.

[12] *See* 45 C.F.R. §§ 164.102 – 164.106 (2013) (defining security and privacy); 45 C.F.R. §§ 164.500 – 164.532 (2013) (regulating protected information).

[13] See, e.g., Mark Graber et al., *Effect of a Patient's Psychiatric History on Physicians' Estimation of Probability of Disease*, 15 J. GEN. INTERN,MED. 204 (2000) (survey of 300 family physicians determined that "past psychiatric history influencesphysicians' estimation of disease presence and willingness to order tests.").

[14] In addition, persons may withhold information or avoid care, with ill effects on controlling costs and on research to improve care, if they are unable to control the distribution of sensitive information. *Ensure "Meaningful Use" by Giving Consumers Control*, CONSUMER ACTION (June 2009), http://www.privacy-information.org/articles/ensure_meaningful_use_by_giving_consumers_control_over_their_health_information. Teens especially are concerned with privacy. Kenneth Ginsburg, *Earning a Teenager's Trust* (April 1, 2013), *available at* http://www.medscape.com/viewarticle/781366. The willingness of teens to seek and stay in care, as well as disclose sensitive information increases significantly with assurances of confidentiality. Carol A. Ford, et al., *Influence of Physician Confidentiality Assurances on Adolescents'*

will promote the elimination of stigma is not coherent or grounded in any research or even logic. Until the wonderful day when stigma is a thing of the past, our emphasis must be to mitigate the serious harm that results from discrimination. Therefore, please add a new section that requires ACOs to develop and report on plans to provide patient control over the sharing of their psychiatric information with other providers.

b. *Patient access to all records is necessary to correct errors and eliminate stigma.*

MHLAC also recommends that patients be given full and complete access to all their medical records, including psychiatric records, through a patient portal or other means. The error rate of electronic medical records is extremely high. Both accurate and erroneous information is more easily shared when it is stored and transmitted electronically, which heightens the need for a check on damaging dissemination of false information. Patients that have ready access to electronic medical records can serve this function.[15] This benefits patients, of course, but also makes it more likely that providers will have good information with which to work.

Patient access also will also begin to erode the tendency, documented in research, for mental health care providers to stigmatize their own patients. Patient access to "Open Notes" will obviously deters providers from drafting unduly judgmental or stereotyping therapy summaries. Mental health clinicians, as well as other health care providers, will be driven to consider and better perceive how their thoughts will appear to their patients. This eventually will change the way they actually regard those entrusted to their care, as perceptions become less attached to stereotype.[16]

Willingness to Disclose Information and Seek Future Health Care, 278 J. AM. MED. ASSOC. 1029 (1997). *See also,* Debra J. Rickwood, et al., *When and how do young people seek professional help for mental health problems?*, 187 MED. J. AUSTL. S35 (2007) "Confidentiality remains of utmost importance when engaging young people, and this is particularly important in the context of accessing alcohol and other drug services." *Id.* at S57.

[15] *Ensure "Meaningful Use" by Giving Consumers Control*, CONSUMER ACTION (June 2009), http://www.privacy-information.org/articles/ensure_meaningful_use_by_giving_consumers_control_over_their_health_inform.

[16] Working as colleagues with persons with lived experience of psychiatric challenges is also effective in eliminating psychiatric bias. P. Solomon. *Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients.* PRJ Spring 27.4(4) (2004). See also, A. Llerena, M. Caceres, and E. Penas-LLedo. *Schizophrenia stigma among medical and nursing undergraduates*. EUR PSYCHIATRY 2002; 17: 298-9;S. Williams, *A person, not a patient: Words about the words we use*, MinnPost (Nov. 22, 2013), https://www.minnpost.com/mental-health-addiction/2013/11/person-not-patient-words-about-words-we-use (last accessed Jan. 27, 2016) (quoting Professor Patrick Corrigan, director of the National Consortium on Stigma and Empowerment). "The best way to change stigma is contact…meeting people with serious mental illness, finding out that recovery is the rule and that they're people like everyone else." Sensitivity training for health care professionals is unlikely to be effective. J. Horsfall, M. Cleary, and G. Hunt. *Stigma in Mental Health: Clients and Professionals,*31 ISSUES IN MENTAL HEALTH NURSING 450 (2010); P. Corrigan and B. Gelb. *Three Programs That Use Mass Approached to Challenge the Stigma of Mental Illness.* PSYCHIATRIC SERVICES (March 2006), 57(3); M. Kolodziej and B. Johnson. *Interpersonal Contact and Acceptance of Persons with Psychiatric Disorders: A research*

Unfortunately, persons do not have an automatic right to their mental health records under current law, which will permits withholding records due to patent paternalism.[17] But the HPC criteria can be more restrictive of providers' right to withhold records and, by so doing, improve care and reduce stigma. In fact, entities piloting "Open Notes" report positive experiences.[18] Participating doctors have not tended to withdraw.[19]

2. *A meaningful appeal process must include a free and independent second opinion.*

Procedural protections for persons denied serves by ACOs ought to be highly protective. Unlike in a fee-for-service setting, physicians associated with an ACO may have a financial incentive to deny care or direct the individual to services that, while less effective, are less costly.[20] It is therefore imperative that patients have access to an independent and free second opinion to support appeals. Without a supporting medical opinion, a layperson has little or no chance of prevailing in any internal or external appeal process. Further, the prospect of independent scrutiny itself will deter inappropriate service denials and reduce the need for second opinions and the incidence of appeals.

As a further check on financially motivated care denials, the HPC should collaborate with the Office of Patient Protection (OPP) to create an ombuds program that can gather information as well as advocate on behalf of ACO members. In order to keep track of negative trends in care provision, the OPP should publicly report on an annual basis the number and types of internal and external grievances and appeals filed with each ACO, as well as if and how they were resolved.

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synthesis, 64 JOURNAL OF CONSULTING AND CLINICAL PSYCHOLOGY 1387 (1996). *See also*, T. Pettigrew and L. Tropp. *How does intergroup contact reduce prejudice? Meta-analytic tests of three mediators.* EUR. J. SOC. PSYCHOL. 38, 922-934 (2008)(also suggesting that reduced anxiety resulting from intergroup contact may be a prerequisite to increased knowledge of and empathy for the stigmatized population).

[17] Health and Human Services recently published guidelines concerning patient access to medical records. They state that access may only be denied if it is "reasonably likely to endanger the life or physical safety of the individual or another person." This standard ought to be "narrowly construed." http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html (last accessed Jan. 21, 2016) "General concerns" about patients' reactions to data (e.g. they "will not be able to understand the information or may be upset") are insufficient, as is the "mere possibility" of harm. *Id.* HPC's criteria should require ACO's to comply with these guidelines.

[18] Kahn, *et al.*, *Let's Show Patients Their Mental Health Records,* 311 J. AMER.MED.ASSOC. 1291 (2014).

[19] *See generally,* OPEN NOTES, www.myopennotes.org (last visited April 7, 2015).

[20] Current OPP appeal procedures were formulated in an environment where insurers were the entity denying physician-requested services and physicians were natural allies of their patients. Given that physicians will now have some of the same financial interests as insurers and will be in the position of denying services, it is imperative that appeal procedures be even more protective of patients.

3. *Provider and provider group financial incentives must be transparent to patients.*

The presumption that financial incentives drive treatment decisions is the basis for payment reform. Elemental fairness dictates that patients have a right to know how their treatment may be affected by these incentives. They therefore should be privy to the criteria used to determine incentive payments as well as shared savings, and the relative influence of each criterion on provider and/or provider group income.

4. *Patient choice and continuity of care must be protected to ensure patient engagement and enhance care quality.*

Continuity of care and the therapeutic relationship are fundamental to effective mental health care. The criteria should include more specific requirements to ensure continuity of care against disruption caused by inflexible choice of provider rules, including how consumers can access providers outside of an ACO network. More specifically, ACOs should be mandated:

- To allow patients to continue treatment with an existing provider at the co-pay rate for an in-network, preferred provider;
- To enter into single-case out-of-network agreements at in-network rates if:
    - an individual is in a course of treatment with a provider,
    - network providers do not have the same level of expertise, specialization, or cultural and/or linguistic appropriateness as the requested out-of-network provider, or
    - a network provider is not readily available or is otherwise geographically or temporally inaccessible.

These rules could be added to criterion # 9 (collaboration with a continuum of providers and organizations) or included as separate criteria.

5. *Include peer services in ACO care coverage.*

Though these services are highly effective, some insurers and provider groups have been slow to employ certified peer specialists and peer respites. The lack of investment in peer services has led to a shortage of these vital resources.[21] Without mandatory criteria, we can expect ACOs to continue to ignore the potential benefits of peer services, to the detriment of patients, the availability of peer services themselves, and the success of health care reform.

[21] For example, there is only one peer-run respite, Afiya, in Massachusetts. http://www.westernmassrlc.org/afiya (last accessed Jan. 28, 2016).

6. *Quality measures should reflect outcomes and include PROMs.*

Quality measures should look at outcomes, not processes, to avoid perverse results.[22] Pay for performance incentives are problematic because of the potential impact on outcomes or processes that are not incentivized.[23] In addition, processes may be incentivized unnecessarily because they are already being incorporated in the standard of care, or[24] be counterproductive because they motivate "cherry picking" of patients. [25,26] Processes are otherwise subject to

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[22] Process incentives are often ineffective and unrelated to quality of care. "The process-outcome relationship has been inconsistent in numerous heath care settings." R. Werner, *Quality Improvement under Nursing Home Compare: The Association between Changes in Process and Outcome Measures*, 51 *MED. CARE. 582 (2013); see also*, Ryan, *Effects of the Premier Hospital Quality Incentive Demonstration on Medicare Patient Mortality and Cost*, 44 HEALTH SERV. RES. 821 (2009) (process incentives reduced neither mortality nor cost); B. Reames, *et al.*, *Evaluation of the Effectiveness of a Surgical Checklist in Medicare Patients*, 53 MED. CARE 87 (2015) (no decrease in mortality or costs from use of surgical checklist); T. Shih, *et al.*, *Does Pay-for-Performance Improve Surgical Outcomes? An Evaluation of Phase 2 of the Premier Hospital Quality Incentive Demonstration*, 259 ANN. SURG. 677 (2014) (redesigned pay for performance did not improve surgery outcomes).

[23] *See* Stephen J. Gillam, et al., *Pay-for-Performance in the United Kingdom: Impact of the Quality and Outcomes Framework: A Systematic Review*, 10 ANN FAM MED. 461, 463 (2012). A recent study found that achievement for conditions outside the incentive worsened relative to those within, and that the person-centered nature of the care and continuity of care generally suffered. *Id.* One study of pay for performance with primary care providers in England found that while the payments accelerated improvements in quality for two of the three chronic conditions targeted, the rate of improvement soon slowed and the quality of non-incentivized care actually declined. Campbell et al., *Effects of Pay for Performance on the Quality of Primary Care in England*, 361 New Eng. J. Med. 368 (2009). *See also Health Policy Brief: Pay-for-Performance*, HEALTH AFFAIRS (Oct. 11, 2012), http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=78 (describing limited effect of pay-for-performance on quality improvements and concerns about its use).

[24] "Evidence suggests that quality for some aspects of care was already improving before 2004, and could have been approaching its achievable limit in affluent areas, which would mean that the incentive scheme was introduced at a time when inequalities had already peaked." *See* T. Doran, et al., *Effect of financial incentives on inequalities in the delivery of primary clinical care in England: analysis of clinical activity indicators for the quality and outcomes framework*, 372 LANCET 728-736 (2008). The evidence regarding quality improvements is mixed, with some studies showing financial incentives neither lower nor improve quality of care. *See id.*

[25] Jeffrey S. Berns, M.D., *P-4-P and Dialysis Centers: A Look Beyond URR*, (Jan. 30, 2012), *available at* http://www.medscape.com/viewarticle/757433, *citing* N. Tangri et al., *Both Patient and Facility Contribute to Achieving the Centers for Medicare and Medicaid Services' Pay-for-Performance Target for Dialysis Adequacy,* 22 J. AM. SOC. NEPHROL. 2296-2302 (2011). Performance-based funding can either be renewed or increased if levels of performance increase, however funding can be decreased or terminated as a result of lower levels of performance. *Id.* Outcomes are therefore highly dependent upon patient mix. *Id.* For example, ninety percent of the variability in hemodialysis units' ability to meet quality goals could be explained by patient mix. *Id. See also,* U. Pape, et al., *Impact of 'Stretch' Targets for Cardiovascular Disease Management within a Local Pay-for-Performance Programme*, PLoS ONE 10(3):e0119185, doi:10.1371/journal.pone.0119185 (2015)(In an incentive arrangement where practices could exclude "inappropriate patients" from the target population, achievement of higher payment

manipulation. For example, admissions to hospitals can be reduced, even when it is medically necessary, by treating them as observation holds.

While we support criterion #14, which requires ACOs to conduct an annual survey to evaluate patient and family experiences and deploy plans to address identified deficiencies, the criteria should mandate use of the most promising system for measuring quality: "Patient Reported Outcome Measures" (PROMs), which rely on patients as the best source of information on the impact of care on health. The methodology should be holistic, measuring wellness (e.g., work, social functioning, housing), and not merely the cessation of acute symptoms.

7. *Increased patient representation*[27] *and access to relevant data are necessary for meaningful consumer participation in ACO governance.*[28]

A single patient representative on ACO governing bodies is inadequate. A single layperson cannot be reasonably expected to resist the pressure to conform to professionals' views. If consumers are truly to have a voice on governing Boards, representatives need the support of another consumer. Therefore, at least two patients should be represented on the ACO governing board.[29]

The interests of patients and family members are not always the same. This is particularly true for persons with lived experience of psychiatric challenges. Family member representation should not be considered a replacement for patient representation Further, the interests of persons with psychiatric challenges are unique. A patient with lived experience should be included in ACO governance.

To have an adequate and meaningful voice, patient representatives, as well as the rest of the membership of the governing body, must be provided access to critical information such as redacted claims, complaint and appeals data, as well as protocols and other policies that reflect

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thresholds in the pay for performance scheme was mainly attributed to increased exclusion of certain patients with no discernable improvements in overall clinical quality.)

[26] Given the strong influence of the patient population on the ability to earn any performance incentives, including shared savings (particularly if risk adjustments do not capture relevant population characteristics), concerns arise about cherry-picking of patients. J. Berns, *supra at__*. If quality goals are tied to patient mix, providers will avoid those patients who would diminish their ability to enhance the providers' finances. *Id.* See L. Page, *Why 'Cherry-Picking' Patients Is Gaining Ground,* Medscape, Dec. 19, 2013.

[27] Patient representatives include consumer advocacy groups, albeit not groups primarily representing family members. As noted below, people with lived experience should be included on the governance body.

[28] The recommendations in this section are all applicable to the formation and functioning of a Patient/Family Advisory Council. MHLAC supports the formation of a Patient and Family Advisory Council (Criterion #5), but does not see it as a substitution for patient representation on a governing body that has actual authority to make decisions about ACO operations.

[29] See Experiments 17 and 18, Miligram, S., Obedience to Authority: An Experimental View (Harper Perennial Modern Classics 2009), Asch, S.E., *Opinions and social pressure*, 193 Scientific American, 35–35 (1955), and self-categorization theory generally.

the actual operations of the ACO. Concerns about proprietary information should not form an excuse to withhold information from an ACO governing body. Genuine concerns can be addressed with confidentiality agreements.

8. *Quality, not cost alone, must drive health care savings.*

As noted, ACOs, like managed care entities, have an incentive to reduce costs and increase profits by denying services. Not all denials of service result in ironic consequences (preventable high cost procedures or hospitalization). Denials may merely cruelly increase patients' pain and suffering.[30] To safeguard members of groups that have historically suffered disparately from care denials (e.g., persons with psychiatric diagnoses, racial minorities, and low income persons) under-service and underutilization should be tracked and monitored through both concurrent and retrospective methodologies, using annual claims data and PROMs results. Further, uniformity of data reporting across ACOs would facilitate the discovery of and distribution of best practices. These suggestions could be a separate criterion or included under criterion # 13 (analytic capacity).

9. *The definition of "evidence-based" care should be broadened to include new services and treatments that show promise.*

Capitation and other alternative payment arrangements can actually impede the adoption of quality improvements. ACOs may be fearful of adopting innovations, such as peer and supportive services, as well as assistance with housing and work, until they are the routine standard of care and definitively proven to reduce cost.[31] If we are to achieve the best results from payment reform, we must approach health care in a new manner. If ACOs merely perpetuate the medical model of care,[32] little good will be achieved by shifting financial incentives. The HPC should make it clear that reliance on "evidence-based" care is not an excuse to deny potentially cost-effective services that could assist in an individual's recovery and maintenance of wellness.[33]

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[30] See generally, S. Fendell, The Unintended Results of Payment Reform and Electronic Health Records, 10 J. Health & Biomed. L. 173 (2014).

[31] Scott Gottlieb, *Accountable Care Organizations: The End of Innovation in Medicine?* AM. ENTER. INST. FOR PUB. POLICY RESEARCH, Health Policy Outlook No. 3 (Feb. 2011), *available at* http://www.aei.org/files/2011/02/16/HPO-2011-03-g.pdf.

[32] For a definition of the medical model of care, see Wikipedia, https://en.wikipedia.org/wiki/Medical_model (last accessed Jan. 28, 2016).

[33] For example, animal-assisted treatment has a growing body of evidence that it is a useful tool in recovery and wellness. J. Andraka, *Paws with a Purpose: Evidence Supporting the Use of Animal-Assisted Treatment to Improve Quality of Life in Adults with Psychiatric Diagnoses* (Thomas Jefferson Univ. 2013), http://jdc.jefferson.edu/createday/8/ (last accessed Jan. 28, 2016) (pdf link at bottom of page contains two pages of cites to studies on animal-assisted treatment).

10. *Tiering of providers should place more weight on quality than on cost.*

Tiering of providers[34] fundamentally affects quality of and access to care. If the attribution of providers to a preferred category is primarily based on cost and not quality, patients will be steered to providers who are less likely to achieve the improvements in health care we all desire. Further, making high quality providers unaffordable limits access to quality care, and in some instances where specialists are in short supply, limits access to any timely care.

In addition to Criteria 24, we suggest that ACO certification criteria require that the weight given to quality significantly outweigh that given to cost, and that the tiering process be transparent. Patients have a direct interest in knowing how providers are tiered as their copays will vary based on provider tiering. Such information could affect an individual's desire to associate with a particular ACO.

11. All submissions for ACO certification should be available to the public.

MHLAC strongly supports public access to certification applications and supporting documents, including the financial arrangements ACOs make with each provider. Prospective patients, researchers, and policy analysts all have a stake in the details of ACO operations. The broader the audience, the more likely that best practices – including best systems and managerial practices – will be ascertained, replicated, and improve the quality of health care delivery.

In conclusion, we appreciate HPC's attention to social determinants of care, public health initiatives, and peer services. We hope that you will consider our suggestions for additions and revisions closely. MHLAC looks forward to working with you toward the goal of better quality care for all.

Sincerely,

Susan Fendell
Senior Attorney

[34] Co-pays for preferred providers are lower than for non-preferred providers.