NEW ENGLAND COLLEGE OF OPTOMETRY

Clifford Scott, OD, MPH
President

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

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

Dear Chairman Altman and Director Seltz,

On behalf of the New England College of Optometry ("NECO"), we are writing to submit comments relative to the Health Policy Commission's ("HPC's") proposed Accountable Care Organization ("ACO") Certification Standards. NECO has been educating optometrists in Massachusetts for over a century and is acutely aware of the importance of vision screenings, comprehensive eye exams and corrective treatment in children, patients with behavioral health concerns and intellectual or physical disabilities. Optometrists can and will play a key role in ACOs by working to contain costs through the provision of high-value health services as part of a care coordination team. To that end, NECO offers the following recommendations:

Mandatory Criterion #4. Meaningful participation of providers requires ACO inclusion of a comprehensive range of provider types *and* a variety of practice locations and settings.

(1) While meaningful participation of specialty providers on an ACOs governance structure is important, it is absolutely critical for there to be meaningful participation of different provider types in the actual delivery of ACO services to members. Different provider license types can offer an ACO and its members opportunities for increased efficiencies and lower costs. To that end, NECO recommends that the HPC require ACOs to ensure that its members can receive services from a range of provider license types.

(2) The ACO model requires providers to coordinate and collaborate under one virtual roof, however, extra caution should be taken to prevent an ACO's providers from being clustered or organized under only one actual roof. Patients are served best if they can receive care in their communities and outside of the hospital setting, where possible – especially for routine and/or preventative care. The ACO's governing structure should have a clear responsibility for determining that there is meaningful representation of providers delivering services in different types of care settings, sufficient to meet the members' needs.

Reporting Only Criterion #24. The HPC should confirm that ACOs have an established and uniform process for the addition of providers to its network.

(1) To ensure that the ACO's process for identifying "preferred providers" is equitable, the ACO must establish a uniform pathway for providers to apply and set of criteria for providers to be evaluated for "preferred provider" status. At this early stage, however, the HPC should first define "preferred provider".[1] Once defined, the HPC should clarify to ACOs that other provider-types (or independent providers) are not to be patently excluded due to their license or practice type.[2] The pathway for a provider to obtain the designation of "preferred provider" should be open to any provider type rendering services available under the ACO and should not rely on hospital affiliations. This is especially important for independent non-MD practitioners, such as optometrists, who would not automatically be swept into an ACO model as a result of a hospital or other clinical affiliation.

(2) As well, the HPC should emphasize that ACOs increase the use of providers in the patient's community, as appropriate, for vision health and eye care, as these services present care coordination opportunities for all patient populations. Comprehensive eye exams are included as an essential health benefit for all ages.[3] Such exams often reveal latent health issues, such as early stage disease, but can also play a role in chronic care management in diseases such as diabetes. In fact, it is part of the standard of care for diabetic patients to have annual comprehensive eye exams. In children, vision screenings produce information that helps to rule out behavioral health or developmental issues – often all that is needed is a pair of corrective lenses. In the elderly, regular vision health and eye care can work well to address balance troubles and prevent falls. These optometric preventative and management services are often available in the patient's community and can help to save on health care costs that would otherwise result if not identified and addressed early on. NECO encourages the HPC to increase the use of providers providing vision health and eye care services in the patients' communities in addition to the other specialty preferred providers mentioned in criterion #24.

(3) Finally, ACOs should have a clear, uniform process in place that individuals may use to be recognized as ACO providers (despite not necessarily receiving the designation of "preferred-provider"). Because care coordination is a critical priority for the HPC and its ACO models, the ACO must have a method for coordinating care with "non-preferred" providers.

Mandatory Criterion #9. ACOs must maintain robust and diverse provider networks to ensure ongoing collaborations and provide a cross continuum of care for patients.

In order for an ACO to demonstrate that it has ongoing collaborations and a true cross continuum network, the ACO must demonstrate relationships with a broad range of provider types, practicing in a variety of settings. Only robust provider networks will provide for the cross continuum of care sought by the ACO Certification program. An ACO with a mechanism in place for coordinating care and services even if rendered by providers outside of the ACO should be considered to have an effective collaborative network. Effective collaboration requires flexible and robust provider networks. Patients that are attributed to the ACO

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[1] At this time, it is unclear whether "providers" are individuals (i.e. Dr. John Doe, OD), entities (i.e. a provider organization), or simply different provider-license types (i.e. ophthalmologist v. optometrist).

[2] See Mass. General Laws ch. 176D, Section 3A, which provides that selecting or contracting with a health care facility or provider not based primarily on cost, availability and quality of covered services is an unfair method of competition and unfair or deceptive act or practice.

[3] Massachusetts' Essential Health Benefits ("EHB") Benchmark Plan includes a comprehensive eye exam every 24 months for adults and every 12 months for children. (See CMS's Summary of Massachusetts 2017 EHB Benchmark Plan, available at https://www.cms.gov/CCIIO/Resources/Data-Resources/ehb.html).

will have to go outside the ACO to receive care from time to time, whether due to a lack of available providers for a given service, a geographical limitation or other emergency situation.

Thank you for considering these recommendations. The New England College of Optometry continues to offer itself as a resource to the HPC on all matters concerning vision health and eye care. Please do not hesitate to contact either of us if you have any questions.

Sincerely,

Clifford Scott, OD, MPH
President

Gary Chu, OD, MPH
Director, Community Collaborations