
Planned Parenthood League of Massachusetts

Health Policy Commission
ACO Certification Standards Comments
29 January 2016

Planned Parenthood League of Massachusetts (PPLM) plays an important role in the Commonwealth's health care delivery system, serving as the largest freestanding reproductive health care provider and advocate in the state. Each year, PPLM provides sexual and reproductive health care to more than 30,000 patients. This includes a wide range of preventive health care services including lifesaving cancer screenings, birth control, testing and treatment for sexually transmitted infections (STIs) as well as abortion services. For 88 years, PPLM has protected and promoted sexual and reproductive health and rights through clinical services, education and advocacy. PPLM's promise to its patients is: Care, no matter what.

PPLM looks forward to working with the Health Policy Commission (HPC), MassHealth and EOHHS to ensure transformation efforts in Massachusetts consider the distinct health care needs of women. This priority has far-ranging cost and quality impacts even for young, healthy women where, for example, labor and delivery is one of the largest categories of spending for MassHealth and many commercial health plans.

PPLM is pleased to see the level of stakeholder and expert engagement in the development of Accountable Care Organization (ACO) standards and MassHealth ACOs and urges HPC to consider three things:

1. Encouraging ACOs to partner with a range of outpatient providers, including those that provide population-specific primary preventive care.
2. Adopting metrics that reflect high-quality sexual and reproductive health care.
3. Designing savings models that incorporate prevention and population health.

Ensure women's access to care by promoting meaningful participation of women's health providers in new models.

Massachusetts General Laws Ch. 224 Section 15(c)(3)(2012), authorizing establishment of ACO standards beyond minimum statutory requirements, directs policymakers to "ensure patient access to health care services across the care continuum, including, but not limited to, access to ... obstetrics and gynecology services ... [and] family planning services." As health care transformation proceeds, we believe that ensuring access to these basic women's health care services will require robust availability of women's health providers. Almost 6 in 10 women (58 percent) report seeing an OB/GYN provider on a regular basis and one-third of women (35 percent) view their OB/GYN provider as their main source of care. For many women (4 in 10), an OB/GYN provider is the first provider they choose as an adult.¹ Women trust OB/GYN providers to play an important role in their entire adult life – not only providing birth control and cancer screenings but also information on proper exercise, healthy nutrition, preventive care, and navigating the broader health care system.

¹ PerryUndem Research & Communication. "Women & OB/GYN providers". Research conducted for Planned Parenthood Federation of America, November 2013.

We believe that flexibility in ACO design and development will be key to ensuring these services are robustly available to all women in Massachusetts, and are encouraged that the draft certification standards would allow a range of configurations and participating providers in ACOs. We would like to see a final version that more concretely articulates a role for women's health providers, as they are critical to providing access to preventive services and can play a key part in care coordination strategies for women of reproductive age. Below are more specific comments and suggestions:

Governance (No. 4). The draft calls for “meaningful participation of primary care, addiction, mental health (including outpatient), and specialist providers.” We strongly recommend a criterion that specifically requires a certain number or percentage of practicing specialty and primary care providers on each board or committee.

Recommendation: The proportions for types of provider representatives should be set and maintained to promote balance between community-based and institutionally-based roles and weights in decision-making.

Risk Stratification and Population Specific Interventions (Nos. 7-10). We support the draft standard requiring ACOs to have and disclose risk stratification criteria for specified patient groups, and especially support the consideration of social determinants and health literacy among these approaches.

Recommendation: “Women of reproductive age” should be added to the list of patient groups, understanding the needs of this group can inform decisions concerning ACO network capacity. There should be an expectation that community collaborations will be robust in reach and number, committed to addressing identified disparities, and regularly held to account for their progress on stated goals. Focused prevention initiatives should be standard in this domain. We support the intent of requirement (No. 10) for the ACO to have adequate capacity to serve people with mental illness, substance use disorders, and all disabilities. However, the draft language too narrowly references “mental health providers, addiction specialists, and LTSS providers,” in that primary care providers are often able to serve in such capacities. A more appropriate final standard could read: “As appropriate for its patient population, the ACO has adequate provider capacity to meet the needs of people living with disabilities, mental health concerns, and substance use challenges.”

PCMH Adoption Rate. (No. 12) We believe that a focus on PCMH adoption alone is not sufficient to encourage or assess appropriate and effective care coordination for all patient groups, especially women. Current NCQA PCMH standards do not recognize a role for OB/GYN practices as medical homes for women. Nonetheless, OB/GYN providers do play and will continue to play such a role for many women, as a trusted source of primary preventive care, referrals, and ongoing care coordination. Their contribution in health system transformation should be elevated along with other models such as medical homes.

Recommendation: We suggest omitting this standard as a stand-alone criterion.

Patient and Family Experience and Community (Nos. 14 and 15). Local data are most relevant to ACO strategies to improve performance in this area and to assess progress on addressing disparities. We support the additional requirement for ACOs to have strategies “to advance or invest in the population health of one or more communities where it has at least 100 enrollees through a collaborative, integrative, multi-organizational approach that acknowledges and accounts for the social determinants of health.”

Recommendation: We urge the Commission to adopt a final standard requiring ACOs to gather data annually on their patient and family experiences, rather than relying exclusively on statewide surveys as permitted by the draft. Covered and non-covered populations in ACO communities should be surveyed, preferably based on the CAHPS instrument.

Consumer Price Transparency (No. 21). We strongly support the standard requiring ACO oversight of providers with respect to Massachusetts consumer price transparency requirements. This will be critical as insurers increasingly place significant financial responsibility on patients with high deductible/high copay plans. In a patient-centered system, patients should have sufficient information and flexibility to choose lower-cost providers meeting quality standards.

Care Coordination (No. 24). We support the emphasis on using “providers in the patient’s community” as preferred providers for care coordination, especially obstetrics as the draft references.

Recommendation: In this area, there should be a mandatory standard for certification. We urge consideration of adding gynecology to the list.

Peer Support (No. 27). We strongly support the draft standard promoting peer support programs in ACO care strategies. Peer education and support offered by community-based family planning providers are key components in reducing STIs and unintended pregnancies, and can play a key part in meeting ACO goals to improve population health.

Recommendation: A standard promoting—and requiring ACOs to pay for—peer support and other community outreach programs should be a mandatory criterion. PPLM strongly recommends, on behalf of all providers who invest in community outreach to improve access, that ACO payment for outreach be included in any plan.

Promote quality approaches and related metrics that improve women’s health status and capture the value of women’s health care services.

We commend the HPC for its leadership to elevate preventive health in strategies to improve health care quality in the Commonwealth. Women of reproductive age need not only blood pressure screenings, tobacco cessation counseling, and Body Mass Index (BMI) assessments but also high-quality contraceptive counseling, STI screenings, cancer screenings, and well-woman exams. For example, the Office of Population Affairs (OPA) and the Centers for Disease Control and Prevention (CDC) recently set forth a [developmental contraceptive quality measure](#), which evaluates the proportion of women at risk of unintended pregnancy who choose a contraceptive method that is most effective (i.e. IUD or implant) or moderately effective (i.e. oral contraceptive pills, patch, ring). Fourteen states, including the Commonwealth, have received federal funding to actively integrate this measure into their Medicaid programs. We are hopeful that as the standards

evolve with the progress of system transformation, all ACOs will be encouraged and supported to improve performance on women's health measures.

Recommendations: In final ACO standards, we would like to see more explicit emphasis on deploying and evaluating prevention strategies, particularly for women's health. For instance, the ACO quality committee required by the standards (No. 6) should have guaranteed representation by a women's health clinician. The quality committee should, further, have a charge to identify indicators and improvement measures to address disparities across gender, race, and ethnicity. PPLM recommends the currently used HEDIS measures for pap smears, chlamydia screening, BMI counseling, and tobacco screening and cessation counseling. We also recommend using a quality metrics such as the developmental contraceptive quality measures and HPV vaccination rates as these are particularly relevant measures for addressing health disparities across race and gender. With respect to proposed domains on risk stratification and cross-continuum networks (Nos. 8 and 9), we believe the standards could go further to promote a focus on improving health outcomes of identified risk groups, particularly those typically experiencing disparities. ACOs should be held to outcome as well as process measures, and should identify community/ collaboration measures of success and report on them annually. All ACOs should be held to the same rigorous standards of quality and performance analytics (No. 13).

Design savings models that incorporate prevention and population health

For the Commonwealth and its diverse communities to realize population health goals, reduce disparities, and achieve high-performing health systems that are fully sustainable, continued investments must be made in proven preventive health services and strategies. Some of these strategies are suggested above. Further, including prevention in shared savings approaches is key to ensuring actual investments. The evidence is available to craft savings methodologies that capture the value of preventive interventions proven to enhance health outcomes and reduce systemic costs. For instance, recent estimates show that evidence-based interventions, such as tobacco cessation and family planning, create a significant return on investment (\$2-3 in tobacco cessation savings and \$7 in family planning savings for every \$1 invested in each category) in addition to improving health outcomes.

Recommendation: High-value preventive services must be reflected in savings calculation and distribution arrangements, so that key providers within emerging delivery networks have incentives to continue providing the most cost-effective intervention across the care continuum. Distribution commitments and methods must be disclosed to providers in advance of their participation agreements. Key partners with the ACO need to be directly involved in the decisions related to distribution of funds for care, equality, and patient experience. (No. 30)

As the HPC, MassHealth and EOHHS work to achieve the triple aim of higher quality, improved population health, and reduced costs, it is imperative the state intentionally designs an enhanced health care system that meets the needs of women of reproductive age so that Massachusetts can continue its legacy pioneering health reform. PPLM looks forward to continuing to be a partner to the Commonwealth on this important work.

Should you have any questions or want to discuss these comments further, please contact our Director of Public Affairs, Michael Falcone, at mfalcone@pplm.org