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Thank you for allowing Signature Healthcare to comment on the revised Health Policy Commissions ACO Certification Standards for 2022-2023. Overall, the changes are thoughtful and cover the important categories of work that will ensure ACO's meet the needs of the citizens in the Commonwealth. They reflect advancing health equity, a high priority for Signature and the Commonwealth, notwithstanding the challenges of doing so with the lowest economic reserves, not unlike Dr. David Williams, reference to low income racially diverse populations at the 2020 Cost Trends Hearing.

The standards appear designed to address the underlying assumption that an Accountable Care Organization creates financial incentives that could be perceived as in opposition, rather than synergistic with value (exceptional, equitable, quality, service, and efficient care). However, the standards do not address patient safety, which should be a basic foundational assumption for any health system. The Betsy Lehman Center published a report in 2019,[i] which identified 62,000 preventable harm events and more than $617 million dollars in excess health care insurance claims. Over the course of the last 20 years, the Institute of Medicine (IOM), and others have estimated the lost lives due to medical error at 100,000 to 200,000 per year in the US. Assuming the lower estimate of 100,000 lives lost due to either error or even impacted by medical error that number remains high more than 20 years after the IOM released a report called: *To Err is Human: Building a Safer Health System.*[ii]

Providers seeking comparable data related to medical errors, and causes of harm that might drive improvement, are stymied by the lack of available data. Independent providers lack the connections, and resources to obtain un-blinded benchmark data that would foster investigation, and replication of best practices; even simple information on employee injury rates, serious safety event rates, and department specific culture of safety survey responses are not accessible to either the public or providers. Boards of Directors lack even the most rudimentary data to hold providers and their organizations accountable for employee and patient safety without this information. Furthermore, based on history, it is unreasonable to expect the provider industry to resolve this lack of data.

In part, this is a domain that the Health Policy Commission should appropriately consider in the development of criteria for ACO's to be measured and certified. With appropriate foresight, the HPC realized the need to establish criteria that included quality and patient experience, while establishing an incentive for savings that might have a negative impact on quality. Unfortunately, the ACO criteria and quality incentive measures promulgated through insurance contracts have fallen short of the basic pre-cursor for quality, which is safety (both employee and patient).

Our experience has shown that improving quality through work on focused measures such as readmissions and hospital acquired conditions will not necessarily result in improvements in safety. The process improvements and standardized care that improve these measures do not necessarily overlap with the human thinking, cognitive bias, communication and cultural causes of harm.

If the providers in our state are going to be encouraged and given the opportunity to lead the nation on reducing high costs, we should also advance simultaneously toward safer delivery of care. Having the data be available through the HPC would be applying the power and influence of the HPC and all available levers to create the channels that would provide the information needed for change, on behalf of the citizens of the Commonwealth. Improving Health Equity, Innovative Care and Controlling TME growth are important, relevant, yet the very basic of first delivering safe care are missing from the additional questions and from the basic criteria.

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[i] https://betsylehmancenterma.gov/assets/uploads/Cost-of-Medical-Error-Report-2019.pdf

[ii] Institute of Medicine (US) Committee on Quality of Health Care in America; Kohn LT, Corrigan JM, Donaldson MS, editors. To Err is Human: Building a Safer Health System. Washington (DC): National Academies Press (US); 2000. Available from: https://www.ncbi.nlm.nih.gov/books/NBK225182/ doi: 10.17226/9728