

June 6, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1345-P
P.O. Box 8013
Baltimore, MD 21244-8013

To Whom It May Concern:

As organizations dedicated to disease prevention and promoting public health, those who represent public health officials and practitioners, and others, we are pleased to comment on the proposed rule on Accountable Care Organizations (ACOs). We believe that novel efforts to coordinate and support primary care are crucially needed, and that efforts to manage costs should be accompanied by steps to maintain and improve the quality of care.

As we think long-term about transforming our health care system into one that focuses on disease prevention and wellness in lieu of our current focus on treating acute and chronic illness and disease, we believe ACOs afford us a critical opportunity to integrate community and clinical prevention efforts to achieve better health outcomes at lower costs. Importantly, the proposed rule notes that the goal of ACOs is to serve the “three-part aim” of “better care for individuals, better health for populations, and lower growth in expenditures.” As organizations committed to public health, our comments focus on the aim of “better health for populations.” The proposed rule contains a number of provisions that promote population health and prevention. We support these provisions, and suggest additional provisions to maximize the positive impact on population health.

Quality measures

We strongly endorse the inclusion of quality measures related to preventive health. We note the public health importance of all nine of the proposed Preventive Health measures included under the goal of “Better Health for Populations”:

- **Influenza Immunization:** Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February);
- **Pneumococcal Vaccination:** Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine;
- **Mammography Screening:** Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months;
- **Colorectal Cancer Screening:** Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening;

- **Cholesterol Management for Patients with Cardiovascular Conditions:**
 - The percentage of members 18–75 years of age who were discharged alive for acute myocardial infarction (AMI), coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year:
 - LDL-C screening
 - LDL-C control (<100 mg/dL);
- **Adult Weight Screening and Followup:** Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented.
 - Parameters:
 - Age 65 and older BMI ≥ 30 or < 22 ;
 - Age 18-64 BMI ≥ 25 or < 18.5 ;
- **Blood Pressure Measurement:** Percentage of patient visits with blood pressure measurement recorded among all patient visits for patients aged >18 years with diagnosed hypertension;
- **Tobacco Use Assessment and Tobacco Cessation Intervention:** Percentage of patients who were queried about tobacco use. Percentage of patients identified as tobacco users who received cessation intervention; and
- **Depression Screening:** Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow up plan documented.¹

These measures reflect a range of significant health problems that represent a large proportion of the enormous burden of chronic disease, not only for the Medicare population but for all Americans. We believe that requiring ACOs to report on these measures for their attributed patients, and show improvements in performance, will be a key step in improving the provision of clinical preventive care for their total patient population.

While there are other significant public health issues that affect both the Medicare and the broader population, we understand that ACOs will be collecting a sizeable set of quality measures across five domains. For the first three years, we believe it is appropriate to focus on these measures in the preventive area. However, we believe that CMS should work with the Centers for Disease Control and Prevention (CDC) and other relevant agencies to identify potential preventive health measures that could be added to the reporting requirements as the ACO program matures. We likewise encourage CMS to incorporate, where possible, recommendations from the National Quality Strategy, also developed under the Affordable Care Act. This should include both examining the aims, priorities, and goals for improving quality as well as the policies and infrastructure

¹ Preamble, Table 1, “Proposed Measures for Use in Establishing Quality Performance Standards that ACOs Must Meet for Shared Savings.”

sections of the March 2011 report to look for opportunities to further strength the quality improvement aspects of the ACO framework.

Health Information Technology

Throughout the proposed rule, CMS affirms a commitment to aligning ACO efforts with those currently being implemented under the Electronic Health Record (EHR) incentive program. Like ACOs, the push towards nationwide adoption of health information technology (HIT) represents another key opportunity to integrate care across clinical and community settings and establish a meaningful national quality initiative. HIT has the potential to help us improve disease surveillance, outbreak response, and implementation of effective preventive services such as recommended vaccinations, screening and counseling services. We urge you to ensure that ACO HIT policy ensures that participating providers can interface with state and local health agencies, community health centers, and other public health organizations.

State and Local Health Department Involvement

State and local health departments have always served at the front lines of efforts to improve population health. Health departments carry out core public health functions that include identifying and tracking disease threats; educating the public and community partners; preparing for and responding to disasters; and enforcing state health laws. They work with local providers and facilities, and understand the health needs of their communities.

The proposed rule offers a number of opportunities for health department involvement that we believe would benefit the ACOs, their providers, and their patients, while improving overall population health. This involvement should be accompanied by appropriate compensation to health departments for their expertise and time.

Health Needs Evaluation

The first such example is a health needs evaluation. The proposed rule would require ACOs to demonstrate “patient-centeredness” by addressing a set of areas, including:

- (3) A process for evaluating the health needs of the ACO’s assigned population, including consideration of diversity in its patient populations, and a plan to address the needs of its population.²

The preamble, noting that several entities have produced standards related to evaluating population health and diversity, states that “Establishing partnerships with a State or local health department which performs community health needs assessments and applying

² Proposed Rule, §425.5 (d)(15)(ii)(B)(3).

these findings to the ACO's population and activities may be another viable option for meeting this criterion."³

We believe that health department involvement in the health needs evaluation should be not only an option but a requirement. For an ACO to meaningfully understand the health status and needs of its patient population and of the diverse subpopulations that make it up, it must communicate with the entity most likely to understand the broader health needs of the community in which it is situated.

Integration with Community Resources

Another proposed requirement for demonstrating patient-centeredness is that ACOs have:

- (4) Systems in place to identify and update high-risk individuals and processes to develop individualized care plans for targeted patient populations including integration of community resources to address individual needs.
 - (i) Such plans must promote improved outcomes for, at a minimum, high-risk and multiple chronic condition patients, and as appropriate, other patients with chronic conditions.
 - (ii) The plan must be tailored to the beneficiary's health and psychosocial needs, account for beneficiary preferences and values, and identify community and other resources to support the beneficiary in following the plan.

We believe that ACOs should be required to consult with health departments to ensure that their providers and their patients are aware of the full range of community resources that are available. Some health departments are themselves providers of medical or support services, and all have relationships with a range of medical and social service providers in the community. ACOs should be required to consult with health departments to ensure that individual needs are being met with a full range of community resources and supports.

Clinical Guidelines

A third key area in which health departments should be involved is the use of clinical and medical care guidelines. The proposed rule requires ACOs to use evidence-based clinical guidelines in patient care:

The ACO must implement evidence-based medical practice or clinical guidelines and processes for delivering care consistent with the aims of better care for individuals, better health for populations, and lower growth in health care expenditures. The guidelines and care delivery processes must cover diagnoses with significant potential for the ACO to achieve quality and cost improvements, taking into account the circumstances of individual beneficiaries.⁴

³ Preamble, II(B)(10)(c), "Evaluation of Population Health Needs and Consideration of Diversity."

⁴ Proposed Rule, §425.5(a)(9)(vi).

Implementation is to be accompanied by strict compliance measures:

(vii) ACO participants and providers/suppliers must agree to comply with these guidelines and processes and to be subject to performance evaluations and potential remedial actions, including their expulsion from the ACO. The ACO must have policies and procedures for expulsion of ACO participants and ACO provider/suppliers from the ACO.⁵

We strongly endorse these requirements, and believe that they offer an opportunity for the improvement of population health through prevention and screening guidelines. Specifically, ACOs should be required to consult with their health departments to identify the public-health-related clinical guidelines that they should be using with their ACO patients and with their other patients. For example, CDC has sets of evidence-based guidelines for screening related to TB, HIV, and hepatitis. Depending on the outcome of the population health needs evaluation discussed above, as well as other information the health department has about risk factors and epidemiology within the community, the department may recommend specific screening protocols that meet the need of that particular ACO population. Requiring health department involvement with this step will create linkages and lead to technical assistance that will be beneficial to the ACO, its providers, and ultimately its patients.

Federally-Qualified Health Centers

As noted in the preamble to the proposed rule, federally-qualified health centers, along with rural health centers, “play a critical role in the nation’s health care delivery system.”⁶ Federally-qualified health centers include community health centers, migrant health centers, health care for the homeless programs, and public housing primary care programs. FQHCs meet certain criteria under the Medicare and Medicaid programs, and receive funding under Section 330 of the Public Health Service Act.

FQHCs are a major source of primary care and other health services for millions of Americans. There are currently 1200 FQHCs nationwide, with over 7,500 delivery sites that serve 20 million people each year.⁷ They provide coordinated, cost-effective care to predominantly low-income populations, often with serious health needs. Out of the 20 million people served, 7% are Medicare beneficiaries⁸, meaning that 1.4 million FQHC patients would be potential enrollees in FQHC-formed ACOs.

The preamble to the proposed rule acknowledges the importance of FQHCs in the provision of primary care. However, it states that under current FQHC billing protocols,

⁵ Proposed Rule, §425.5(a)(9)(vii).

⁶ Preamble, II(B)(1), “Eligible Entities.”

⁷ National Association of Community Health Centers, “America’s Health Centers” (Aug. 2010) (online at <http://www.nachc.org/client/America's%20Health%20Centers%20updated%2002%2011.pdf>).

⁸ *Id.*

the data would not permit appropriate assignment of beneficiaries to FQHC-based ACOs, nor would it allow a determination of costs in the three-year benchmark period.⁹

We understand that the health center community will be commenting with specific recommendations on how to incorporate FQHCs into the ACO model. While detailed alternatives are outside the scope of this letter, we urge you to seriously consider the suggestions that you receive. As a key component of the healthcare safety net, and longtime pioneers in coordinated primary care, FQHCs should be permitted to reap the benefits of the shared savings program while serving as a model for care collaboration.

Conclusion

Thank you for the opportunity to comment on the proposed rule for Accountable Care Organizations. We believe that this program will set important precedents for coordinated payment and delivery systems. Therefore, it is crucial that the final rule reflect all meaningful opportunities to improve health at a population level. If you have any questions, please do not hesitate to contact Jack Rayburn, Government Relations Representative for Trust for America's Health (202-223-9870, x 28 or jrayburn@tfah.org).

Sincerely,

Association of State and Territorial Health Officials

Boston Public Health Commission

National Association of Community Health Centers

National Association of County and City Health Officials

Public Health - Seattle & King County

Trust for America's Health

⁹ Preamble, II(B)(1), "Eligible Entities."