



December 3, 2010

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

RE: Medicare Program; Request for Information Regarding Accountable Care Organizations and the Medicare Shared Saving Program

The National Association of Community Health Centers (NACHC) appreciates the opportunity to comment on the above Request for Information on Accountable Care Organizations (ACOs) and Medicare Shared Savings Program. Health centers nationwide are interested in the development of ACOs and are pleased to provide CMS with the health center perspective on the questions that were posed. Please also refer to the **enclosed** principles on ACOs developed by NACHC. We believe they provide helpful background as well as address some of the questions posed in the Request for Information.

There are, at present, approximately 1200 FQHCs serving over 20 million patients nationwide through 8,000 urban and rural delivery sites. Most FQHCs receive federal grants under Section 330 of the Public Health Service (PHS) Act (42 U.S.C. 254b) from the Bureau of Primary Health Care (BPHC), within the Health Resources and Services Administration (HRSA) of HHS.

Under this authority, health centers fall into four general categories: (1) those centers serving medically underserved areas, (2) those serving homeless populations within a particular community or geographic area, (3) those serving migrant or seasonal farm worker populations within similar community or geographic areas, and (4) those serving residents of public housing.

To qualify as a Section 330 grantee, a health center must be located in a designated medically underserved area or serve a medically underserved population. In addition, a health center's board of directors must be made up of at least fifty-one percent users of the health center and the health center must offer services to all persons in its area, regardless of his or her ability to pay. BPHC's grants are intended to provide funds to assist health centers in covering the otherwise uncompensated costs of providing comprehensive preventive and primary care and enabling services to uninsured and underinsured indigent patients, as well as to maintain the health center's infrastructure. Patients from eligible communities, who are not indigent and are able to pay or who have insurance (public or private)

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are expected to pay for the services rendered. Currently, 37 percent of health center patients are Medicaid recipients, 7.3 percent are Medicare beneficiaries, and 38 percent are uninsured.

FQHCs provide comprehensive primary care services and serve as medical homes for the over 20 million patients they serve. As such, FQHCs utilize a team model approach with primary care services provided by physicians, nurse practitioners, nurse midwives, physician assistants, case managers, health educators, and other staff. Most health centers also provide dental services and behavioral health services, and these staff are integrated into the medical team. Over seventy percent of health centers provide these services onsite and in 2009 health centers employed nearly 15,000 medical provider FTEs and at least 2,500 licensed mental health providers.

As many have noted, **primary care should serve as the foundation for ACOs**, and health centers offer the primary and prevention care base that will be essential for successful ACOs. Health centers typically provide an enhanced level of services that their underserved patient population requires in order to overcome the social determinants of ill health. Health centers also deliver care in team-based settings and are patient-centered. Both features will be essential for capitalizing on the potential quality gains and expenditure reductions within ACO structures that build off medical homes. Health centers are also actively pursuing accreditation as patient-centered medical homes.

Q: What policies or standards should we consider adopting to ensure that groups of solo and small practice providers have the opportunity to actively participate in the Medicare Shared Savings Program and the ACO models tested by CMMI?

In order to ensure FQHCs are active participants in ACOs, we encourage CMS to include FQHCs (as defined in Section 1861(aa)(4) of the Social Security Act) in the definition of “other such groups of providers of services and suppliers” as prescribed in Section 3022 of the Affordable Care Act. Additionally, Section 3022 authorizes the Secretary to attribute Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided by an ACO professional, but limits such professionals to physicians, thus excluding recognized Medicare providers such as Nurse Practitioners and Physician Assistants. We urge CMS to expand the definition of an ACO professional to include these other provider types. Moreover, it is our understanding that the attribution of beneficiaries to an ACO will be accomplished by securing three pieces of information: the beneficiary, the service code, and the provider information code (NPI). While FQHCs bill Medicare in a way that is unique and different from how physicians bill Medicare, the data needed by CMS to attribute to an ACO those beneficiaries who utilize FQHCs is currently being submitted to CMS Fiscal Intermediaries by FQHCs for each Medicare encounter. We urge CMS to ensure that it gathers this information from Fiscal Intermediaries or Medicare Administrative Contractors, in order to facilitate the attribution of health center patients to ACOs.

Additionally, in order to make certain that FQHCs and other small group practices serving the safety net community have an opportunity to participate in ACOs, we urge CMS to provide incentives for ACOs to contract with FQHCs and other safety net providers, and to require such

contracting for any organizations that propose to serve underserved communities. Specifically, health centers' experiences and successes can foster ACOs' potential to reach population health goals. Through the unprecedented levels of funding under the Affordable Care Act, health centers are positioned to rapidly grow into new, previously underserved communities with extensive and costly health care needs. Other providers creating ACOs should be incentivized to contract with health centers, to ensure that health centers and their patients are not left out of these critical systems. One means for doing so, as noted later in this document, would be for CMS to state that the inclusion of one or more FQHCs in an ACO network shall serve to satisfy CMS' concern regarding avoidance of at-risk patients.

CMS should consider policies to ensure access to hospital and specialist care for ACO patients, making clear its expectation that providers who participate in Medicare and Medicaid are expected to accept beneficiaries enrolled in an ACO for care, in order to ensure that those patients seen at health centers or small group practices do not encounter difficulties receiving these types of care.

As a final comment to the question posed here, CMS should consider the needs of uninsured patients when developing the ACO model. As a way to do that, health centers should serve on the governing board of the ACO.

Q: Many small practices may have limited access to capital or other resources to fund efforts from which “shared savings” could be generated. What payment models, financing mechanisms or other systems might we consider, either for the Shared Savings Program or as models under CMMI to address this issue? In addition to payment models, what other mechanisms could be created to provide access to capital?

Payment models must factor in several important features of effective primary care practices, particularly among the safety net. First, methods for distributing shared savings should cover primary care practices' full costs of care. This includes costs associated with serving complex patients.

Second, they should reward, through shared savings, those providers who produce on a risk-adjusted basis the “downstream” savings experienced within a health care system through fewer hospitalizations, 30-day readmissions, emergency department visits, and specialty care visits. In addition, payment systems should recognize and reward high-performing providers for their provision of effective preventive care. For example, this can be measured through the inclusion of quality benchmarks and paid through bonuses.

Third, capital and other resources must be available to build the infrastructure necessary to enhance care coordination across providers, such as advanced capacity for health information exchange for ensuring appropriate and timely access to specialty care, as well as enhanced capacity for assessing performance in quality and cost. This is particularly critical for not-for-profit safety net providers. Capital must also be available for provider network development to address contracting and resources required to implement effective delivery systems. Grants

and/or loans should be made available to support these costs, in particular for organizations formed by not-for-profit safety net providers or networks of such providers.

Fourth, ACO payment incentives must bolster accountability across multiple providers but also support the investments needed to sustain medical homes. These include strengthening performance measurement and improvement, implementing meaningful use of electronic health records, access to specialty care, and, where appropriate, staff development and professional training.

Finally, given the realities of multiple revenue sources and serving complex patients, including the uninsured, multi-payer ACOs are more effective than single-payer ACOs. Single-payer ACOs are difficult to operationalize at the health center level. ACOs should therefore be expected to build multiple payers into their cost structures to effectively address population health. Uninsured patients should not be left out of the care integration benefits of ACOs. Similarly, health centers and other providers should be allowed to participate in multiple ACOs, in order to ensure that they are not excluded from providing services to any patient who may be assigned to an ACO other than the one in which the health center or provider already participates. Health centers have unique populations and by allowing them to participate in multiple ACOs, they will be able to provide comprehensive care to all of their patients, regardless of their status.

Q: The process of attributing beneficiaries to an ACO is important to ensure that expenditures, as well as any savings achieved by the ACO, are appropriately calculated and that quality performance is accurately measured. Having a seamless attribution process will also help ACOs focus their efforts to deliver better care and promote better health. Some argue it is necessary to attribute beneficiaries before the start of a performance period, so the ACO can target care coordination strategies to those beneficiaries whose cost and quality information will be used to assess the ACO's performance; others argue the attribution should occur at the end of the performance period to ensure the ACO is held accountable for care provided to beneficiaries who are aligned to it based upon services they receive from the ACO during the performance period. How should we balance these two points of view in developing the patient attribution models for the Medicare Shared Savings Program and ACO models tested by CMMI?

Patient assignment should occur prior to a performance period. Patients must be advised of any enrollment in an ACO and given full opportunity to opt out, if they so choose. They should not be required to find new primary care clinicians. Beneficiaries should be aware of participation and should receive incentives for engaged behavior. Moreover, the ACO should be easy to navigate and transition to ACOs should be seamless for patients. To monitor the transition process and represent patients' interests, consumers should be represented on ACO governing boards. Additionally, providers should not be penalized if a patient chooses to opt out of the ACO.

As noted earlier, we also would like to ensure that FQHCs are assigned beneficiaries to participate in ACOs, regardless of the method used to assign them. We understand that the assignment of beneficiaries to an ACO will be accomplished by securing three pieces of information: the beneficiary, the service code, and the provider information code (NPI). We are told that, because of the current Medicare FQHC billing process, it may be difficult to assign to an ACO those beneficiaries who utilize FQHCs. However, we believe that the data needed by CMS to make such assignments is currently being submitted to CMS on the UB-04 form, which is submitted for each Medicare FQHC encounter. It contains the patient information, service code, and “attending physician” information. CMS should ensure it can gather this information from Fiscal Intermediaries or Medicare Administrative Contractors to determine assignment of health center patients in ACOs.

During a performance period, ACOs must have a mechanism in place to monitor which patients remain in or opt out of the ACO. Performance along benchmarks should determine payment across participating providers after the performance period.

Finally, the methodology for attribution or assignment of ACO patients needs to distinguish between primary care and hospital patterns of use. It should recognize that many patients receive care from primary care groups with only loose affiliations with hospitals and be cognizant of the risk of misattributing patients to ACOs as a consequence of a flawed enrollment or attribution methodology.

Q: How should we assess beneficiary and caregiver experience of care as part of our assessment of ACO performance?

Assessing beneficiary and caregiver experience are critical for assessing quality and performance. Patient experience assessments must be done in a culturally competent manner, and they should be conducted using a balanced mix of qualitative and quantitative measures. Quantitative measures should account for care continuity and voluntary patient departure from the ACO. Data can be collected by surveying patients as well as through focus groups. Because of the inherent bias in surveying patients during clinical visits, patient surveys should be done outside of the care giving setting.

Q: The Affordable Care Act requires us to develop patient-centeredness criteria for assessment of ACOs participating in the Medicare Shared Savings Program. What aspects of patient-centeredness are particularly important for us to consider and how should we evaluate them?

Primary care practices involved in ACOs should be certified as patient-centered medical homes through a recognized accrediting entity such as NCQA. Beyond these standards, however, CMS should collect data on practices’ enabling and patient-support services, such as translation, transportation, health coaching, case management, and other services that facilitate access to appropriate care and assist patients with healthy behaviors. CMS should also collect information on the extent to which practices serve complex patients as a mechanism for disincentivizing “cherry picking,” and provide services not traditionally found in primary care,

such as behavioral health, dental, pharmacy, vision, and other critical services. Finally, CMS should monitor the level of interaction between ACO practices and public services, such as those provided through public health departments and social services agencies.

Q: In order for an ACO to share in savings under the Medicare Shared Savings Program, it must meet a quality performance standard determined by the Secretary. What quality measures should the Secretary use to determine performance in the Shared Savings Program?’

ACOs should be structured around population health goals. Partnerships between health centers and public health entities, for example, are created with the goal of improving health status through focused community health interventions that contribute both to overall savings and to improved population health.

Core measures should reflect the population health goals of the ACO. Performance indicators should account for improved access to care and outcomes. ACOs should incorporate key social services and public health services to address impediments to good health. ACOs should also have a standard for community and patient engagement. In addition, all ACOs must be able to provide evidence of an effective organizational culture of patient safety and a culture of excellence through continuous improvement.

Organized evidence-based protocols should drive the appropriate use of all types of referrals from primary care.

Q: What additional payment models should CMS consider in addition to the model laid out in Section 1899(d), either under the authority provided in 1899(i) or the authority under the CMMI? What are the relative advantages and disadvantages of any such alternative payment models?

We ask CMS to clarify that in any payment agreement allowed under Section 1899(d) or (i) ACOs would be expected pay any participating FQHCs in accordance with their current Medicare or Medicaid/CHIP payment system. This is fully consistent with the law’s treatment of physicians and other providers in such arrangements, and it is consistent with the way in which FQHCs have been treated in other managed care arrangements such as Primary Care Case Management systems. It is also consistent with the history of Congressional action to ensure that FQHCs are adequately and appropriately reimbursed by public payers in a way that ensures that they can utilize their Public Health Service Act grant funds as intended, to support the cost of care provided to uninsured and under-insured individuals.

We also strongly encourage CMS to appropriately risk-adjust benchmarks for shared savings to reflect the beneficiary characteristics of the patients of participating providers that could affect overall performance, such as their proportion of patients who are uninsured, Medicaid-insured, low income, culturally diverse, and those who have limited English, low health literacy, multiple chronic illnesses, poor physical and mental functioning patients, and other factors.

Finally, in accordance with Section 1899(d)(3), which calls for the monitoring of avoidance of at-risk patients, we suggest that CMS state that the inclusion of one or more FQHCs in an ACO network shall serve to satisfy CMS' concern regarding avoidance of at-risk patients.

Thank you for the opportunity to respond to this important Request for Information. NACHC appreciates your consideration and favorable action on these comments. Please do not hesitate to contact Susan Sumrell or Michelle Proser on the NACHC staff at 202.296.3800 if you have any questions or comments or if you require any clarification on the comments presented herein.

Respectfully Submitted,

A handwritten signature in black ink, appearing to read "Roger Schwartz". The signature is written in a cursive, flowing style.

Roger Schwartz, Esq.
Associate Vice President and Legal Counsel

Federally Qualified Health Centers (FQHCs), also known as “health centers,” provide comprehensive primary and preventive care services and currently serve as medical homes to over 20 million patients. They serve as an integral part of the health care safety net, serving Medicare, Medicaid, CHIP and uninsured patients, and receive federal grants under Section 330 of the Public Health Service Act.

The National Association of Community Health Centers (NACHC) supports efforts that aim to improve care coordination for underserved patients, and ultimately improve community health. Accountable Care Organizations (ACOs) are largely untested models of locally integrated care with payment incentives to promote shared accountability for patient quality and costs. ACOs are a complex and evolving system of care. As such, these principle statements are intended to guide the development of ACOs involving FQHCs.

- **Primary health care should serve as the foundation for any ACO. Primary health care includes medical, behavioral health and oral health. Health centers are leaders in effective and efficient primary health care delivery.** They offer the primary care base that will be essential for ACOs. They typically furnish an enhanced level of services that their underserved patient population requires to overcome the social determinants of ill health. Health centers also deliver care in team-based settings and are patient-centered – features that will be essential for capitalizing on the potential quality gains and expenditure reductions within ACO structures that build off patient-centered medical homes.
- **As leaders in patient-centered care, health centers are well positioned to participate in and/or lead ACOs. ACOs should be strongly incentivized to include and contract with health centers and other safety net providers, and should be required to do so in cases where their service areas include underserved communities.** Health centers’ experiences and successes foster ACOs’ potential to reach population health goals. Health centers are also positioned to rapidly grow into new, previously underserved communities with extensive and costly health care needs. Contracting with health centers ensures that their patients are not left out of these systems and that the ACOs do not “cherry pick” both healthier patients and providers. ACOs must incorporate existing organizational structures and expertise already meeting a community’s diverse health care needs. Consideration must also be given to the special challenge of forming ACOs in rural communities.
- **Health centers, community members, and patients should be fairly represented in ACO governing boards.** This ensures that ACOs are responsive to population health care needs.
- **ACOs should be patient-, family- and community-centered.** Patients should be able to easily navigate ACOs. All services offered throughout the ACO must be culturally and linguistically appropriate to the populations served. Health centers employ culturally competent staff to facilitate access to care and help patients navigate provider networks and insurance systems. Moreover, patients should not be required to find new primary care clinicians. They should be advised of any enrollment in an ACO and given full opportunity to opt out, if they so choose.
- **ACO structures must have the capacity to ensure appropriate and timely access to specialty care, including specialty diagnostic and treatment services.** Evidence-based referral guidelines should drive the appropriate use of specialty care referrals from primary care practices.

- ***Fair and adequate distribution of payment and operational support are necessary.*** ACO payment incentives must bolster accountability across multiple providers but also support the investments needed to sustain medical homes. These include strengthening performance measurement and improvement, implementing meaningful use of electronic health records, access to specialty care, and, where appropriate, staff development and professional training. Payments to health centers under ACO arrangements must ensure health centers' full costs of care are covered. These include costs associated with serving complex patients. Payment should also adequately reward providers for "downstream" savings experienced within a health care system through fewer hospitalizations, emergency department visits, and specialty care visits. Additionally, health centers require resources to build the infrastructure necessary to enhance care coordination across providers, such as advanced capacity for health information exchange and assessing performance in quality and cost. Payment must cover the various modalities for patient care and consult, including tele-health, emails, and texting.
- ***Multi-payer ACOs are more effective than single-payer ACOs. Consideration should be given to address the needs of all patients when developing the ACO model.*** Investments in ACO infrastructure directly benefit all patients, yet are largely driven by particular payers. This has important implications for a provider's entire patient population, particularly the uninsured, who should not be left out of ACOs' care integration benefits. Health centers rely on multiple payer sources and serve large numbers of uninsured patients. Single-payer ACOs are difficult to operationalize at the health center level. ACOs should therefore be expected to build multiple payers into their cost structures in order to effectively address population health.
- ***ACOs should be structured around population health goals. With their long history and track record of integrating medical and public health at the local level to achieve better health status for communities, health centers are in a position to collaborate with the new CMS Center for Medicare and Medicaid Innovations to develop and test such models of care.*** ACOs must develop partnerships with health centers and public health entities with the goal of improving health status through focused community health interventions that contribute both to overall savings and to improved population health.
- ***Core quality and performance measures should reflect the population health goals of the ACO, and effective organizational culture of safety and continuous improvement.*** Performance indicators should account for improved access to care and broad population health improvements. ACOs should incorporate key social and public health services to address impediments to good health. ACOs must also have a standard for community engagement.
- ***ACO payers must aptly adjust benchmarks and targets for savings.*** Such adjustments must account for two types of factors contributing to patient outcomes and expenditures. These factors are prevalent among health centers and other safety net providers. The first is the relative health status and risk of individual beneficiaries assigned to the ACO. The second is participating providers' population characteristics that could affect overall performance. These include the proportion of patients who are uninsured, Medicaid-insured, low income, culturally diverse, and those who have limited English, low health literacy, multiple chronic illnesses, poor physical and mental functioning patients, and other factors.