AAPCHO
Association Of Asian Pacific Community Health Organizations

Electronically submitted through: www.regulations.gov
June 6, 2011

Dr. Terri Postma
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
P.O. Box 8013
Baltimore, MD 21244-8013

ATTN: File Code CMS-1345-P

Dear Dr. Postma:

The Association of Asian Pacific Community Health Organizations (AAPCHO) respectfully submits these comments on the Proposed Rule for Medicare Shared Savings Program Accountable Care Organizations. AAPCHO is a national association representing community health centers serving Asian Americans, Native Hawaiians, and other Pacific Islanders. We work to create a national voice for the unique and diverse health needs of Asian Americans, Native Hawaiians, and other Pacific Islanders communities, and advocate for the empowerment of community health providers that serve those needs. As an association of providers of primary care to hundreds of thousands of patients throughout the U.S., AAPCHO is very interested in ensuring that models of accountable care organizations are inclusive of, and demonstrate quality improvements and cost reductions by our member community health center providers and for our patients.

1. Interpret the Patient Protection and Affordable Care Act to allow full participation of Federally Qualified Health Centers, including aligning its Medicare fee-for-service beneficiaries, in Medicare Shared Savings Program Accountable Care Organizations.

Despite some of the methodology challenges in assigning or aligning Medicare fee-for-service beneficiaries provided primary care services by physicians working at Federally Qualified Health Centers, the final rule should allow Federally Qualified Health Centers (FQHCs) to not only participate in a Medicare Shared Savings Accountable Care Organization (ACO) but also have their Medicare fee-for-service beneficiaries be aligned with the ACO. As the proposed rule itself notes FQHCs provide primary care to an increasing number of Medicare beneficiaries. FQHCs providers and FQHC patients should be included in this important program. This is particularly important for the many dually eligible Medicare-Medicaid beneficiaries that are served by FQHCs. We endorse and support the comments submitted by the National Association of Community Health Centers (NACHC) on this issue, including the use of alternate cost benchmarking methods for Medicare fee-for-service beneficiaries served by FQHCs.

2. Support the requirement that all Medicare Shared Savings Program ACOs address issues of beneficiary diversity.

We strongly support the requirement in the proposed rule that all Medicare Shared Savings Program ACOs address issues of beneficiary diversity as part of meeting the ACA requirement of patient-centeredness.[1] If sustainable population level health improvements are to be achieved in a geographic area served by an ACO, the improvements cannot come from adversely selecting patients. The ACO must strive to improve the quality of health care through increased coordination and other quality improvements for *all* the patients residing in its service area.

In the final rule, the Centers for Medicare and Medicaid Services (CMS) should require that applications from Medicare Shared Savings Program ACOs include a demographic profile of the proposed service area (using data from the U.S. Census, American Community Survey, Medically Underserved Area and Medically Underserved Populations designations, and other readily available sources), accompanied by a specific action plan to address that beneficiary diversity in all the activities of the ACO.

3. Add an explicit requirement for all Medicare Shared Savings Program ACOs to identify and address disparities in health care as part of its quality improvement interventions.

The final rule should include an explicit requirement that the Medicare Shared Savings Program ACOs identify and address disparities in health care as part of its quality improvement interventions.[2] Such a requirement would be consistent with the goals of Healthy People 2020,[3] the U.S. Department of Health and Human Services (HHS) Action Plan to Eliminate Disparities in Health and Health Care,[4] the HHS National Strategy for Quality Improvement in Health Care,[5] and the HHS Strategic Framework for Optimum Health and Quality of Life for Individuals with Multiple Chronic Conditions.[6]

Medicare Shared Saving Program ACOs could use frameworks and measures such as the U.S. Department of Health and Human Services Office of Minority Health's Culturally and Linguistically Appropriate Services Standards,[7] the National Quality Forum's "disparities-sensitive" measures for ambulatory health care quality[8] and framework and

---

[1] 76 Fed. Reg. at 19550 (April 7, 2011)

[2] Pollack CE, Armstrong K. Accountable care organizations and health care disparities. *JAMA*. 2011;305(16):1706-1707

[3] http://www.healthypeople.gov/2020/

[4] http://minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[5] http://www.healthcare.gov/center/reports/quality03212011a.html

[6] http://www.hhs.gov/ash/initiatives/mcc/mcc_framework.pdf

[7] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlID=15 Resources for physicians are available at https://www.thinkculturalhealth.hhs.gov/

[8] http://www.qualityforum.org/Publications/2008/03/National_Voluntary_Consensus_Standards_for_Ambulatory_Care—Measuring_Healthcare_Disparities.aspx
The National Quality Forum (NQF) is also developing consensus standards on reducing health care disparities and cultural competency.
http://www.qualityforum.org/Projects/h/Healthcare_Disparities_and_Cultural_Competency/Healthcare_Disparities_and_Cultural_Competency.aspx?section=ReviewoftheProposedRoster2011-05-162011-05-30#t=1&s=&p=

preferred practices for cultural competency,[9] or the National Committee for Quality Assurance (NCQA) Multicultural Health Care distinction program,[10] to meet such a requirement. At a minimum, the ACOs should collect race, ethnicity, language, disability and other relevant demographic data from beneficiaries served, stratify quality data by those demographics, and develop and implement specific interventions to reduce any identified disparities.[11] This may be done using retrospective population level data, including any data shared with the ACO by CMS.

4. Add an explicit requirement that all Medicare Shared Savings Program ACOs must comply with Title VI and the HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons.

The final rule should include an explicit requirement that all Medicare Shared Savings Program ACOs comply with Title VI and the HHS Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons.[12] This requirement would include collecting data on Medicare beneficiary primary language and ensuring language assistance services at all points of contact. These requirements would also be consistent and aligned with section 1557 of the ACA and the requirements for CMS Electronic Health Record Incentive Payments under the Health Information Technology for Economic and Clinical Health (HITECH) Act,[13] the updated 2011 standards for Patient-Centered Medical Homes issued by NCQA,[14] and the recently finalized standards for Primary Care Medical Homes issued by the Joint Commission.[15]

5. Add enabling services, including interpretation and translation, case management, health education, and transportation services, as required services for all Medicare Shared Savings Program ACOs.

Community health centers have documented the importance of enabling services to meet the needs of diverse and underserved patients.[16] These enabling services should

---

As these measures are developed and endorsed by NQF, they should be considered for inclusion in the Medicare Shared Savings Program ACOs.

[9] http://www.qualityforum.org/Projects/c-d/Cultural_Competency_2010/Cultural_Competency_2010.aspx

[10] http://www.ncqa.org/tabid/1157/Default.aspx This NCQA distinction program was specifically referenced in the proposed rule. 76 Fed. Reg. at 19550 (April 7, 2011).

[11] Washington DL, et al. "Transforming clinical practice to eliminate racial-ethnic disparities in healthcare." *J Gen Intern Med.* (2008);23(5):685-691; Beach MC, et al. "Improving health care quality for racial/ethnic minorities: a systematic review of the best evidence regarding provider and organization interventions." *BMC Public Health.* (2006);6:104; Chin MH, Walters AE, Cook SC, Huang ES. Interventions to reduce racial and ethnic disparities in health care. *Med Care Res Rev*. (2007);64(5 Suppl):7S-28S

[12] http://www.justice.gov/crt/about/cor/lep/hhsrevisedlepguidance.php

[13] 42 Code of Federal Regulations (CFR) section 495.6(f)(6) and section 495.6(d)(7).

[14] http://www.ncqa.org/tabid/631/Default.aspx

[15] http://www.jointcommission.org/accreditation/pchi.aspx

[16] Weir RC, et al. "Use of enabling services by Asian American, Native Hawaiian, and other Pacific Islander patients at 4 community health centers," *Am J Public Health* (2010);100: 2199-2205; Association of Asian Pacific Community Health Organizations, *Impact of Enabling Services Utilization on Health Outcomes* (2009); Association of Asian Pacific Community Health Organizations, *Evaluation of Culturally Appropriate Community Health Education on Diabetes*

be specifically listed as the types of services to be provided by the Medicare Shared Savings Program ACO through its participating providers to ensure quality improvement and quality outcomes for the ACO's aligned beneficiaries.

6. Add explicit requirements for beneficiary engagement and community engagement.

We strongly support the concepts of beneficiary engagement and community engagement[17] to ensure success of Medicare Shared Savings Program ACOs. These are essential elements of patient-centered care.[18] While we support the requirement of consumer representation on the governing board of the ACO, we note that FQHCs have the requirement that a majority of its board members be consumers. In order for there to be meaningful representation, we urge that the requirement of consumer representation on the governing board be increased beyond a single seat.

In addition, we urge that the applications from Medicare Shared Savings Program ACOs include the applicant's plan for beneficiary engagement, and for community engagement and partnerships, to ensure the achievement of the population health improvements. The concept of an ACO is complex. While aligned beneficiaries will still have the choice to see any Medicare fee-for-service provider, it is important for participating physicians to proactively explain to their beneficiaries that they are participating in the ACO to improve their health care quality and outcomes, and explain the services being offered by the physician through the ACO to support patient engagement and patient self-management.[19]

Outcomes (2008), at http://enablingservices.aapcho.org/

[17] Institute for Family- and Patient-Centered Care, *Partnering with Patients and Families To Design a Patient- and Family-Centered Health Care System: Recommendations and Promising Practices* (2008), at http://www.ipfcc.org/pdf/PartneringwithPatientsandFamilies.pdf; Institute for Family- and Patient-Centered Care, *Advancing the Practice of Patient- and Family-Centered Care: How to Get Started...* (2008), at http://www.ipfcc.org/pdf/getting_started.pdf; Institute for Family- and Patient-Centered Care, *Partnering with Patients and Families To Design a Patient- and Family-Centered Health Care System A Roadmap for the Future* (2006), at http://www.ipfcc.org/pdf/Roadmap.pdf

[18] Berwick DM. "What 'patient-centered' should mean: Confessions of an extremist." *Health Aff* (2009); 28(4):w555-w565; Epstein RM, Fiscella K , Lesser CS, Stange KC. "Why the nation needs a policy push on patient-centered health care." *Health Aff* (2010); 29(8):1489-1495; Berenson RA, et al. "A house is not a home: Keeping patients at the center of practice redesign." *Health Aff.* (2008); 27(5):1219-1230; Tang PC, Lansky D. "The missing link: bridging the patient-provider health information gap." *Health Aff* (2005);24(5):1290-1295; Bechtel C, Ness DL. "If you build it, will they come? Designing truly patient-centered health care." *Health Aff* (2010); 29(5): 914-920

[19] Institute for Healthcare Improvement, Partnering in Self-Management Support: A Toolkit for Clinicians (2009), at http://www.improvingchroniccare.org/downloads/partnering_in_selfmanagement_support___a_toolkit_for_clinicians.pdf; Braddock CH, et al. "Informed decision making in outpatient practice: time to get back to basics." *JAMA (*1999);282(24):2313-2320; Wood SH, et al. "Promoting informed choice: transforming health care to dispense knowledge for decision making." *Ann Intern Med.* (2005);143(4):293-300.

The requirement in the proposed rule to simply provide a notice to the beneficiaries and allow them to opt out of some data sharing would likely only result in greater confusion among beneficiaries. We strongly urge that participating physicians in ACOs be the ones to communicate with the beneficiaries, and seek to proactively engage them in quality improvement activities.

In supporting community partnerships, we note that CMS supports the use of local assets and resources "on the ground" in the ACO by requiring the Chief Medical Officer to be licensed to practice medicine and reside in the state where the Medicare Shared Savings Program ACO operates. Similarly, the application from the ACOs should demonstrate how it would leverage or partner with local community health education, social service, and other resources to support the quality improvement activities of the ACO.

7. Support the exemption from the minimum savings rate when Federally Qualified Health Centers participate in a Medicare Shared Savings Program ACO.

The proposed rule would allow "first dollar" shared savings when Federally Qualified Health Centers or Rural Health Centers participate in a Medicare Shared Savings Program ACO, without having to surpass a minimum savings rate of 2%-3.9%. This financial incentive to include FQHCs in Medicare Shared Savings Program ACOs should be included in the final rule.

8. Support the increased shared savings for both the Track 1 One-Sided and the Track 2 Two-Sided Medicare Shared Savings Program ACOs when Federally Qualified Health Centers participate in such ACOs.

The proposed rule would increase the shared savings available when Federally Qualified Health Centers or Rural Health Centers participate in a Medicare Shared Savings Program ACO by up to 2.5% in one-sided ACOs and by up to 5% in two-sided ACOs. This financial incentive to include FQHCs in Medicare Shared Savings Program ACOs should be included in the final rule.

9. Include explicit alignment with HITECH meaningful use requirements.

The HITECH Act provides incentives for hospitals and physicians to achieve "meaningful use of certified electronic health records." There is great potential for health information technology to improve communication and quality for underserved populations.[20] Accordingly, we support the explicit alignment of the requirements for Medicare Shared Savings Program ACOs with the meaningful use requirements.

10. Include explicit adoption of/alignment with patient-centered medical home standards.

[20] Gibbons MC. "Use of health information technology among racial and ethnic underserved communities." *Pers Health Inform Manage* (2011); 1-13; Gibbons MC, Casale CR. "Reducing disparities in health care quality: The role of health IT in underresourced settings" *Med Care Res Rev.* (2010); 67(5 Suppl):155S-162S; Millery M, Kukafka R. "Health information technology and quality of health care: strategies for reducing disparities in underresourced settings." *Med Care Res Rev.* (2010);67(5 Suppl): 268S-298S; Ngo-Metzger Q, Hayes GR, Chen Y, Cygan R, Garfield CF. "Improving communication between patients and providers using health information technology and other quality improvement strategies: Focus on Asian Americans." *Med Care Res Rev.* (2010);67(5 Suppl):231S-245S

Similarly, patient-centered medical homes have the potential for improving quality of care for underserved populations.[21] Accordingly, we support the explicit alignment of the requirements for Medicare Shared Savings Program ACOs with current requirements for medical homes.[22]

We appreciate the opportunity to comment on this proposed rule, and hope you will consider our feedback in CMS's final version. If you have any questions, please feel free to contact me at jeffc@aapcho.org or at 510-272-9536 x. 105. Thank you.

Sincerely,

Jeffrey B. Caballero, MPH
Association of Asian Pacific Community Health Organizations

[21] The Commonwealth Fund, *Closing the Divide: How Medical Homes Promote Equity in Health Care* (2007), at http://www.commonwealthfund.org/usr_doc/1035_Beal_closing_divide_medical_homes.pdf?section=4039; Qualis Health, *Safety Net Medical Home Initiative: Change Concepts* (2009), at http://www.qhmedicalhome.org/safety-net/change-concepts.cfm; California Pan-Ethnic Health Network, *How Medical Homes Can Advance Health Equity* (2010), at http://www.cpehn.org/pdfs/Medical%20Homes.pdf

[22] RCHN Community Health Foundation, *The Next Shiny Object: Understanding ACOs in the PCMH and Meaningful Use Context* (2011), at http://www.rchnfoundation.org/images/FE/chain207siteType8/site176/client/NextShinyObject.pdf