Centers for Medicare & Medicaid Services

Department of Health and Human Services

Attention: CMS-1345-NC

P.O. Box 8013

Baltimore, MD 21244-8013

Electronic Submission

December 3, 2010

Dear Sir:

The Association for Community Affiliated Plans (ACAP) appreciates this opportunity to comment on the Request for Information on certain aspects of the policies and standards that will apply to accountable care organizations (ACOs) participating in the Medicare program under section 3021 or 3022 of the Affordable Care Act. ACAP is association of 53 nonprofit safety net health plans that serve approximately 7 million individuals who are publicly insured in 26 states.

ACAP is a strong supporter of the triple aim and attempts to improve quality, decrease costs and improve the patient experience, including the development of Accountable Care Organizations. However, as new delivery systems are developed where any form of risk is assumed by a provider or the delivery system, it is critical that adequate consumer protections be in place. In situations, where an ACO is contracting with a Medicare or Medicaid managed care organization, the managed care organization is obviously responsible for ensuring that all Medicare or Medicaid required patient protections are in place. For an ACO operating in the Medicare fee-for-service environment under the Shared Savings Program or as part of a CMMI demonstration, comparable protections should be required, monitored and enforced.

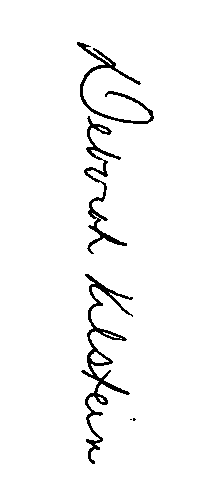
Specific to the questions raised, we agree that it is critical to ensure that solo and small group practices, as well as other safety net providers such as community health centers, have the opportunity to participate in accountable care organizations. Access to quality primary care providers that can provide care coordination and integrate services across the delivery system should be the predominant focus of the ACO model. In the fee-for-service environment, CMS must develop appropriate standards and monitoring mechanisms to ensure that ACOs are not utilizing exclusion practices as a means to avoid at-risk individuals that may reside in areas only served by small groups or other safety net providers.

Regarding beneficiary attribution, ACAP is less concerned about when the attribution occurs for purposes of measuring performance, but more concerned about ensuring patient protections are in place. We believe beneficiaries should be notified at the beginning of the performance period that they are being seen by a practice that is participating in an ACO; how they go about opting out of participation in the ACO if they wish to do; what participating in the ACO means in terms of their care, including impact on referral patterns and waiver of rules that would apply in the fee-for-service environment; and what actions they can take if they are concerned about the service being rendered. We also strongly advocate for a mechanism to monitor and report on the flow of beneficiaries into and out of the ACO to ensure there is no potential for cherry picking to avoid at risk beneficiaries.

Important aspects of patient-centeredness that should be included in the criteria under development by CMS should include requirements for ensuring the development of robust models of care, including activities geared to ensure appropriate transitions in care. In addition, in fee for service where this role is not assumed by a managed care organization, the need to provide enabling services, for example, help with transportation, and referrals to community resources, is critical, especially for low income and at-risk individuals who may lack access to resources and have unmet needs that impact their health status.

In terms of measuring patient experience, we believe that CAHPS should be used to measure patient satisfaction across the entire ACO, not just at the clinician level. However, we support addressing some of the current limitations of CAHPS that adversely impact the ability to provide a true multicultural assessment of patient satisfaction.

Finally, the quality performance standards utilized to share savings under the Shared Savings Program should foster comparable quality reporting, regardless of delivery system. Therefore, we strongly advocate for the use of HEDIS measures to evaluate the ACO delivery system as a whole, although we believe the measures should be appropriately adjusted to take into the consideration the population being served. For safety net providers, such as FQHCs, we would support deeming of quality reporting where appropriate and comparable measures such as the UDS are currently in place.

Thank you again for this opportunity to comment on this important issue.

Sincerely,

Deborah Kilstein

Director of Quality Management