November 29, 2010
Dr. Donald M. Berwick
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attn: CMS-1345-NC
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore MD 21244

Dear Dr. Berwick:

ASTHO thanks you for the opportunity to provide comments on Accountable Care Organization (ACO) models. ASTHO is a membership organization representing the state and territorial health officials in the 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and the Pacific territories: American Samoa, Federated States of Micronesia, Guam, Marshall Islands, Northern Mariana Islands, and Palau. ASTHO’s members are primarily responsible for ensuring the health of the residents in their states and territories. This includes ensuring access to health care, providing continuous surveillance, investigation and response to emerging health issues, coordinating care via community health teams, carrying-out statewide health and health care planning, and collecting data.

Effective implementation of the ACO model requires the inclusion of state and territorial health agencies to improve quality of health care and lower health care costs. The established infrastructure of state health agencies can readily support the development of ACOs.

ACOs must be required to demonstrate coordination and collaboration with state and territorial health agencies in order to participate and not duplicate services. Rather than encouraging fragmented and siloed systems, state health agencies must receive and maintain appropriate funding to support development and implementation of this model. This will ensure an integrated health care system and foster increased efficiencies.

**State Health Agency Infrastructure:**
The established state health agency infrastructure can readily support the development of ACOs. State health agencies are an integral part of the health care delivery system and already partner with insurers, hospitals, local health departments, community health centers and other providers to improve access to high quality care and reduce costs through core public health functions. For example, every state health agency provides immunization services, benefiting the payer and community. They continually partner with clinical providers to integrate public health services such as diabetes self management, tobacco cessation services, and to set standards of care. In addition, these agencies help hospitals and other health care providers meet the requirements needed to establish and maintain successful ACOs by monitoring population health status to identify community problems; informing, educating, and empowering the population about health issues; developing policies and plans that support
individual community health efforts; linking people to personal health services; and assuring the
 provision of health care when it is otherwise unavailable.

For instance, through coordination and collaboration with providers, state public health
 agencies have reduced health care acquired infections in Massachusetts, reduced admissions to
 emergency departments for non-emergency care in North Carolina, and coordinated care across
 health providers in Vermont, empowering patients and creating a system focused on wellness.

The state and territorial health agency infrastructure can continue to help providers define
 processes to promote evidence based medicine and patient engagement through self
 management programs. It can also define processes to report on cost and quality measures and
 to coordinate care through already established community care teams and tele-health, as
 required by Section 3022 of the Patient Protection and Affordable Care Act.

In order for an ACO to improve the quality of care and reduce costs, the state health agency
 must be a part of the model and share in the savings. Continued recognition of the role of
 public health in this model will ensure success in improving the population’s health.

ASTHO’s Response to Solicitation of Comments

1) 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?

CMS must consider the impact of policies and standards on the unique needs of patients
 living in rural and underserved areas and on the health care providers of these areas. Many
 of these providers are solo or small practice groups with limited resources, time, or
 infrastructure to support and implement integrated health system change. State offices of
 primary care and rural health are well positioned to help rural providers build their capacity
 and expertise to meet the policies and standards established by CMMI, another key role and
 contribution of state health agencies. We recommend that policy standards for ACOs
 include the role of state health agencies in supporting solo and small group practices to
 successfully meet the unique health needs of the citizens in these areas.

2) 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?

One payment model ASTHO recommends CMMI consider is a consortium of smaller
 providers, including state and local public health agencies. This will reduce redundancy. For
 example, some state health agencies currently provide self management courses for
diabetes self management and other programs that improve population health and reduce
 costs, thus leveraging existing state resources to support smaller practices. In addition, the
 infrastructure of state public health agencies, including data systems, human resources,
 quality improvement programs, and medical oversight, can support small practices through
coordination or sharing of resources, freeing these practices from the costly and time consuming development of these systems.

3) 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?

ASTHO encourages CMMI to consider the recommendations of the National Committee for Quality Assurance Physician Practice Connection – Patient Centered Medical Home (NCQA PPC-PCMH) standards. In addition, ASTHO recommends that CMMI use HEDIS measures. The wide use of such an established measurement tool will reduce the burden on health care providers.

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

ASTHO recommends that CMMI support the use of state public health agency data collection and analysis to assess beneficiary and caregiver experience. As the trend toward quality improvement in public health continues to accelerate and given recent health reform opportunities, state health agencies are increasingly using assessment data to incorporate performance improvement within agency functions. With the establishment of the first national public health agency accreditation program, states are working to meet national performance standards and measures and building on the essential foundation of health assessments and health improvement. State public health agencies regularly conduct community assessments to determine population health and inform state health improvement planning. These assessments can be modified to include evaluation of ACOs. Further, as part of the Public Health Accreditation Board standards, state public health agencies will implement evaluation and continuous improvement of processes, programs, and interventions, all of which could be adapted to assess beneficiary and caregiver experience for measuring ACO performance. To conduct this work, state public health agencies must receive adequate support.

5) 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?

As noted above, ASTHO encourages CMMI to consider the recommendations of the NCQA PPC-PCMH standards. Additionally, drawing on already gathered HEDIS measures will reduce the burden on providers and redundancy within the health care system.
6) **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?**

To reduce costs and promote good health, ACOs must provide or establish linkages to primary prevention efforts in their catchment areas. This should involve recognition of the community level impediments or positive factors that contribute to a patient’s ability to follow recommended clinical guidance from ACO providers. Such guidance might involve eating healthier foods, exercising, or compliance with other action steps. Therefore, there should be established incentives to encourage ACOs to work through the area’s municipal public health departments and others involved in optimizing the social and environmental circumstances in which patients reside.

In closing, state health agencies must be incorporated into the ACO model. Requiring participating providers to coordinate and collaborate with these agencies will reduce redundancy in the health care system, improve quality of care and population health outcomes, and reduce costs.

ASTHO thanks CMS for providing the opportunity to comment. We look forward to continuing as an active partner in supporting the success of accountable care organizations which will improve quality of care and lower health care costs.

Sincerely,

Paul E. Jarris, MD, MBA
Executive Director