September 5, 2013

Marilyn Tavenner, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Mail Stop 314G
200 Independence Ave., S.W.
Washington, DC 20201
Attention: CMS–1600–P

Dear Ms. Tavenner:

I am writing on behalf of the National Association of ACOs ("NAACOS") to express our members' strong opposition to several changes proposed by the Centers for Medicare & Medicaid Services ("CMS") to the determination of quality benchmarks for Accountable Care Organizations ("ACOs").

NAACOS is the only member-owned and governed association representing the interests of ACOs. Our members comprise about a third of the ACOs in the Medicare Shared Savings Program ("MSSP") and Pioneer programs, with over one million assigned beneficiaries.

Members of NAACOS believe passionately in the goals of those programs, including the creation of incentives for high quality services and the use of data to benchmark quality goals and accomplishments. However, the proposed change to 45 CFR § 425.502(b)(2) of the MSSP regulations is flawed because it would use an inappropriately narrow data set in establishing the benchmarks and would not properly measure ACO achievements against quality performance in the rest of the Medicare fee-for-service ("FFS") program. Moreover, the proposal to use a standardized method for calculating benchmark rates when a measure's performance rates are tightly clustered will create artificial distinctions among ACOs that are not clinically or statistically justified.

If finalized, the proposals would have serious negative impacts on the development of these important programs. In combination they would create additional hurdles for ACOs seeking to receive a sufficient portion of the savings they generate to remain viable entities. CMS would then lose both the progress on quality and all the savings they are able to generate for the FFS program. NAACOS believes CMS must avoid any such actions, particularly given that the ACO program has just begun and it is critically important that ACO participants — who may already be expecting reduced revenues based on a more efficient delivery of care — have confidence in CMS's commitment to the long-term success of these programs. Some of those expectations are also reflected in the ACOs receiving Advanced Payments.

Accordingly, NAACOS strongly recommends that CMS instead adopt interim measures that will continue to encourage the delivery of quality health care until a more robust and appropriate set of data is available, or in the case of the clustered measures, until more meaningful distinctions can be identified (either in the existing measures or in alternative measures). We describe several possible alternatives below. NAACOS looks forward to a constructive dialogue with CMS on this critical issue.

Proposed Use of ACO Data

Under CMS's proposed change to § 425.502(b)(2), performance benchmarks used in calculating ACO quality performance scores will use Medicare Advantage ("MA") and FFS data, except when data are "unavailable, inadequate, or unreliable" (in which case flat percentages would be used). We understand that the change will allow CMS to use MSSP and Pioneer ACO data (and if applicable, MA data) to be submitted through the Group Practice Reporting Option ("GPRO") web interface in setting certain quality measures. Thus, as CMS explains in the preamble to the proposed rule, data submitted by MSSP and Pioneer ACOs in 2013 for the 2012 reporting period would establish the performance benchmarks for the 2014 reporting period. Performance benchmarks for future years would be established in the same way. In the regulatory impact analysis in the preamble, CMS expressed the view that "There is no impact for the additional proposals related to requirements for setting benchmarks…"

NAACOS strongly disagrees with CMS's assessment of the impact. Of the current 33 quality measures in the ACO programs, 22 are reported through the GPRO web interface. We understand that only about 100 entities reporting through the GPRO web interface in April 2013 were not Medicare ACOs. Moreover, those non-ACO entities are all larger and more sophisticated group practices with experience in coordinating care. This means that a significant portion of the FFS benchmarking data for the GPRO metrics (and thus for the MSSP quality measures as a whole) come from entities that are not representative of the FFS program as a whole.

In fact, most of the entities reporting through the GPRO web interface in April 2013 were MSSP and Pioneer ACOs. Therefore, if CMS were to adopt its proposal to use such ACO data in establishing quality benchmarks, it would make the data even less representative of the FFS program as a whole.

Using such skewed data in establishing quality benchmarks will cause serious harm to individual ACOs and to the larger programs. In general, the benchmarks for measures reported through the GPRO web interface are determined by establishing percentiles of quality scores achieved by the organizations in the benchmark database. Comparing each ACO only to other high performing organizations means clinical activities that measure at the low end of the scale may still compare very well to activities by non-ACOs that aren't represented in the database. Accordingly, it is likely that some ACOs will achieve low quality scores when compared to these benchmarks, even though the care the ACOs provide is extremely good compared to other providers in the FFS program.

Particularly at risk would be MSSP ACOs that consist of smaller group practices and solo physician practices that need to invest heavily in redesigned care processes, care coordination and technologies to generate significant savings and achieve higher quality scores. Even if providers in those ACOs compare very favorably to similarly situated FFS Medicare providers in their areas, they could be at a significant disadvantage in terms of quality scores as compared to larger physician practices and integrated care systems, including those in other parts of the country. (While some of the measures reported through GPRO remain "pay for reporting" in performance year two for ACOs, the potential adverse impacts will still apply to the remaining measures. And of course the impacts broaden in performance year three as "pay for performance" is fully implemented.)

As a result, NAACOS fears that this CMS proposal, if finalized, would cause many ACOs to receive much lower shared savings payments than they otherwise should when compared to the FFS program as a whole. It could even create the risk that some ACOs fail to meet minimum attainment levels to qualify for shared savings. Moreover, Pioneer ACOs currently have downside risk if costs exceed benchmarks, and CMS regulations require downside risk for MSSP ACOs in future contracts. The performance benchmark problem created by the CMS proposal in an environment of potential downside risk significantly increases the potential for individual ACOs to become disillusioned and abandon the program.

Note that our concern about ACO data skewing quality benchmarks applies to all quality measures, not just those reported through the GPRO web interface. The overall goal of ACO shared savings is to promote and incentivize more efficient and higher quality care as compared to how such care is delivered in the existing FFS program. Accordingly, ACO quality should be measured only against non-ACO entities and individuals caring specifically for beneficiaries in the traditional FFS program. Nothing in the statute prevents this approach. Moreover, to do otherwise would be fundamentally unfair since (for the reasons described above) many ACOs could end up receiving a lower share of the savings they generate for Medicare which are insufficient to justify the significant investments in care processes, etc., and despite achieving high quality scores compared to providers outside an ACO program.

Also, from a broader health policy perspective, quality scores developed in the way proposed by CMS could create the false impression that many ACOs are failing to deliver on the promise of better quality that is a core element of MSSP and ACO programs. In other words, the skewed data will not provide an accurate picture as to how the ACO program is improving quality relative to non-coordinated care. By contrast, measuring ACO quality only against non-ACO entities and individuals, CMS would be advantaged for being able to truly measure quality in the FFS program and for improving policy decisions and directives.

Proposal on Clustered Data

NAACOS agrees with CMS's observation that in the case of some measures that have performance rates that are tightly clustered, that "quality scores for the measure may not reflect clinically meaningful differences between the performance rates achieved by reporters of quality." NAACOS also agrees with CMS that "a clinically meaningful assessment of ACO quality is important." Accordingly, a change would be appropriate for quality measures that are tightly clustered.

However, NAACOS does not agree with CMS's proposed solution, which is to essentially adjust benchmarks without any statistical basis for the adjustment. The proposal still purports to assign different scores to ACOs along a sliding scale despite any clinically meaningful difference in quality. NAACOS believes instead that a more fundamental change would be required for such measures.

NAACOS Proposals

We understand that over time, the GPRO web interface program will be expanded to smaller physician groups. This suggests that at some point in the future, the data base should be sufficiently robust that it will provide a fair measure of comparison. Until such time, however, we strongly recommend that CMS modify its proposal to reflect one of the following approaches:

1. CMS currently determines quality scores based on reporting for an ACO's first performance year. CMS could continue this "pay for reporting" approach for subsequent performance years for measures like those reported through the GPRO web interface in which an accurate FFS comparison is currently impossible.

2. Alternatively, for a brief transitional period pertaining to performance years beyond the first performance year, CMS could base scores on how much an ACO improves its quality scores over the prior year. For example, an ACO could achieve maximum points for a domain through improvements in the ACO's aggregate scores in that domain by a small set percentage from the prior year. This approach would avoid the data problems associated with the current CMS proposal, while providing additional incentives for improvement in quality metrics. Any proposal based on continued improvement should be implemented only as a short-term solution, until appropriate FFS data is available for comparison. Further, the level of expected improvements must be reasonable and achievable.

As a variation, this continued improvement approach could be made available to ACOs as an alternative to the approach proposed by CMS. That is, an ACO's points for a given domain would be the greater of (i) the points determined based on a benchmark established using ACO data, and (ii) the points as measured by the ACO's improvement under the NAACOS proposal outlined above. This would allow ACOs that are already performing highly to receive the maximum points and those much lower able to achieve points with a modest improvement. In summary, we believe everyone gains with an approach that includes some form of improvement. The Beneficiary's quality is better, the ACOs are rewarded for the correct behavior and the government has a sustainable ACO program that lowers costs over the long run.

With respect to clustering, NAACOS also recommends that CMS modify the proposal to reflect one of several alternatives. One approach would be for CMS to continue to use pay for reporting for the affected measures. While information reporting about the measure may still be valuable, if there is not widespread variation among performance among ACOs, then CMS should not attempt to manufacture it.

Alternatively, if CMS does implement pay for performance, NAACOS recommends assigning full quality points to all ACOs that are so clustered. Some portion of the points could then be subtracted or added only for those ACOs that are significantly below or above the clustered performance level. This would offer an incentive for achieving especially high quality on the measures, while still avoiding arbitrary distinctions that are not clinically meaningful.

Conclusion

The overall goals of the MSSP and ACOs programs are to create incentives that promote higher quality and more efficient delivery of services to Medicare beneficiaries throughout the country through greater accountability for patient populations, care coordination, and investment in infrastructure and redesigned care processes. These goals will not be pursued by a sufficient number of organizations if these incentives lack predictability or are unachievable. The members of NAACOS believe that the CMS proposals, particularly taken together, are so flawed that they would create serious barriers to many ACOs meeting the goals and will threaten the viability of these programs in an unavoidably public manner. Accordingly, NAACOS recommends that CMS modify each proposal by adopting one of the alternatives described herein.

Respectfully submitted,

Clifton Gaus
President and CEO

cc: Jonathan Blum
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Elizabeth Richter