March 1, 2016

Mr. Andrew Slavitt
Acting Administrator
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Submitted via email to MACRA-MDP@hsag.com

Re: CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs) (DRAFT)

Dear Acting Administrator Slavitt:

The National Association of ACOs (NAACOS) submits the following feedback in response to the draft *CMS Quality Measure Development Plan: Supporting the Transition to the Merit-based Incentive Payment System (MIPS) and Alternative Payment Models (APMs),* as released December 18, 2015. This document provides a strategic framework for the future of measure development for clinician quality reporting to support MIPS and APMs, and we are pleased to contribute to the ongoing dialogue on quality and how it fits into the broader transition from fee-for-service to APMs. Measuring quality is an essential part of evaluating ACO performance, and ACOs strive to continuously improve quality.

NAACOS is the largest organization of Medicare Shared Savings Program (MSSP) ACOs, representing approximately 175 MSSP, commercial, Next Generation, and Pioneer ACOs. NAACOS is a member-led and member-owned non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and health care cost efficiency. Our members, more than many other healthcare organizations, want to see an effective, patient-centric care transition process. Our recommendations reflect our expectation and desire to see the MSSP achieve the long-term sustainability necessary to enhance care coordination for Medicare beneficiaries, reduce healthcare costs, and improve quality in the Medicare program.

Quality reporting and improvement will play an integral role for providers in MIPS and APMs, and we recognize the work already underway by CMS and the healthcare industry to improve current quality measures and reporting programs, which aim to enhance beneficiary care. ACOs across the country are committed to delivering high quality care, and NAACOS advocates not only for improving quality but also for reducing the burden associated with quality reporting. The draft Quality Measure Development Plan (MDP) addresses a number of areas related to NAACOS' quality principles, which are outlined along with our

feedback below. As CMS moves forward with its rulemaking related to implementation of the Medicare Access and CHIP Reauthorization Act (MACRA), we urge the agency to consider incorporating this feedback.

NAACOS Quality Principles and MDP Feedback

Reduce quality reporting administrative burden

The administrative burden of quality reporting must be limited, and reporting tasks need to be streamlined so that delivery of patient-centered care is the principal focus. The complexity and burden of quality reporting have grown over time and rarely has there been an effort to step back and evaluate overall quality reporting burdens across Medicare and the industry as a whole. We strongly support efforts to evaluate the overall quality reporting burden and to identify ways to simplify and streamline existing quality reporting requirements. Quality reporting should be designed to collect data as part of the existing clinical workflow, and it should support, not detract from, the provision of effective, highly coordinated patient care.

Align quality measures across payers

For too long, providers have been overburdened by multiple quality reporting requirements, often inconsistent across payers and with the practice of medicine, which add administrative complexity that hinders patient care. Varying reporting requirements across payers and within the Medicare program, as well as conflicting measure specifications, create confusion and unnecessary work as providers struggle to understand a myriad of measures. We strongly support industry efforts to align quality measures across payers and to coalesce around a unified set of clinically relevant measures that support high quality patient care for population-based payment models.

The recent announcement from CMS and America's Health Insurance Plans (AHIP) about the first core set of clinical quality measures designed for use by both public and private payers, which includes a specific measure set for ACOs/primary care/patient-centered medical homes, is promising. This Core Quality Measures Collaborative includes measures designed to be used across payers as the industry shifts to value-based payment models. We urge payers to implement these measures in a coordinated manner to realize true quality measure alignment, and as part of that process, payers must replace – not add to – current measures.

Emphasize outcome measures

Valid and reliable outcome measures are direct indicators of healthcare quality that should be emphasized, especially in population-based payment models which have the large beneficiary populations necessary to properly evaluate outcomes. As recommended by MedPAC, CMS should move toward publicly reporting on a small set of population-based outcome measures concerning preventable hospital admissions and emergency department visits and condition-specific mortality for ACOs. However, it is essential that existing methodological issues, such as those related to risk adjustment and attribution, be addressed prior to CMS assigning more weight to outcome measures.

Use transparent measure evaluation

Quality measure methodologies and performance assessment must be transparent so that providers have confidence in not only the measures they are evaluated on but also on *how* they are evaluated. In addition to being transparent, CMS must also be timely in releasing its quality performance data and evaluations. Providers needs to be confident in the quality performance feedback they receive, and in order to positively affect care delivery, this feedback must be timely – within weeks or months, not years following the delivery of care.

Solidify necessary methodologies
Many quality measures require patients to be attributed to a provider or organization and necessitate risk adjustment to account for existing patient acuity. These methodologies are essential to performance evaluation on quality and cost measures, and we call on CMS to conduct the exhaustive research and necessary analysis to create scientifically sound and widely accepted patient attribution and risk adjustment methodologies. For too long the healthcare industry has relied on methodologies plagued with flaws, which can unfairly penalize providers and hold the potential to dramatically undermine the credibility of value-based payment models that rely on quality and cost measure evaluation.

Positively reward, rather than penalize, quality performance
In many Medicare programs, quality performance has shifted from being rewarded to being required in order to avoid penalties. The shift from rewards to penalties has exacerbated provider frustration with burdensome reporting requirements and competing measures across payers. MSSP ACOs must attain a perfect quality score to keep their full portion of shared savings, and less than perfect quality performance results in decreased savings. As a result, quality performance is only a punishment, not a reward, for ACOs.

In contrast, this is not the case for other Medicare programs, such as Medicare Advantage (MA), where MA plans are rewarded with higher benchmarks for higher quality. ACOs that attain high quality should be rewarded, not merely avoid penalties. Further, to positively recognize exceptional quality performance, ACOs in the top quartile of quality performance should be eligible to earn higher shared savings, up to a 10 percentage point increase in shared savings on a sliding scale based on performance.

Reward quality improvement
In addition to evaluating quality performance compared to established measure thresholds, it is imperative to recognize – and reward – quality improvement relative to an ACO's previous performance. In fact, we recommend that quality performance and improvement be equally weighted, which would provide a strong incentive for ACOs to focus on improvement.

CMS sets MSSP performance levels for quality measures that demand higher performance on quality, while achieving those higher performance levels merely prevents an ACO from forfeiting the shared savings payments it has earned. There is no direct financial reward for improving quality of care, and there is no penalty for poor quality unless the ACO has generated savings. This lack of reward for performance improvement can be a strong disincentive for ACOs to invest in quality improvement. We recommend that ACOs that are above average in their quality performance or in improvement in their quality performance from one year to the next be rewarded, such as by having their minimum savings rate reduced.

Deem ACOs successful for MIPS quality reporting
As CMS implements provisions of MACRA, including MIPS and APMs, the agency is tasked with developing quality measures under both programs and ensuring those measures are comparable. However, given the differences between MIPS and APMs, we urge CMS to use a broad approach when determining if MIPS and APM measures are comparable overall, not directly comparable.

We advocate that all ACO providers qualify as eligible APM participants and would thus be exempt from MIPS. However, should ACOs be subject to MIPS, they should not have to worry that the MSSP quality measures may fall short of MIPS requirements as implemented by CMS. If ACO providers are subject to MIPS, CMS should deem ACOs successful for all MIPS quality reporting requirements. Subjecting ACO providers to MIPS quality reporting requirements, on top of the already burdensome MSSP requirements, would be a tipping point for many ACOs and may cause them to leave the MSSP. Congress intended MIPS to be the default program for

Medicare providers as they prepare to enter into APMs and intended to incentivize the use of APMs. Subjecting ACOs, who are already in Medicare's premier APM, to MIPS quality reporting requirements would serve to undermine APM participation rather than encourage it.

Integrate measures from existing programs to MIPS/APMs in a meaningful way

As CMS evaluates existing measures under quality reporting programs (MSSP, Physician Quality Reporting System, value-based payment modifier, the Electronic Health Record Meaningful Use Incentive Program) and considers what measures to retain or retire, we urge the agency to take significant steps to streamline and simplify Medicare quality reporting. MACRA intended to replace the current programs and did not intend for CMS to merely combine the existing, flawed requirements under new names. We urge CMS to use this unique opportunity to redefine quality reporting in a meaningful, streamlined way, which necessitates abandoning many components of the existing morass of Medicare quality reporting requirements.

Conclusion

CMS' draft Quality Measure Development Plan (MDP) provides a strategic framework for the future of measure development for clinician quality reporting to support MIPS and APMs. In the MDP, CMS outlines a number of areas where the agency is already active, such as efforts to align measures across payers, and we recognize and value this work. We also realize the significant challenges of reshaping Medicare quality reporting in a short timeframe to meet statutory deadlines, and we appreciate the opportunity to contribute the ACO perspective to this critical dialogue.

Thank you for your consideration of our comments,

Clif Gaus
President and CEO