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November 19, 2010

Ms. Margaret E. O'Kane
President
NCQA
1100 13th Street NW, Suite 1000
Washington, DC 20005

                   Re: Comments on Draft Accountable Care Organization Standards

Dear Peggy:

The Pacific Business Group on Health and undersigned organizations support the NCQA's desire to support the formation of sustainable Accountable Care Organizations (ACOs) by establishing clear standards for assessing capabilities that portent potential ACO success. However, by focusing on many of the core competencies by which health plans have traditionally been measured, the proposed standards fall short in defining the organizational attributes that can deliver on the triple aim of affordability, quality and population health.

If our common goal is to drive health care transformation rather than affirm the status quo, we need to adopt a higher standard that advances payment reform and care delivery re-engineering. The promise of ACOs is to offer significant improvements in quality and care coordination and decreased cost. Purchasers believe plan and provider organizations can deliver on these objectives if performance is measured based on outcomes rather than process and structure. Therefore, we believe that any ACO standards should be constructed around the following principles:

1) ACOs must support a competitive marketplace and operate in a transparent way. Much as the NCQA Physician and Hospital scoring detail was publicly reported by Element, we propose that NCQA should provide this information for ACOs. ACOs should:
   a) Participate in public and/or privately organized collaborative reporting efforts to support the availability of consumer information,
   b) Report publicly dashboard measures at multiple levels including individual physician and/or facility site and service line,
   c) Make information regarding provider financial arrangements available to the public,
   d) Refrain from contractual non-disclosure provisions that preclude community-level quality and efficiency measurement, consumer access to information and comparative performance reporting,
   e) Refrain from contractual prohibitions on provider differentiation by payers.

2) ACOs must use a robust measurement dashboard that is outcomes-focused and patient-centered. The metrics should include benchmarks and performance thresholds for the following:
   a) Clinical outcomes,
   b) Functional status,
   c) Appropriateness,
   d) Patient experience,
   e) Care coordination and care transitions,
   f) Cost, and
   g) Resource use.

3) ACOs must address affordability and cost management by demonstrating the ability to manage financial performance with specific objectives such as:
   a) Management of trend at CPI + 1%,
   b) Maintenance of sound fiscal policies and financial management practices that assure oversight of risk-based contracts, and
   c) Expectations for resource stewardship and reduction of waste.

4) ACOs must structure provider payment to advance payment reform objectives that support evidence-based care and reward quality, not quantity. ACOs should also seek to align private and public sector approaches. Specific provisions could include the following:
   a) Use of risk-adjusted, episode payment or bundling methodologies,
   b) Non-payment for "never events," errors and inappropriate use,
   c) Use of an incentive to reward physicians and other health professionals with at least 20% of provider compensation allocated to performance-based rewards, and
   d) Participation in shared risk and or gainsharing arrangements.

5) ACOs must use a patient- centered, team-based approach to care delivery and member engagement. ACOs should require that individuals with multiple chronic conditions have a shared care plan that is accessible electronically to all providers or members of the care team (including patient and family). Delivery system elements should include, but are not limited to:
   a) Use of qualified health professionals to deliver coordinated patient education and health maintenance support,
   b) Inclusion of the patient in the care process,
   c) Support for shared decision making,
   d) Support for self-care, self-management and risk reduction, and
   e) Patient access to their health information.

6) ACOs must demonstrate robust and meaningful use of health information technology. Beyond requiring that a high percentage of participating practitioners meet the Meaningful Use targets on a concurrent basis, ACOs should federate with the NHIN structure and set rigorous Health IT adoption expectations as a practitioner entry requirement, such as:
   a) Use of information systems for clinical decision support,
   b) Demonstration of clinical integration among medical providers, enabling the ACO to set standards, evaluate performance and set improvement goals for incentive programs,
   c) Management of the care process such as electronic ordering and results and information sharing among providers,
   d) Information exchange among providers, and
   e) Information exchange with the member.

Our specific comments on each individual standard are provided in the attached Public Comment Submission Form. Our review of the Draft Standards materials leaves us with some general overarching concerns and comments that I would like to reiterate below:

Transparency of NCQA Reporting
NCQA took a major step forward in making the summary performance report for Physician Hospital Quality available. ACO accreditation should have a similar level of transparency by cataloging each organization's capabilities and allowing effective comparison among ACOs. Such information anticipates future integration of NCQA requirements with eValue8 and other purchaser RFPs to minimize duplication, and purchasers' ability to differentiate high-performing ACOs.

Limit the Number of Accreditation Levels
The proposed 4 accreditation levels reduces the distinction between high- and low-performers when any ACO can point generally to "NCQA accreditation." It is in NCQAs interest to raise the bar on ACO accreditation to assure that only high-performing groups merit distinction. We recommend that NCQA use 3 accreditation levels instead of 4, and moving the currently proposed Level 3 to Level 1. We believe that Outcomes Measurement and Health IT adoption should be threshold requirements for an organization to hold an ACO distinction.

Market Competition
This is a critical issue as recently highlighted by the Workshop Regarding Accountable Care Organizations, and Implications Regarding Antitrust, Physician Self-Referral, Anti-Kickback, and Civil Monetary Penalty Laws that was held on October 5, 2010. Noting that this is a complex issue, NCQA can play a role in minimizing the effect of ACOs on market concentration by allowing for groups of various sizes to achieve ACO accreditation. We also recommend that NCQA retain flexibility on organizational composition.

Set a High Bar
Set a high threshold based on performance – *not* process or structure, for level designation so that no organization would receive recognition for providing less than high value care. Similarly, ACOs should be expected to set minimum benchmarks that providers must meet in order to reach performance goals.

Support Innovation and Delivery System Re-engineering
There is widespread agreement that we need new approaches for care delivery to leap ahead of our current shortfalls. NCQA should consider value-differentiating strategies for consumer engagement and provider accountability that supports true innovation rather than incremental improvement. Such strategies should be information-driven and patient-centered. The PBGH "Breakthrough Strategy" that was articulated a decade ago is a model for sponsorship of value-promoting strategies that contribute to more dynamic accreditation criteria around consumer engagement and provider-level measurement.

Maintain Flexibility for Evolving Standards
It is important to recognize that there will be early adopters whose experience we can learn from. The lengthy life cycle of accreditation standards needs to be addressed such that early adopters are recognized but at the same time held to an improvement standard that is consistent with late implementers who may benefit from rapid cycle learning processes. Similarly, where external standards – such as meaningful use or maintenance of certification – are evolving, NCQA should track to those specifications.

Affordability and Provider Payment Reform
We are at a critical juncture in shifting to payment methods that reward performance and value, not quantity. Yet the proposed standards address this area in a minimalist way, when it should be central to distinguishing organizations that assume risk or performance accountability for overall trend. Without this distinction, the NCQA standards cannot distinguish value and ACOs will not impact affordability.

Support Primary Care and Workforce Issues
While we applaud the stated principle of supporting primary care and addressing workforce issues, the proposed standards do not address these issues. Some possibilities are to address education and training or care team management, but it is not clear whether such elements would be appropriate for accreditation given the variety of potential participating organizations.
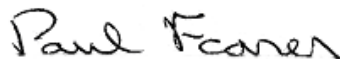
Thank you for this opportunity to provide input to NCQA's proposed ACO standards. It is an important first step in addressing the structural design of ACOs, but we encourage NCQA to look further to establishing value-differentiating criteria than can define a future generation of integrated care delivery. We look forward to refining a measurement system that purchasers can use to recognize quality and value.

Sincerely,

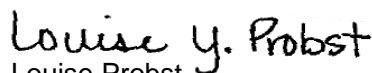David Lansky, PhD
President & CEO
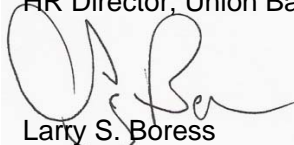Pacific Business Group on Health

Paul Fearer
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HR Director, Union Bank, N.A.

Sally Welborn
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Louise Probst
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Larry S. Boress
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Midwest Business Group on Health

Barbara Belovich
Executive Director
Health Action Council

Laurel Pickering, MPH
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New York Business Group on Health

Lauren Vela
Executive Director
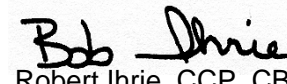Silicon Valley Employers Forum

Becky J. Cherney
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Donna Marshall
Executive Director
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Robert Ihrie, CCP, CBP
Senior Vice President,
Employee Rewards and
Services
Lowe's Companies Inc.

Enclosure

cc: Don Berwick, MD, Administrator, Centers for Medicare & Medicaid Services
     Richard Gilfillan, MD, Acting Director, Center for Medicare & Medicaid Innovation
     Peter V. Lee, Director of Delivery System Reform, US Department of Health & Human Services
     Robert Margolis, MD, Chair, NCQA ACO Task Force

Attachment: Comments submitted by Pacific Business Group on Health on behalf of large employer coalitions and purchasers

<u>**Program Operations 1: ACO Structure**</u>

Overall: The definition of ACO should be broadened to include physicians with a strong primary care base <u>and</u> sufficient other "providers with knowledge of social and community supports". Creating a strong foundation of primary care is not just about physicians but also other health and social service providers that keep patients well and living in the community.

Element A: Program Structure

Factor 2: Consumer and purchaser representatives should be included in the designated members of the ACO governing body.

Factor 3: We strongly support the recommendation ACOs must define goals for clinical quality, patient experience and cost. We propose additional specifications that performance goals should take into account community AND national benchmarks and make explicit the improvement targets.

While cost goals are defined by example, we recommend the addition of Appropriate use as distinct from Resource use. We recommend similar explanation for clinical quality and patient experience as follows.

Clinical quality goals may include those addressing:
- Health status
- Clinical processes
- Clinical outcomes
- Functional outcomes
- Care coordination and care transitions.

No more than 50 percent credit should be permitted for clinical process measures.

Patient experience goals may include those addressing:
- Access
- Treatment option decision support
- Self-care
- Provider communications

No more than 50 percent credit should be permitted for organization-level measurement of patient experience, with the remaining credit subject to physician or practice-level measurement.

Additional Factors: We recommend the inclusion of three additional factors: 1) Information about the organization's financial arrangements with its providers, 2) .Defined infrastructure and performance criteria for provider credentialing and program participation and 3) Defined fiscal policies commensurate with financial risk-bearing level of the organization.

Element B: Stakeholder Participation

Factor 2: We agree that consumers or community representatives should be one of the stakeholder groups involved in the oversight of ACO functions. We also believe that employers

should be included. Consumer and employer participation on boards and subcommittees should be proportional to other stakeholders.

Program Operations 2: Resource Stewardship

Element A: *Clinical Utilization Management*

Factor 3: Modify to specify risk assessment and adjustment to ensure the inclusion of appropriate analytics to support the process

New Factor: We recommend the inclusion of an additional factor: Process for review of resource use and appropriateness of care such as clinical complications, readmissions, emergency room utilization, facility type and level.

Element B: Resource Stewardship

Factor 3: In order to recognize the complexities of patients with multiple chronic conditions the written policies for applying criteria based on individual need, particularly those for length of hospital stay should also include availability of an informal caregiver and the availability of community service and supports.

New Factor: We recommend the inclusion of an additional factor: Use of decision support tools at the point of care to support evidence-based care. To enforce prospective care decisions vs.the somewhat dated focus on retrospective analysis.

Program Operations 3: Health Services Contracting

Element A: Skilled nursing, rehabilitation services and hospice should be included in the list of services. If an organization is responsible for managing transitions of care, they need to demonstrate the ability to manage and support the continuum of care, even if the provider relationship is on a referral basis.

Element B: Practitioner Payment Arrangements

Factor 1: We strongly support basing a portion of practitioners' compensation on performance. To ensure a delivery system based on value, the ACO should use an incentive to reward physicians and other health professionals of at least 20% of compensation allocated to performance-based rewards.

Add new factor: Structures its compensation to promote accountability for the total cost of episodes of care.

Element C: Payer Contracts

Payer contracts must include provisions that allow for transparency of financial and quality performance information at the physician-level.

Access and Availability 1: Availability of Practitioners

Element A: Assessing Network Needs

Factor 1: Geriatricians should be included as a primary care practitioner.

Element C: Assessment of Access

The explanation should include an assessment that evaluates potential seasonal variation in access.

Element E: Practitioner Directory

Overall: Since not all patients have access to the internet ACOs must find other ways of providing these patients with the complete practitioner directory. Other options include: making hard copy versions of the directory available to federal repository libraries, senior centers, and patients upon request.

The practitioner directory should include office hours and quality indicators, and HIT capability (including email with patient, EHR, and PHR support) while board certification is included, recent studies have shown that that does not correlate with high quality, therefore, it is insufficient as an indicator of quality and therefore, the directory should include performance indicators of quality process and outcomes and patient experience.

Element F: Provider Directory

Overall: Since not all patients have access to the internet ACOs must find other ways of providing these patients with the complete provider (hospital) directory. Other options include: making hard copy versions of the directly available to federal repository libraries, senior centers and patients upon request.

The provider directory should include quality indicators. and HIT capability (including email with patient, EHR, and PHR support) while certification is included, recent studies have shown that that does not correlate with high quality, therefore, it is insufficient as an indicator of quality and therefore, the directory should include performance indicators of quality process and outcomes and patient experience.

Element G: Cultural Needs and Preferences

Factor 2: Given current demographics and the supply of practitioners, it will not always be possible to adjust practitioners within its network to meet preferences. Organizations should provide cultural competency training based on the assessment of cultural, ethnic, racial and linguistic needs of its patients.

Primary Care 1: Practice Capabilities

Element E: Managing Care:

Factor 1: Pre-visit planning should be conducted for 100 percent of appropriate patients – not the at least 75 percent included in the element. If it is not possible for an ACO to meet the 100 percent figure immediately then a 3-year staged move to 100 percent coverage should be allowed.

Factor 2: The individualized care plan that the ACO team is required to develop should include *care* goals in addition to *treatment* goals. Some patients may not want treatment per se preferring palliative care.

Factor 3: Care plans should be conducted for 100 percent of appropriate patients – not the at least 75 percent included in the element. If it is not possible for an ACO to meet the 100 percent figure immediately then a 3-year staged move to 100 percent coverage should be allowed.

Factor 4: The barriers to treatment and care goals should also include lack of: support for family caregivers, resources, and community services and supports.

Factor 5: Clinical summaries should be conducted for 100 percent of appropriate patients – not the at least 50 percent included in the element. If it is not possible for an ACO to meet the 100 percent figure immediately then a 3-year staged move to 100 percent coverage should be allowed. Clinical summaries must be written in easy to understand, consumer friendly language.

Factor 6: Referrals should be a routine practice for older patients with multiple chronic conditions especially dementia. Referrals should also include culturally appropriate local social service providers and community supports.

Factor 7: Follow-ups with patients who have not kept important appointments should be conducted for 100 percent of appropriate patients – not the at least 50 percent included in the element. If it is not possible for an ACO to meet the 100 percent figure immediately then a 3-year staged move to 100 percent coverage should be allowed.

New element: Uses standardized tools for assessment of health status, functional outcomes and behavioral health screening for 100% of appropriate patients. Examples SF12, PHQ9, etc.

Element F: Manage Medications

Factor 2: The ACO should provide patients/families with clear information about new prescriptions in language they understand.

Element G: Self Care Process

Overall: The ACO should conduct self-management activities with 100 percent of patients/families – not the 50 percent included in the element. If it is not possible for an ACO to meet the 100 percent figure immediately then a 3-year staged move to 100 percent coverage should be allowed.

Element H: Test Tracking and Follow-Up

Factor 4: In addition to notification of normal and abnormal test results the ACO must also ensure that patients receive help in understanding the results, the appropriate follow-up care, and treatment recommendations.

Element I: Referral Tracking and Follow-Up

Factor 3: Once the practice receives the report from the specialist the information is shared with the patient in a timely fashion.

Element J: Quality Improvement Activity

Overall: This element seems to overlap with PR 2: Quality Improvement. We recommend using the elements in PR 2: Quality Improvement with the addition of Factor 3.

Element K: Identify High Risk Patients

Factor 1: Lack of family or community support resources and Dementia should be added to the list of criteria for identifying high risk patients.

CM 1: Data Collection and Integration

Overall: This should be a "must pass" standard for ACOs. ACOs should maintain an accessible provider directory that includes email and IP addresses so that external parties can locate address information to send electronic messages to provider organizations and individual practitioners. The standards should better align with the current HIE efforts that are underway. The ACO should demonstrate that it has clinically integrated the medical providers delivering its services. This will enable the ACO to set standards, incentives, and evaluate its services.

Element A: Process for Data Collection and Integration
Patient experience and patient reported outcomes should be included as data sources.

Element B: Data Collection and Integration
Patient experience and patient reported outcomes should be included as data sources.

Element C: Patient Information

Factors 1, 2, 3, 4, 5: Date of birth, gender, race, ethnicity, and preferred language should be collected for 100 percent of patients – not the at least 50 percent included in the element. ACOs should be held to a much higher standard than that set by the meaningful use requirements that were designed to permit solo practices to qualify.

Element D: Clinical Data

Factors 3, 4, 5, 6, 7, 8: Blood pressure, height, weight, BMI, length/height, weight, head circumference and pediatric BMI, tobacco use should be recorded and chart changes for 80 percent of patients – not the at least 50 percent included in the element.

CM 2: Initial Health Assessment

Element A: Health Assessment

Overall: Follow-up with patients who could not be reached or did not participate in the initial health assessment should also include family caregivers where appropriate – particularly for dementia patients.

CM 3 Population Health Management

Element B: Data Sources for Identification
Patient reported outcomes and/or functional status should be included as a source of data for identifying patients.

CM4: Practice Support

Element A: Patient Care Registries

Overall: ACOs should maintain registries for at least 5 chronic conditions for purposes of not only patient care, but to improve data collection that can be used for longitudinal analysis of global patient outcomes.

Element D: Self-Management Support

Overall: All self management materials must be written in clear, consumer-friendly language. Self-management support must be integrated into the care process at the point of care.

CT1: Information Exchange for Care Coordination and Transitions

Overall: Care providers may include, but are not limited to, primary care practices, specialists, and hospitals. Other providers may include home health, nursing homes, and hospice.

Element B: Process for Transitions:

Factor 5: The ACO should, when appropriate, follow-up with the caregiver to evaluate the patient's status and any required follow-up appointments.

RR1: Patient Rights and Responsibilities

Element A: Rights and Responsibilities Statement

Factor 1: In plain language, patients should be informed of their assignment to an ACO and are given an opportunity to opt out. Patients are notified of ACO providers and facilities' financial incentive to reduce costs.
Factor 4: Patients should be informed that they have access to an external appeals process.

Element D: Policies and Procedures for Complaints

Overall: Patients should be informed that they have access to an external appeals process.

PR1: Performance Reporting

Overall: ACOs take responsibility for simultaneously improving health, improving patient experience and reducing costs. This is reflected in Program Operations 1, Element A, Factor 5 and other areas throughout the standards. Performance reporting should reflect this as well. The intent should be revised to: "…to improve the quality of its services *and moderate costs* by measuring performance…).

Element A: Core Performance Measures

Overall: Purchasers expect ACO's to use a robust measurement dashboard that is outcomes-focused and patient centered. The metrics should include the following: clinical outcomes, functional status, appropriateness, patient experience, care coordination, cost and resource use.

While we strongly support patient experience surveys being a required measure, we are very disappointed only eleven other measures are required. To be able to better assess and compare across ACOs NCQA should require a core set of at least thirty-five measures by all ACOs. The core set should capture preventive care and a portfolio of measures that address

the breadth of care for three chronic conditions. Additionally, there should be a greater focus on outcomes, resource use, and cost. Missing from the Appendix A: ACO Measure Grid are more measures related to patient engagement, patient safety, care coordination, outcomes, functional status, episodes of care, resource use, and hospital patient experience. See Appendix ## for examples.

Element A: Core Performance Measures

Factor 4: ACOs must report on resource use and cost. The factor should not be constructed so this can be avoided (e.g., only report on appropriateness).

Element B: Performance Measure Data Sources

Patient surveys should be included as a necessary data source for supporting performance measurement. An alternative to these structural measures would be to focus on; a) ACO's accountability to ensure data is valid and complete, b) ensuring that "like data" that comes from different sources (claims, lab, EMR) is truly the same data, and c) provide the definitions/specifications for measures in each of these data source settings to ensure they are the same (e.g. measure x requires prescription dispensed not prescription ordered.

Element C: Practitioner Performance Reporting

Overall: Quality data should be publicly reported and stratified by race, ethnicity, language, and gender. Practitioner performance reporting should include the following information: a) baseline vs. change over time, b) reliability/variation properties of the metrics, and c) absolute vs. relative performance comparisons.

Factors 2 and 3: The organization should distribute reports both at the practice-level and individual practitioner-level. Since there is a lot of variation that is masked at the practice level, to effectively stimulate quality improvement it is necessary to include results on individual performance. This should be a "must pass" element.

Element D: Reporting Performance Publically

Overall: The information for patients should be clearly written, with explanations for how to interpret the information. Materials should be provided electronically and hard copies should be made easily available to patients/caregivers without access to the internet. Performance should be reported at the individual provider/physician level wherever possible. Quality data should be publicly reported and stratified by race, ethnicity, language, and gender.
The reports must include standard/benchmarks suggesting that ACOs should participate in larger regional collaborative in order to obtain regional benchmarks for comparative purposes.

Factor 4: ACOs must report on resource use and cost. The factor should not be constructed so this can be avoided (e.g., only report on appropriateness).

PR2: Quality Improvement

Element B: Patient Experience Improvement

Overall: There should be a process for collecting information on the family caregiver's experience, especially if the patient has cognitive impairment or dementia. In addition, a focus

should be on the experiences/needs of chronically ill, high risk, complex patients. This would include domains of self-care management, care coordination, shared decision making and care system integration.