National Business Group on Health

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

November 29, 2011

The Honorable Marilyn B. Tavenner
Acting Administrator
Centers for Medicare and Medicaid Services (CMS)
Room 314 G
U.S. Department of Health and Human Services (HHS)
7500 Security Boulevard
Baltimore, MD 21244–1850

RE: RIN 0938-AQ22, Final Rule, Section 3022 of the Affordable Care Act, Medicare Shared Savings Program: Accountable Care Organizations

Dear Acting Administrator Tavenner:

The National Business Group on Health appreciates the opportunity to comment on the final rule implementing Section 3022 of the Patient Protection and Affordable Care Act (ACA) establishing the Medicare Shared Savings Program and Accountable Care Organizations (ACOs).

The National Business Group on Health (Business Group) represents over 330, primarily large, employers (including 68 of the Fortune 100) who voluntarily provide health benefits and other health programs to over 50 million American employees, retirees, and their families.

Our members, America's largest employers, have long advocated for fully integrated and organized health care systems that are patient-centered and focused on improving the health care of populations. We continue to believe that if CMS implements ACOs correctly, CMS has the potential to truly reform health care by incentivizing and rewarding networks of providers (hospitals, primary care physicians, specialists and other health care professionals) who succeed in truly coordinating patients' care, controlling costs and improving quality to move us all towards an effective and efficient health care delivery system.

We appreciate the final rule's provisions for CMS to share aggregate Medicare claims data from applicants and ACO application information with the antitrust agencies to aid in monitoring for anti-competitiveness and to examine private and Medicare data for price and cost shifting patterns. However, we are ***strongly*** disappointed that CMS removed the pre-screening process for ACOs with 30-50% of local market share from the

proposed rule, which could increase prices for employers and employees if the ACOs exert undue market leverage and shift costs to patients and private payers.

In our June 6th comment letter, we stated that a successful ACO program will have a strong foundation in primary care; require reporting and high levels of performance on consensus-approved quality measures; engage patients to participate in their own care; provide greater payments (rewards) for better performance and penalties for failure to meet quality or savings standards; maintain an openness to innovative payment methods and avoid overvalued, unnecessary and potentially harmful care.

We are pleased the final rule incorporates a number of our proposals, but we continue to make the following recommendations, which reflect the specific suggestions and concerns of our member companies:

The National Business Group on Health applauds the following provisions in the final rule

- **Sharing CMS' aggregate Medicare claims data from applicants and ACO application information with the Federal Trade Commission (FTC)/Department of Justice (DoJ) to aid in monitoring for anti-competitiveness**
- **Conducting a study examining how ACOs participating in the shared savings program have affected the quality and price of health care in private markets**
- **Working with the federal anti-trust agencies to examine private and Medicare data for price and cost shifting patterns and identify any necessary responses**
- **Placing a preference on National Quality Forum (NQF)-endorsed measures**
- **Adopting a phased approach to quality measure selection by initially limiting measures to leverage the data that hospital providers and health plans are already capturing, measuring, monitoring and providing**
- **Using ACOs' internal claims and administrative data to monitor and identify patterns of avoiding at-risk beneficiaries and misuse, underuse, and overuse of services over time**
- **Allowing ACOs to assign seniors to ACO qualified providers/suppliers (physicians, nurse practitioners, physicians assistants or clinical nurse specialists) that actually handle most of their primary care needs**

The National Business Group on Health is disappointed CMS removed the following important anti-trust, patient safety protections and risk-sharing provisions from the proposed rule

- **The anti-trust protection to bar ACOs that have 50%+ local market share from participating**
- **The mandatory prescreening for anti-competitive impact of ACOs with 30-50% of local market share**

- **The reporting of patient safety measures for the health care-acquired conditions (HACs) composite**
- **The provision for both ACO tracks to share the financial risk for losses as well as savings**

<u>The National Business Group on Health continues to provide the following recommendations to implement the final rule</u>

- **Update the quality measures on an annual basis taking into account any updates by the NQF, new information garnered from the comparative effectiveness research of the Patient-Centered Outcomes Research Institute (PCORI), and removing any measures that are no longer supported by the evidence**
- **Add quality measures promoting patient responsibility and accountability for health and wellness**
- **Publicly report quality performance standard scores to rank ACOs and create a public, searchable database for Medicare beneficiaries to compare ACOs based on quality**
- **Create a public, searchable database of ACOs' shared savings and losses that is easy-to-understand and use**
- **Publicly report ACOs' results on the patient and caregiver experience quality measures**

Again, thank you for the opportunity to comment. You are doing a commendable job steering the Medicare program to become more effective and efficient. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012, if you want to discuss our comments in further detail. We look forward to continuing our work with you to ensure the successful implementation of the ACO program.

Sincerely,

Helen Darling
President

cc: The Honorable Donald Berwick, M.D., Administrator, CMS
The Honorable Kathleen Sebelius, Secretary, HHS
Dr. Richard Gilfillan, Acting Director, CMS Innovation Center
The Honorable Christine Varney, Assistant Attorney General, U.S. Department of Justice
The Honorable Jonathan D. Leibowitz, Chairman, Federal Trade Commission

The National Business Group on Health applauds the following provisions in the final rule

- **Sharing CMS' aggregate Medicare claims data from applicants and ACO application information with the FTC/DoJ to aid in monitoring for anti-competitiveness**

Under the final rule, CMS will provide the antitrust agencies with aggregate claims data regarding allowable charges and fee-for-service payments from applicants and ACO application information for ACOs participating in the shared savings program to help identify potentially anticompetitive conduct, including consolidation.

We applaud the final rule's requirement for CMS to share aggregate Medicare claims data from applicants and ACO application information with the antitrust agencies to aid in monitoring for anti-competitiveness. While CMS weakened many of the antitrust protections in the proposed rule, we commend CMS' efforts to improve the oversight of ACOs to help guard against unwarranted higher prices and lower quality for Medicare as people with private coverage.

- **Conducting a study examining how ACOs participating in the shared savings program have affected the quality and price of health care in private markets**

The final rule requires the antitrust agencies to conduct a study examining how ACOs participating in the shared savings program have affected the quality and price of health care in private markets. CMS will use the study's results to evaluate whether they should expand ACO eligibility criteria during the application review process to address competition concerns in the future.

We applaud the final rule's requirement for the antitrust agencies to conduct a study examining how ACOs participating in the shared savings program have affected the quality and price of health care in private markets. Private payers—self funded employer plans, commercial insurers, and people who buy their own insurance or pay part of the cost of their coverage through employers—are likely to feel the brunt of anti-competitive effects because they cannot set prices administratively like Medicare, which can mitigate the harmful effects of market power.

- **Working with the federal anti-trust agencies to examine private and Medicare data for price and cost shifting patterns and identifying any necessary responses**

The final rule requires CMS to work with the antitrust agencies and the HHS Office of the Inspector General (OIG) to detect patterns for cost shifting by the ACOs and identify any necessary responses.

We applaud the final rule's requirement for the antitrust and other agencies to work together to detect patterns of cost-shifting by the ACOs and identify any necessary

responses. We also continue to recommend that CMS deny or reduce shared savings payments to ACOs that demonstrate evidence of increased "cost shifting" to private payers and non-Medicare beneficiaries. Producing "savings" for the Medicare program and then making up for lost revenues by charging non-Medicare payers and patients more should not be mistaken as evidence for the more efficient provision of care and CMS should not reward it.

- **Placing a preference on NQF-endorsed measures**

The final rule places a preference on NQF-endorsed quality measures with a few non-endorsed measures for ACOs.

We applaud CMS' preference for consensus-based, NQF-endorsed quality measures for ACOs. CMS and NQF have a long tradition of collaboration on quality measures. However, we also recommend that CMS not use measures that the NQF has not yet endorsed and allow private- and public-sector stakeholders to work together to craft and implement quality improvements in the American health care system.

- **Adopting a phased approach to quality measure selection by initially limiting measures to leverage the data that hospital providers and health plans are already capturing, measuring, monitoring and providing**

The final rule's quality measures use data that hospital providers and health plans are already capturing, measuring, monitoring and providing under the Agency for Healthcare Research and Quality (AHRQ) indicators, measures from the Healthcare Effectiveness Data and Information Set (HEDIS), the Electronic Health Record (EHR) meaningful use Stage 1 measures, and the Physician Quality Reporting System (131 quality measures for claims based reporting that become mandatory in 2015). CMS will update ACOs' quality measures as the program progresses.

We strongly applaud the final rule's adoption of a phased approach to quality measure selection by initially limiting measures to leverage the data that hospital providers and health plans are already capturing, measuring, monitoring and providing. Adopting this approach will reduce ACOs' administrative burdens by focusing on performance data that relies mostly on claims or survey data rather than new data gathered through additional manual collection processes that take place outside the normal workflow of providing patient care. Of the proposed rule's 65 measures, 50+ would have imposed a significant data collection burden on ACO providers.

- **Using ACOs' internal claims and administrative data submitted to monitor and identify patterns of avoiding at-risk beneficiaries and misuse, underuse, and overuse of services over time**

CMS will use internal claims and administrative data submitted from ACOs, without requiring additional measures, to monitor and identify patterns of avoiding at-risk beneficiaries and misuse, underuse, and overuse of services over time.

We strongly support CMS' efforts to use internal claims and administrative data submitted from ACOs to monitor and identify patterns of avoiding at-risk beneficiaries and misuse, underuse, and overuse of services over time. We still recommend that CMS focus on misuse and overuse as much as underuse when measuring ACOs' performance on the quality measures and target the areas for misuse identified by the National Priorities Partnership. An October 2011 study in the Archives of Internal Medicine found that the top 5 *overused* clinical activities across 3 primary care specialties (pediatrics, internal medicine, and family medicine), as chosen by physician panel consensus, including complete blood count (CBC) tests for adults older than 18; prescribing antibiotics for children with pharyngitis; prescribing expensive statins; annual electrocardiograms (ECGs) for adults older than 18; CTs and MRIs for adults 18-55 with lower back pain; etc. exceeded $5 billion in 2009.

- **Allowing ACOs to assign seniors to any ACO qualified providers/suppliers (physicians, nurse practitioners, physicians assistants or clinical nurse specialists) that actually handle most of their primary care needs**

Under the final rule, if Medicare beneficiaries have not received care from a primary care physician, then CMS assigns them based on where they receive a plurality of primary care services for any ACO qualified provider/supplier (physicians, nurse practitioners, physicians assistants or clinical nurse specialists).

We applaud the final rule's provision allowing CMS to assign beneficiaries who have not received care from a primary care physician to the ACO qualified provider/supplier where they receive a plurality of primary care services. Seniors may receive most of their primary care services from nurse practitioners, clinical nurse specialists, or physician assistants. CMS should assign seniors to ACOs with the providers that actually handle the majority of their primary care needs.

The National Business Group on Health is disappointed CMS removed the following important anti-trust, patient safety protections and risk-sharing provisions from the proposed rule

- **The anti-trust protection to bar ACOs that have 50%+ local market share from participating**

The final rule removes the provision from the proposed rule that would have barred entities that have 50+ local market share from participating in the shared savings program.

We are strongly disappointed that CMS removed the anti-trust protection in the proposed rule to bar entities that have 50%+ local market share from participating which would have erred on the side of caution to prevent harm to consumers. While not all market consolidation is anticompetitive, given the recent wave of hospital consolidation and hospital purchase of physician practices, consumers and payers have legitimate reason for concern that the ACO program could lead to additional consolidation that proves anti-competitive. Because antitrust agencies and courts have found anti-competitive harm to consumers at levels below 50%, and because of the newness of the program and the proposed voluntary screening process for review for entities with >30% local market share, barring entities that have 50% local market share would have reduced the possibility that ACOs will harm consumers.

- **The mandatory prescreening for anti-competitive impact of ACOs with 30-50% of local market share**

The final rule removes the provision from the proposed rule that would have required mandatory prescreening of ACOs with between 30-50% of local market share for anti-competitive impact.

We are strongly disappointed CMS removed the mandatory prescreening of ACOs with market shares between 30-50% for anti-competitive impact from the proposed rule. We believe the antitrust agencies should assure sufficient mandatory prescreening of ACOs to prevent harm to consumers for several reasons. First, because of the newness of the ACO and shared savings program, the antitrust agencies should review more rather than fewer entities. Not only is the ACO program new, but also its approach to analyzing entities based on primary service areas (PSAs) is new. Second, the potential harm and cost to consumers of false negatives—insufficient review of entities that could exercise market power—warrant the additional caution. Finally, proactive prevention by antitrust agencies at the outset rather than enforcement after the fact would have prevented litigation and improved the chances for ACOs to succeed.

- **The reporting of patient safety measures for the HAC composite**

The final rule removes the HAC composite measure from the final ACO rule due to complications in measuring the data (claims vs. surveillance data, reducing and not eliminating HACs, risk adjustment, ACOs that do not include hospitals, etc.). However, CMS may break out the 10 HAC components from the proposed rule and score the measures individually and consider claims-based HAC measures calculated at the patient level for populations assigned to ACOs.

We are strongly disappointed that CMS removed the patient safety quality measures for the HACs. While removing the HAC composite measure does eliminate rewarding preventable medical errors for providers who reduce, but do not eliminate these conditions, it also removes the incentive for ACOs providers to ensure they meet these basic quality improvements for a Foreign Object Retained After Surgery; Air Embolism; Blood Incompatibility; Pressure Ulcers, Falls and Trauma, Catheter-Associated UTI, Manifestations of Poor Glycemic Control, Central Line Associated Blood Stream Infection (CLABSI), Surgical Site Infection, etc. The measures include nine areas already targeted by CMS' Partnership for Patients. In addition, the Affordable Care Act will reduce Medicare payments to hospitals based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions for the conditions endorsed by NQF, beginning in 2012. NQF has endorsed measures to reduce HACs for years. Accordingly, ACOs that include hospitals will already have to meet many of these common sense quality measures and because they are "rare" events, they should be easy for every Medicare ACO provider to attain.

- **The provision for both ACO tracks to share the financial risk for losses as well as savings**

The final rule removes the provision from the proposed rule that would have required Track 1 ACOs to share financial risk as well as savings in the third year of their agreements with CMS. Now, these ACOs only have to transition to a shared savings/shared losses model after year 3.

We are strongly disappointed that CMS removed the provision in the proposed rule for both ACO tracks to share the financial risk for losses as well as savings so all ACOs have an incentive to lower excessive costs. A bonus-only or shared savings model for ACOs meeting quality and cost growth targets does not fully incentivize ACOs to become more effective and efficient. The final rule's change also allows ACOs to enter the program who may not meet the quality or savings targets and saddles CMS with additional costs. ACOs that share financial risk for losses as well as savings have an incentive to lower excessive costs and share the burden with Medicare if they fail to meet their cost and quality targets.

The National Business Group on Health continues to provide the following recommendations to implement the final rule

- **Update the quality measures on an annual basis taking into account any updates by the NQF, new information garnered from the comparative effectiveness research of the PCORI, and removing any measures that are no longer supported by the evidence**

Under the final rule, CMS will add and retire measures through the rulemaking process, tentatively at the 4th quarter of the preceding year or the 1st quarter of the applicable year.

We strongly recommend CMS review the quality measures on an annual basis and take into account any new scientific evidence published in peer-reviewed medical literature, new information garnered from the comparative effectiveness research of the PCORI, and remove any measures that are no longer supported by the evidence.

- **Add quality measures promoting patient responsibility and accountability for health and wellness**

The final rule includes a number of criteria for ACOs to demonstrate patient-centeredness and references our original recommendation to consider measures promoting patient responsibility, but does not include any measures in this area.

We recommend ACOs include quality performance measures promoting patient responsibility and accountability for health and wellness in the final rule, such as providing cost and wellness information to beneficiaries so they have a greater understanding of health care cost challenges and individual accountably. ACOs need to view patients as partners for improving the quality of care. Recent surveys from the National Business Group on Health found that employees want health communications targeted to their needs; employees want to reduce their costs and get more value out of their care; and employees want to live healthier. ACOs should follow our nation's best performing companies by partnering with their patients to lower costs and improve care. We know from our own research that employees at the best performing companies have a greater understanding of health care cost challenges and individual accountability. The best performing companies believe that employees can become better health care consumers by providing them with information and supporting patient responsibility.

- **Publicly report quality performance standard scores to rank ACOs and create a public, searchable database for Medicare beneficiaries to compare ACOs based on quality**

The final rule requires CMS to publicly report certain ACO quality data on the Physician Compare website. The final rule also requires ACOs to describe in their applications how they plan to internally report on the quality and cost metrics.

We continue to recommend that CMS publicly rank ACOs based on quality and cost and inform Medicare patients of high and low quality ACOs. Making this information public will encourage ACOs to manage the cost and care of patient populations. CMS should also create a public, searchable database to compare CMS' quality rankings of ACOs.

- **Create a public, searchable database of ACOs' shared savings and losses that is easy-to-understand and use**

The law requires ACOs to publicly report their shared savings or losses information, including the amount of any shared savings performance payment received by the ACOs or shared losses owed to CMS. The law also requires public reporting of the total proportion of shared savings invested in infrastructure, redesigned care processes and other resources to support the three-part aim goals of better care for individuals, better health for populations and lower growth in expenditures.

We continue to recommend CMS create a public, centralized, searchable database with electronic results of the distribution of shared savings, investments in redesigned care processes and losses of ACOs that is easy for the public to access, understand and use. Centralizing the public reporting of ACOs' shared savings will allow other ACOs, Medicare and private payers to benchmark against successful practices that improved care and reduced costs. Centralized public reporting will also aid patients in choosing high-performing ACOs and avoiding low-performers. Public reporting of ACO losses will also allow stakeholders to avoid any potential financial pitfalls from contracting with more expensive ACOs who failed to achieve the proposed rule's minimum savings rate (MSR).

- **Publicly report ACOs' results on the patient and caregiver experience quality measures**

The final rule states that CMS will address the public reporting of measures of patient experience and claims- and administrative-based measures in future guidance. The final rule proposes 7 Consumer Assessment of Healthcare Providers and Systems (CAHPs) survey quality performance measures under the domain of Patient and Caregiver Experience to determine shared savings. The final rule also added a CAHPs measure designed to assess whether the patient has appropriate access to specialists, rather than including the measure asking patients if their providers' office staff was helpful, courteous and respectful.

We continue to recommend that CMS make all of the ACOs' results on the patient and caregiver experience quality measures available to the public on the Hospitalcompare.hhs.gov website. Patient survey results help the government, patients and private payers indentify high and low value providers based on patient experience.