Comments Submitted to NCQA
April 6, 2012
Technical Specifications for ACO Measures

General Guidelines—SUPPORT WITH MODIFICATIONS
Comment: The Consumer-Purchaser Disclosure Project (CPDP) supports using validated measures and benchmarks to gauge the quality of care. We have concerns with NCQA's statement, in section "*22. Benchmarking*," that benchmarking ACO measurements is valuable "but not yet viable." We suggest NCQA move quickly to ensure viability.

Other comments about ACO technical specifications—SUPPORT WITH MODIFICATIONS
Comment: The Consumer-Purchaser Disclosure Project (CPDP) views ACO design as an opportunity for innovation and reinvigoration of the measurement system. Unfortunately, this draft document includes nothing new. There is nothing innovative or compelling in this approach. We suggest that the NCQA look to gaps in the measures field and capitalize on the power it currently has—designing a relatively new approach to health care—to introduce improvements on how measurement is currently done.

Given that a primary purpose of the ACO model is to manage care for a population of patients, we are disappointed to see that this draft does not include longitudinal measurement. We strongly encourage NCQA to include longitudinal measurement into the program, such as improving care or maintaining health status for chronic conditions.

As we recommended to CMS when they were developing their ACO guidelines, we urge NCQA and ACOs to examine performance measures by race, ethnicity, gender, preferred language, and disability status and report these results. This will move ACOs forward in the drive to reduce and eliminate health disparities and also identify any areas where improvements are necessary. We are disappointed these important variables are not included in the current draft and urge NCQA to include them in the revisions.

NCQA strategic approach to ACO measurement—SUPPORT
Comment: The Consumer-Purchaser Disclosure Project (CPDP) strongly encourages alignment between public and private programs. We believe that when both types of payers address health care quality and cost issues in concert, the impact of its programming is amplified. For that reason, we are pleased to see NCQA adopt the common set of HEDIS measures.

A-2. Attributing patients to ACOs—SUPPORT WITH MODIFICATIONS
The CPDP supports ACOs being built around a core of primary care providers. We recognize that medically underserved communities (both rural and urban) depend heavily on a full range of primary care professionals. In some areas, this includes non-physician primary care providers, such as physician assistants and nurse practitioners. Furthermore, we support alignment with the Affordable Care Act (ACA)'s definition of ACO professionals as "physicians or practitioners." For this reason, we are

encouraged to see physician assistants and nurse practitioners who offer primary care services included as providers for the attribution model.

B-1. Stratifying the population for ACO measurement—DO NOT SUPPORT

Comment: The Consumer-Purchaser Disclosure Project (CPDP) is very concerned about the lack of granularity of data reporting. The amount of transparency on quality performance in these draft technical measures is problematic, given that it includes only reporting at the ACO level. This moves us steps backwards from the individual provider and provider group reporting currently happening in public and private sectors. Therefore, NCQA must require both provider-level and ACO-level reporting. This NCQA draft states that "ACOs—not individual providers—are broadly accountable for care that patients receive across the ACO and its participating providers, and believes that ACO attribution models adequately define patient inclusion criteria for the ACO population being measured." We could not disagree more. Research shows that much of the variation occurs at the individual provider level, not the practice site, group, or health system level. Knowing how an ACO scores is not sufficient to guide incentive programs that can motivate individual physicians. We have seen this for the Sustainable Growth Rate; reporting at an aggregate level does not motivate individual physicians to make change. Moreover, for a program to be truly patient-centered, it must give consumers information at the individual provider level. To not do so is misleading given all the variation in quality that will be present in ACOs.

Topic: C-2. Systematic sampling and sample size requirement—SUPPORT WITH MODIFICATIONS

Comment: The sample size is not designed to have adequate numbers for drilling down to provider level performance and we have concerns with that. See comments under B-1.