



November 19, 2010

Margaret O’Kane, President
National Committee for Quality Assurance
1100 13th Street, NW
Suite 1000
Washington, DC 20005

Dear Ms O’Kane:

The American Medical Group Association (AMGA) appreciates the opportunity to provide comments on NCQA’s Accountable Care Organization (ACO) Draft 2011 Criteria. AMGA is a professional association representing multispecialty medical groups and other organized systems of care. We therefore have a strong interest in criteria for ACOs that may help shape the program as it is implemented in the years ahead.

AMGA suggests that the 30-day comments period is insufficient and restricts the ability to fully expound on and develop written comments. Sixty to ninety days for a comment period should be the norm, as should be allowing unabridged comments. None of our comments is to be construed as an endorsement of the NCQA criteria by AMGA. By offering comments, we take no position on the overall document or its stated purposes.

Absent any Federal rules, issuing draft criteria is premature. Given the nature and origins of ACOs as a Medicare initiative, Federal regulations should be taken into account prior to the creation of such criteria. The nature and scope of specialty care in an ACO should not be set forth in the criteria. In Federal requirements, only primary care capability is stipulated, and that in broad-brush terms.

Reasonable arguments on both sides of the question of levels of ACO scoring exist. We generally oppose a tiered approach to standards for ACOs and believe that, a *per se* approach is superior—either an entity qualifies in its entirety, or it is not an ACO. We believe that creating tiers, putatively geared to opening the model to broad participation, runs the risk of setting standards and capabilities too low. This in turn may end up stifling evolution to becoming a mature ACO, not fostering it, and diluting start-up interest and momentum necessary for a) short term success in garnering of shared savings opportunities and b) killing any chance of the longer term potential of ACOs to redirecting our fragmented care delivery system to one of greater integration, with all of the societal and patient care benefits inherent in a more integrated system. If, as is likely, such a tiered structure is mirrored in tiered reimbursements, that risk is high and ACOs will be hobbled at inception. On the other hand, if

reimbursements were offered only for the “top level” of ACOs, the risks described would be mitigated if not eliminated.

An alternative to including four levels is to have only two; make the lower tier unrenewable, of finite duration (we suggest three years), before requiring the ACO to advance to the higher tier. Failing to evolve, the ACO should not continue in the program. While we believe tiers are unnecessary and may limit the potential for ACO success, if NCQA opts for a tiered approach, we strongly urge limiting ACOs to two stages: 1) Mature ACOs with all capabilities necessary, and 2) Provisional ACOs, those which have sufficient infrastructural and other capability to allow ramping- up to full capability requirements within three years.

AMGA responses to specific draft criteria follow.

PO2 Resource Stewardship

Element A: Clinical Utilization Management. AMGA supports with modification. Stop-loss/reinsurance pertains only to those who are involved in assuming insurance risk. This applies to very few existing entities. Does not pertain to most (nor will it, over the short to medium term) and will not in the Federal manifestation of ACOs—full risk not provided for in the Affordable Care Act of 2010 (ACA). We suggest dropping the stop-loss/reinsurance provision. Similarly, risk adjustment is primarily a tool for insurance companies or entities functioning as such; as a capability criterion it is not necessary for most and should also be dropped.

PO3 Health Services Contracting

Element A: Arranging for Services. Support with modifications. There does need to be some definition of full continuum of care for a defined population.

Element C: Payor Contracts. Support with modifications. This can apply to Federal program participants and it would be better to include even if answers/circumstances are dictated by Federal law and regulations. No compelling reason to limit to private sector only. Making standards and data reporting requirements congruent for all manifestations of ACOs is desirable and should be pursued to the maximum extent possible.

Element A: Access During Office Hours. Support with modifications. Keep Patient Centered Medical Home (PCMH) criteria separate and distinct. Requirement should be more generally stated, e.g., if criteria are otherwise met, such as by those of a PCMH, that may suffice to meet ACO primary care capabilities, as documented. The term “open access” should be used in conjunction with “same day” in discussing access during office hours. “Open access” is a widely recognized term used to describe the ability to schedule same day appointments.

CM 1: Data Collection and Integration

Element A: Process for Data Collection and Integration. Support with modifications. Although it is desirable and useful to be able to access claims or encounter data for non-ACO practitioners and

providers, it will be difficult for most ACOs to do so. Payors are not excluded from being ACOs, but since many ACOs will not be payors, they will generally not have access to claims data other than their own. The ability to perform all aspects of this element may vary by a region's technological capacity and an ACOs ability to receive data from outside their network.

Element C: Patient Information. Support with modification. The percentage thresholds seem arbitrary and either too high or too low. For example, a 50% threshold for date of birth or gender seems too low; whereas 80% for e-mail address and advance directives seems too high. Rationale should be provided to support the percentage thresholds specified in this element.

CM 2: Initial Health Assessment

Element A: Health Assessment. Support with modifications. Health care professionals should be allowed to use a health assessment tool that best suits the population they serve.

RR 1: Patient Rights and Responsibilities

Element A: Rights and Responsibilities Statement. Support.

Element B: Written Policies for Privacy and Confidentiality. Support with modifications. Current HIPAA regulations constitute a "floor," not a "ceiling." NCQA privacy standards should comport with current federal laws and regulations in all cases. When NCQA standards go beyond federal requirements, they should be created with the idea of minimizing the burden to health care providers.

PR 1: Performance Reporting

Element D: Reporting Performance Publicly. Support with modification. Data reported to the public must be in a form and format that is easy to understand.

Thank you for full consideration of our comments. Should you have additional questions, you may contact Karen Ferguson, Associate Director of Regulatory Affairs at kferguson@amga.org or at 703-838-0033x349.

Sincerely,



Donald W. Fisher, Ph.D.
President and CEO

