April 2, 2019

John Pilotte
Director, Performance-Based Payment Policy Group
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, MD 21244

Re: ACO Quality Measure 17, (Prev-10, NQF 0028), Preventive Care and Screening, Tobacco Use- Screening and Cessation Intervention

Dear Mr. Pilotte,

As ACOs have completed their 2018 Medicare Shared Savings Program (MSSP) quality reporting, many are voicing concerns regarding drastic measure changes that occurred with respect to ACO-17 (Prev-10, NQF 0028), Preventive Care and Screening, Tobacco Use- Screening and Cessation Intervention. The specification changes for this measure from 2017 to 2018 are significant, however these changes were not communicated to ACOs until just recently when quality reporting for 2018 was already underway. As required by §425.502(a)(4), newly introduced measures must be set at the level of complete and accurate reporting (or pay-for-reporting) for the first two performance periods for which reporting of the measure is required. **Therefore, we urge the MSSP to make this measure pay-for-reporting for two performance years, as the measure has undergone significant changes from 2017 to 2018.** There are a number of concerns and unintended consequences resulting from these specification changes and the untimely communication of these changes to ACOs. As you know, ACOs are held accountable for quality measure performance standards. ACOs that do not meet quality standards are not eligible to share in any potential savings they may earn. Additionally, ACO shared savings rates may be affected by their quality performance scores. Therefore, addressing the issues related to ACO-17 as detailed below will be critical to ACOs; not doing so could result in certain ACOs limiting or even eliminating their shared savings opportunities.

In 2017, there was one denominator for ACO-17: patients with an applicable office visit within the specified age requirements. In 2018, the measure denominator will be divided into three separate populations with population two (patients who were screened for tobacco use and identified as a tobacco user) being utilized for scoring. These represent significant and substantial changes to the quality measure. As you are aware, CMS Centers for Clinical Standards and Quality staff have determined, "initial analysis conducted on data entered into the CMS Web Interface for 2018 WI reporting thus far indicates that the calculated benchmarks for ACO-17/PREV-10 are acceptable and the change in timing for tobacco intervention guidance does not impact the usability of the established benchmarks." However, many ACOs have contacted NAACOS after completing quality data submission noting a 30 percent or greater drop in their performance scores on this measure from 2017 to 2018.

Another major concern with the changes to ACO-17 is regarding the timing for cessation intervention, which must now occur after the most recent tobacco user status is documented. Previously the intervention could take place at any time within 24 months, if the patient was identified as a tobacco user.

Not only is this a concern in terms of workflows for providers, but it could also have an impact on patients if a provider would need to repeat the cessation intervention each visit. For example, if a patient was seen in October by his or her primary care physician (PCP), who provides tobacco screening and cessation intervention, and the patient returns to the PCP three weeks later for a rash, the patient will receive a subsequent screening but not necessarily a subsequent cessation intervention since the PCP just had the cessation conversation with the patient three weeks prior. To repeat the conversation again would be duplicative and potentially lead to lower patient satisfaction and greater frustration.

As mentioned above, CMS is required by §425.502(a)(4) to establish newly introduced measures at the level of complete and accurate reporting (or pay-for-reporting) for the first two performance periods for which reporting of the measure is required. As a recent example, CMS used this approach for ACO-11, Use of Certified EHR Technology (CEHRT). When the measure underwent changes to move from assessing only PCP use of CEHRT to assessing all eligible clinicians' use of CEHRT, the measure was made pay-for-reporting only for two additional years given the substantial change to the measure and the population assessed. We feel strongly that CMS must similarly make ACO-17 (Prev-10, NQF 0028), Preventive Care and Screening, Tobacco Use- Screening and Cessation Intervention, pay-for-reporting only for two performance years beginning with the 2018 Performance Year.

If CMS does not address this issue, ACOs will be negatively affected and could miss out on shared savings opportunities. We would be happy to provide you with specific examples shared by our members on how performance scores have been affected and urge you to take swift action to address this problem. Thank you for your attention to this important ACO quality performance issue.

Sincerely,

Clif Gaus, Sc.D.
President and CEO