



ACCREDITATION ASSOCIATION
for AMBULATORY HEALTH CARE, INC.

John E. Burke, Ph.D.
PRESIDENT & CEO

May 16, 2014

Chairwoman Edith Ramirez
Federal Trade Commission
600 Pennsylvania Ave NW
Washington, DC 20580

Re: **Health Care Workshop, Project No. P131207 –
Quality Assessment and Related Competitive Issues**

Dear Chairwoman Ramirez:

The Accreditation Association for Ambulatory Health Care (AAAHC) appreciates the opportunity to provide these comments on competition in health care in response to the Federal Trade Commission's request.

AAAHC is a nationally recognized health care accrediting entity. It is one of three accreditors approved by the Centers for Medicare & Medicaid Services (CMS) to accredit qualified health plans (QHPs) offered on health insurance Exchanges under the Affordable Care Act (ACA). AAAHC also accredits non-QHP health plans and is deemed by CMS to accredit Medicare Advantage organizations. In addition, CMS recognizes AAAHC as the largest non-hospital (ambulatory) deeming organization for Medicare in the country. AAAHC is the accreditor chosen by the United States Air Force to accredit its medical treatment facilities and the United States Coast Guard to accredit its ambulatory facilities. It is also the accreditor of choice for many other types of ambulatory health care organizations.

AAAHC's comments in this letter are limited to competition in health care quality measurement and assessment, and what we perceive to be the likely ripple effect dampening health care innovation, and other pro-consumer public policy initiatives, that would flow from anticompetitive practices in the market for health care quality assessment, if allowed to persist.

The health care industry is at a transformative moment. Under the ACA, 8 million people have selected health insurance plans on Exchanges and millions more have purchased coverage directly from insurers. The ACA increases access to coverage on and off the Exchanges by making it easier for individuals to comparison shop for coverage. Moreover, the ACA has added several million people to the Medicaid program, with much of that new enrollment in Medicaid managed care plans.

In order to help consumers select coverage based on quality and value, not just price, CMS has approved three accrediting organizations—the National Committee for Quality Assurance (NCQA), URAC, and AAAHC—to compete for the business of accrediting health plans to be offered on the federal or state Exchanges under the ACA. The choice of multiple accreditors reflects a belief by health care policy makers in the need for viable competition in accreditation instead of a one-size-fits-all approach. States are also expected to encourage a diversity of accrediting bodies for offerings on and off the Exchanges.

While this approach is laudatory, by far the largest of the accrediting entities, NCQA, owns and maintains a proprietary set of health plan quality data measures developed with substantial public input and investment (the Healthcare Effectiveness Data and Information Set (HEDIS)). Many public and private health care programs require participating plans to use these HEDIS measures. Having a common baseline quality measure is useful for consumers trying to comparison shop and for regulators policing minimum quality standards—but when that standard measurement set is owned by one of several competing accrediting bodies and must be licensed by the others in order to enter the market, the dynamic creates several anticompetitive effects:

- (1) Efforts by competing accrediting bodies to improve, supplement or expand upon HEDIS measures, or to take into account innovation in coordinated care delivery, risk sharing or technological breakthroughs by adjusting the care models or underlying algorithms on which HEDIS measures are based, could be thwarted by NCQA by denying HEDIS licenses or conditioning them in adverse ways. The consequence would be the disruption of competition among providers, plans, and accrediting entities.
- (2) NCQA could endeavor to use its privileged position with respect to HEDIS to expand its related businesses—to the disadvantage of competitors in those related fields, such as health plan accreditation, by withholding HEDIS licenses or conditioning them on terms that favor NCQA. This problem is potentially most acute in the new health insurance Exchanges, although this is also an issue in Medicare, Medicaid, non-QHP commercial health insurance, and in accountable care and dual eligible initiatives.
- (3) The very process of having to affirmatively apply to NCQA for HEDIS licenses and await its determination could delay offerings by competing accrediting bodies to the benefit of NCQA and give it an unfair competitive advantage. Reviewing competitors' applications to use HEDIS gives NCQA advance knowledge of competitors' proposed offerings and enhancements, which could diminish competition.
- (4) CMS is developing a quality rating system (QRS) for QHPs that is proposed to rely heavily on HEDIS measures. NCQA's ownership of HEDIS measures gives it a potentially unfair advantage that will decrease competition among the recognized three QHP accreditors and increase accreditation costs to health plans and consumers. Because NCQA controls HEDIS, AAAHC found it necessary to obtain different quality measures in its accreditation of QHPs.

QHPs may be disinclined to use AAAHC for accreditation if they nevertheless have to report HEDIS measures and potentially duplicate efforts and costs.

- (5) In addition to Exchange regulations, some state laws on health plan accreditation give competitive advantages to NCQA and its HEDIS measures. For example, most states require that their Medicaid managed care plans use HEDIS measures with NCQA licensing the auditors that plans must use to implement HEDIS measures, rather than utilizing competitors of NCQA. Similar issues arise in the context of evaluating and accrediting Medicare Advantage plans—and can be anticipated with respect to the evaluation/accreditation of medical homes, accountable care organizations, dual eligible initiatives and other evolving health care provider payment and delivery system reform initiatives.

In short, while health coverage is expanding, regulators are also attempting to contain health costs and improve health quality—but the manner in which aspects of the quality measurement initiative is developing poses very substantial risk of unintended and harmful anticompetitive effects. We believe regulators should treat NCQA’s maintenance of HEDIS as the equivalent of an essential facility under long-standing antitrust doctrine. NCQA’s competitors in health plan accreditation must have immediate access to the HEDIS measures in a manner that creates a level playing field for competition.

Antitrust regulators should establish ground rules for equal and fair access to HEDIS for all competing accrediting organizations, for all potential applications. Without ongoing scrutiny from regulators to assure equal access to HEDIS for a broad spectrum of applications (QHPs, Medicare Advantage, Medicaid managed care, other commercial health insurance coverage), we fear NCQA will have the ability to use its proprietary ownership to stifle competition in the accreditation market—and potentially to stifle emerging efforts to reconfigure the delivery system, including risk taking and care coordination models among providers and plans. HEDIS measures may need to be adapted, supplemented or enhanced so as to reward innovation. This is best done, we believe, through vibrant competition, without one of the competitors (in this case, NCQA) acting as an unrestrained gatekeeper for the accreditation market.

Thank you for the opportunity to provide these comments. We look forward to continuing to work with the FTC in promoting competition in health care quality measurement. Please do not hesitate to contact me or Carolyn Kurtz, AAAHC General Counsel and Vice President for Government Affairs, (847) 853-6072, ckurtz@aaahc.org, if we may be of further assistance.

Sincerely,

John E. Burke, PhD
President & CEO