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June 2, 2011

Donald Berwick, MD
Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1345-P
Hubert H. Humphrey Building
200 Independence Avenue, SW, Room 445-G
Washington, DC 20201

Re: CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations.

Dear Dr. Berwick:

On behalf of the Premier healthcare alliance serving more than 2,500 leading hospitals and health systems and 75,000-plus other healthcare sites, we appreciate the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Accountable Care Organizations (ACOs) proposed rule. Premier, a 2006 Malcolm Baldrige National Quality Award recipient, maintains the nation's most comprehensive repository of hospital clinical, financial and operational information and operates one of the leading healthcare purchasing networks. Our comments primarily reflect the concerns of our member hospitals and health systems. As service providers, the members of our alliance have a vested interest in the effective operation of ACOs. This is particularly true of the nearly 90 health systems participating in our Accountable Care Implementation Collaborative, launched in May 2010.

BACKGROUND

The Premier healthcare alliance believes that, as a nation, we all must work to rein in spiraling U.S. healthcare costs, expand access, promote wellness and improve the consistency of quality outcomes. We know we need to move from a disjointed, siloed "system" of delivery to one that is better coordinated and aligned to provide real *value* to patients, providers and payors alike. But this requires a new vision, new culture, and new practice—none of which are easy to achieve in healthcare.

While still evolving, the concept of ACOs is gaining ground and represents a way to overcome today's challenges without rationing care or dramatically increasing taxes. ACOs are designed to closely connect groups of providers who are willing and able to take responsibility for improving the overall health status, care efficiency and experience for a defined population. Thus ACOs can overcome the fragmentation and volume orientation of our existing fee-for-service system to more appropriately incent health and wellness, rather than treatment for illnesses. Achieving these incentives will "bend the cost curve" and revolutionize how care is paid for, provided and received.

Nearly 90 member healthcare systems have already started this journey with Premier in our Accountable Care Collaboratives to accelerate the development of innovative models for delivering care in the private sector with the goal of participating in the Medicare ACO program as soon as it is operational. However, unless significant changes are made to the final rule, few of these market-leading systems will be willing and able to participate in the program, opting instead to continue working with private payors, employers, self-funded plans and others. Given CMS' desire to move quickly toward new payment and delivery system models, we believe the loss of these provider participants would be regrettable for the Medicare program and could seriously undermine the concept of accountable care in other markets.

Members of the Premier alliance recognize that the concept of accountable care and reimbursement based on shared savings are wholly new concepts for Medicare, and as such, represent a major regulatory challenge. We believe CMS is to be commended for working cooperatively with other agencies that have jurisdiction over parts of the accountable care regulation, and for the willingness to solicit and consider feedback from providers before issuing a final rule. We also support CMS in its efforts to align payment among providers across the continuum of care, as well as the agency's focus on high-quality, people-centered care. We believe that this approach will support greater clinical integration and collaboration among doctors, hospitals and other care providers, and foster alignment of accountable care principles across public and private payors. The end result will be better, safer and more convenient care delivered at a lower cost for the benefit of healthcare consumers nationwide.

Based on our experience with the Accountable Care Collaboratives, Premier believes it is critical that government regulations do everything possible to remove impediments that could derail ACO development, to select strong candidate ACOs and to structure the program to maximize the potential for success. In this regard, the rule requires major improvement to ensure broad participation in the program.

Philosophically, CMS has chosen a very prescriptive approach to regulating ACOs. This micromanagement, in our view, has the potential to stifle innovation and creative new approaches to care delivery. While we wholeheartedly agree that the ACO construct must deliver people-centered, cost-effective and highest-quality care, there are many ways to accomplish

these goals that fall outside of the proposed regulation. Rather than dictate what future models must looks like, a better solution would be for CMS to articulate what models should not look like and give general parameters around legal boundaries of ACO operations, allowing individual providers to develop local solutions that fall below that threshold.

Moreover, CMS needs to provide sufficient incentives for healthcare providers to make the difficult journey away from traditional fee-for-service reimbursement. The existing reimbursement model has directly resulted in the siloed practice of medicine and the perverse incentives that make our healthcare system dysfunctional and uncoordinated. Shared savings payments are critical as part of this transformation and are necessary to incentivize providers to make the technology and other infrastructure investments needed to transform care delivery and processes. Without them, ACOs will struggle to provide care and services needed to appropriately manage the health of the population, undermining the overall goal of the program. However, CMS has short-changed ACOs by limiting these payments to at most 52.5-65 percent of the total, making the program unattractive to applicants.

We are committed to working with CMS to improve the proposed regulations so that the program appeals to the greatest number of applicants, particularly those with accountable care experience in private markets. We urge CMS to continue the public discourse around ACOs, and to consider the suggestions for improvement that will be made across the healthcare field. We believe that with well-developed parameters and enticing incentives, CMS will build on a positive trend that is already improving the overall health and well-being of people across the country. Based on our experience thus far with our members, we provide guidance in this letter that we believe will be helpful to CMS as it formulates the final regulations governing the new Medicare ACO program.

Below we provide detailed comments that reflect this perspective and provide CMS with concrete suggestion on how to successfully alter the program in a final rule to one that will attract an array of ACO participants.

ELIGIBILITY

CMS proposes to recognize certain providers as eligible to *form* ACOs:

- ACO professionals in group practice arrangements;
- Networks of individual practices of ACO professionals;
- Partnerships or joint venture arrangements between hospitals and ACO professionals;
- Hospitals employing ACO professionals; and
- Critical Access Hospitals (method II billing).

Many thought leaders have offered opinions on how ACOs should be structured. Despite varying perspectives, there is agreement that many organizational models could be successful as ACOs. We believe that the inclusion of hospitals in some of these models is critically important to the prospects of successful ACO formation, since in many cases the hospital will be the only entity with sufficient infrastructure, staff, capital risk-tolerance and other resources needed to drive large-scale change. Moreover, hospitals are the participants that have most direct control over the greatest proportion of spending. There are two broad categories of ACO structures:

- ACOs could be single economic entities, as defined under the *Copperweld* doctrine (e.g., a hospital and its employed physicians, perhaps including other owned ancillary providers; a health system consisting of several hospitals and their employed physicians; etc.)
- Alternatively, the ACO could include multiple entities, such as physician network joint ventures or multi-provider networks as described in Statements 8 and 9 of the Statements of Antitrust Enforcement Policy in Health Care (Policy Statements) jointly issued by the Department of Justice (DOJ) and the Federal Trade Commission (FTC).

It is our belief that it is not necessary for a "clinically integrated" provider network—and, by extension, an ACO—to be a single, co-owned legal entity comprised of physicians and/or hospitals whether under Medicare or in the private sector. We believe that accountability requires coordinated relationships, not necessarily corporate integration. A "collaborative arrangement" based upon a contractual relationship among the ACO's owners and participants should be an acceptable "model" for an ACO, although subject to further analysis of its size and operational characteristics if operating in the private sector. **Premier urges CMS to clarify that such "collaborative multi-provider network arrangements" would be considered "partnerships" under the approved list of eligible conveners, and the FTC and DOJ to confirm that they are acceptable whether within the Medicare and Medicaid programs or in the private sector.**

However, it is important to note that many not-for-profit health systems do not fit into the two hospital-led models enumerated by CMS and in the Patient Protection Act of 2010 (ACA). That is, they neither directly employ physicians nor are engaged in partnerships or joint ventures with physicians. In many such cases, physicians are employed by a separate not-for-profit physician organization or have an independent contractor relationship with a not-for-profit medical foundation. These approaches are particularly prevalent in states with laws that preclude direct employment of physicians under the corporate practice of medicine doctrine, and areas in which the preponderance of physicians practice in small groups. CMS would be able to access the needed claims data to complete the beneficiary attribution process for both these types of entities. By providing maximum flexibility in the approved ACO structures, CMS will most certainly increase the size of the program. **CMS should use its authority to recognize ACOs**

comprised of hospitals and affiliated ACO Professionals as eligible to participate in the Medicare ACO program.

Additionally, Premier urges CMS to provide clarity in the definitions between ACO participants and ACO providers/suppliers. The terms are often used interchangeably throughout the proposed rule and, while we believe an ACO participant is an entity that is the "founder, owner or convener" and providers and suppliers are contractors, additional definitional clarity is needed. **CMS should clarify the definitions of ACO participants and ACO providers/suppliers in the final rule.**

STRUCTURE

The proposed rule specifies that each ACO must be constituted as a legal entity appropriately recognized and authorized to conduct its business under applicable State law and it must have a Tax Identification Number (TIN). Further, an ACO must be capable of:

- receiving and distributing shared savings;
- repaying shared losses;
- establishing, reporting and ensuring ACO participant and ACO provider/supplier compliance with program requirements, including the quality performance standards; and
- performing the other ACO functions identified in the statute.

While CMS does not propose to require that existing legal entities appropriately recognized under state law form a separate new entity for the purpose of participating in the program, it does propose that ACOs comprised of independent providers or suppliers must form a new, separate, jointly-owned legal entity with proportionate ownership and representation in governance. Furthermore, if existing entities, such as a hospital employing ACO professionals, would like to include as ACO participants other providers of services and suppliers who are not already part of its existing legal structure, a separate entity would have to be established in order to provide all ACO participants a mechanism for shared governance and decision making.

We believe that the requirement that all ACOs comprised of independent providers or suppliers must form a new, separate, jointly-owned legal entity is unduly burdensome and expensive, places such ACOs at a competitive disadvantage relative to integrated delivery systems, and will likely have a chilling effect on the willingness of such providers and suppliers to participate in the program. **CMS should use its authority to permit ACOs comprised of independent ACO participants to designate one of those ACO participants to function as the "ACO" for purposes of participation in the program, provided that such entity meets the criteria required of an ACO under the final rule.**

CMS also proposes to restrict participation in an ACO to the initial group outlined in its application. This unduly restricts the growth and evolution of ACOs, many of which will begin as a certain group of providers based on historical relationships rather than the ideal structure to support the model. ACOs will undoubtedly seek to add participants over time as weaknesses are identified and to grow the assigned population. Under the proposed rule, the ACOs would be precluded from doing so. It is unrealistic to think, for instance, that there will be no attrition in physician practices or other ACO participants. The ACO must have the ability to alter the makeup of its participants to remain viable. Furthermore, under the proposed rule, existing organizations cannot add partners even at the beginning of the contract. We believe that existing organizations should not be forced to create whole new bureaucracies at considerable expense just to add ACO participants. CMS should be encouraging ACOs to forge new partnerships, not to create boundaries. **CMS should allow existing entities to form ACOs and alter their structure to meet the needs of the new care delivery models being implemented. CMS should also allow ACOs to add participants over the course of the contract.**

GOVERNANCE

CMS proposes that the ACO participants must have at least 75 percent control of the ACO's governing body, with each of the ACO participants choosing an appropriate representative "from within its organization," and at least one beneficiary on the governing body. CMS further proposes that ACOs be required to describe how they will partner with community stakeholders[1] with ACOs that have a community stakeholder organization serving on their governing body deemed to have satisfied this application criterion.

The Premier healthcare alliance is very concerned that CMS believes it is necessary to interfere with business operations such as governance. Congress did not include any requirements in ACA regarding the governance composition of ACOs, other than that an ACO "have in place a leadership and management structure that includes clinical and administrative systems." This level of micromanagement proposed by CMS would increases costs to the ACO for questionable benefit and will discourage organizations from participating. CMS should be concerned with the outcome of the program, not with who is on an ACO's board. CMS should recognize that each board will need to be structured differently depending on its historical makeup, the interest in participation, and other market dynamics. CMS should not try to impose a cookie cutter approach to what is ultimately an issue of business management, not federal regulation. IRS For example, recognition by the Internal Revenue Service that an entity is tax exempt under Section 501(c)(3) of the Internal Revenue Code should be sufficient for establishing an appropriate legal

[1]Community stakeholders (also referred to as community resources) include employers, commercial health plans, local businesses, State/local government agencies, local quality improvement organizations and collaboratives, such as health information exchanges.

structure and governance. **For the purposes of the program's application, CMS should simply review that the entity is licensed and authorized by the state in which it operates.**

Percentage Representation

While we agree that the governing boards should have significant provider representation, CMS should not dictate a specific percentage. This will necessitate even more prescriptive rules on how to count the representatives. For example, it is unclear whether physicians on subcommittees such as quality or information technology count toward the requirement. In addition, ACOs planning to use their existing governing structures would have to make major modifications that would be disruptive. Moreover, this may conflict with the perspective of other payors with which the ACO may be contracting such as state governments in the process of implementing such programs under Medicaid and with their state employees. In fact, in some states the governing boards of some public hospitals must be elected allowing for no flexibility in structure. The governing boards will have to balance representation across all the populations it covers for multiple payors that may, for instance, encourage participation of local businesses on the board. Each payor will have to recognize they are one of many and remain flexible. **CMS should instead require ACOs to include a description of their board and general rationale for its composition in the application. If CMS is concerned about a potential significant imbalance in the board composition, it could then ask for additional detail or modification in order to become an approved CMS ACO.**

ACO Participants

It would be unwieldy to have representatives from *each* participant. An ACO should not, for example, have to include each solo-practitioner physician participant on the board. This would lead to a potentially enormous board that would be difficult to effectively operate. Instead, CMS should allow the boards to show that their composition is balanced and proportional to ensure different perspectives are represented. This could, for example, generally mirror the percentage of services provided to the populations served (not just Medicare). So, if five percent of services are provided by home health agencies, than at least one representative should be included, while physicians providing 50 percent of the services should not make up 90 percent of the board. In addition, existing contracts and relationships in many cases reflect vestiges of an old practice standard; the board should be allowed some latitude to shift over time to reflect new priorities under transformed care. **CMS should not require that each ACO participant have representation on the board, but rather for the ACO to ensure balanced and proportional representation.**

Beneficiary Representation

Given the emphasis on patient-centeredness of the ACO model, we support consumer representation on the governing board of the ACO. However, CMS should again remain flexible as to what form that will take and recognize that similar requirements may come from other

payors as well. Thus, the ACO should be able to include, for example, a consumer organization on the board rather than specifically a Medicare beneficiary. Alternatively, the ACO should be able to create an external advisory panel or create a subcommittee that does not meet with the same frequency as the full board to fulfill this requirement. **CMS should not prescriptively delineate what form consumer representation should take in terms of participation in the governance process.**

CLINICAL AND ADMINISTRATIVE SYSTEMS

ACA requires ACOs to demonstrate "a leadership and management structure that includes clinical and administrative systems." CMS proposes that ACOs meet the following criteria:

- The ACO's operations must be managed by an executive officer, manager, or general partner, whose appointment and removal are under the control of the organization's governing body.
- Clinical management and oversight must be managed by a senior-level medical director who is a board-certified physician, licensed in the state in which the ACO operates, and physically present in that state (the regulation text adds that such individual must be "full-time").
- ACO participants and ACO providers/suppliers must demonstrate a meaningful commitment to the ACO's clinical integration program (this may include a meaningful financial investment in the ACO or a meaningful human investment, such as time and effort, in the ongoing operations of the ACO).
- The ACO must have a physician-directed quality assurance and process improvement committee, which would, among other things, hold ACO providers/suppliers accountable for meeting performance standards.
- The ACO must develop and implement evidence-based medical practice or clinical guidelines and processes covering diagnoses "with significant potential for the ACO to achieve quality and cost improvements," and ACO participants and ACO providers/suppliers would have to agree to comply with these guidelines and processes and be subject to performance evaluations and potential remedial actions.
- The ACO must have "an infrastructure, such as information technology, that enables the ACO to collect and evaluate data and provide feedback to ACO providers/suppliers across the entire organization."

The above requirements notwithstanding, the proposed rule indicates that CMS retains the right to give consideration to an innovative ACO with a management structure not meeting the requirements. **We support CMS' statement that it will consider other management structures ACOs may have in place. In addition, we appreciate the fact that CMS is giving**

ACO applicants the opportunity to describe how they plan to meet the above requirements, rather than taking an overly prescriptive approach to the issues.

CONTRACTS

Terms

For the first round of the Shared Savings Program, CMS proposes to limit the participation agreements to a three-year period. If an ACO were to discontinue its participation in the program prior to the end of the agreement period, CMS proposes to require 60-day advance written notice to CMS and that such organization would forfeit any withheld shared savings. Given that this is a new program, ACOs should be able to withdraw without penalty. CMS can require the ACO, as proposed, to sit out of the program until that three year contract is complete to avoid rapid successive exit and reentry. ACOs that are able to successfully transform care and generate savings should be able to recoup the funds when other circumstances necessitate its withdrawal. For instance, if a major partner is bought by a third party that does not wish to participate. Another example would be a natural disaster like Hurricane Katrina. We learned during the Hospital Quality Incentive demonstration that even hospitals that had been successful in the demonstration prior to the event could simply not keep up with the program requirements while trying to rebuild after the catastrophe. **We concur that a three-year contract period is an appropriate contract length. However, we oppose the forfeiture of withheld savings upon exiting the program.**

CMS also proposes that ACOs be required to provide timely notice to beneficiaries if they will no longer be participating in the program. **CMS should clarify what action and in what time frame ACOs must take to notify beneficiaries of program termination.**

Program Monitoring

CMS proposes that ACOs, ACO participants, ACO providers/suppliers and other contracted entities must give the appropriate federal agencies the right to inspect their books and records. CMS could also inspect, evaluate and audit the ACO at any time if it determines that there is a reasonable possibility of fraud or similar fault. Other contracted entities include any party with an arrangement with the ACO to provide administrative, management or clinical services. As currently defined, this could include virtually ever organization with which an ACO contracts like laundry, dietary and janitorial services. **CMS should narrow the types of organizations to which it applies this open-ended audit policy.**

Reconsideration Review Process

CMS notes that ACA precludes administrative or judicial review of several decisions:

- specification of criteria for meeting quality performance standards;

- assessment of quality of care;
- assignment of beneficiaries to an ACO;
- determination of eligibility for shared savings, the amount of shared savings or the average benchmarks;
- the percent of shared savings and any limit on total shared savings;
- termination of an ACO for failing to meet quality performance standards.

CMS proposes an administrative reconsideration review procedure for denials of initial applications or terminations for reasons other than those precluded from review by statute. If CMS denies an initial application (for a reason other than it not being submitted by the required deadline), or notifies an ACO of a termination, the ACO may, within 15 days, request reconsideration from a CMS reconsideration official. Reconsiderations are scheduled at the discretion of the review official. The burden of proof is on the ACO to demonstrate that the application denial or termination is not consistent with CMS regulations or statute. **CMS should review all cases in which an ACO requests reconsideration.**

While we recognize that CMS is not obligated to create a provider review process that allows participants to review program data, it would be in the best interest of CMS and the participants to ensure the valid and accurate administration of the program. It would also build good will with participants. This process should include CMS furnishing quality measure results and major spending calculations to the ACOs where providers would have a reasonable period of time to review for clerical errors, incorrect data, or other accuracy concerns rather than challenges on the methodology. **CMS should implement a provider review process to ensure the accuracy of program data and the accurate administration of the program.**

ACO PROFESSIONALS

Clinical Capacity

ACA requires a sufficient number of "ACO professionals" to care for a minimum of 5,000 Medicare beneficiaries assigned to the ACO. There is no guidance, however, on how this capacity should be measured. Under the proposed rule, CMS proposes that an ACO would be determined to have a sufficient number of primary care ACO professionals to serve the number of Medicare beneficiaries assigned to it if the number of beneficiaries historically assigned over the three-year benchmarking period using the ACO participant TINs exceeds the 5,000 threshold each year.

If an ACO's assigned population falls below 5,000 Medicare beneficiaries, CMS proposes to issue a warning and place the ACO on a corrective action plan; the ACO would, however, remain eligible for shared savings for the performance year for which the warning was issued. If the ACO again fails to satisfy the minimum beneficiary requirement in the next performance

year, CMS proposes to terminate its ACO participation agreement and forfeit possible shared savings for that year. **We believe CMS' proposal to determine the sufficiency of ACO professionals based on the historic data for initial eligibility and allow one-year of non-compliance before termination is fair.**

CMS also requires an ACO to maintain, update, and annually report to CMS the TINs of its ACO participants and the NPIs associated with the ACO providers/suppliers. However, under the proposal an ACO cannot add ACO participants or ACO provider/suppliers during the three year contract period. This unduly restricts the growth and evolution of ACOs, many of which will begin as a certain group of providers based on historical relationships rather than the ideal structure to support the model. ACOs will undoubtedly seek to add participants over time as weaknesses are identified and to grow the assigned population. Under the proposed rule, the ACOs would be precluded from doing so. It is unrealistic to think, for instance, that there will be no attrition in physician or other providers. The ACO must have the ability to alter the makeup of its participants to ensure that it has a sufficient number of primary care physicians in order to meet the attribution requirement. Furthermore, the inability to replace ACO participants and ACO provider/suppliers will act as a significant disincentive to taking remedial action against providers who do not support Medicare ACO program objectives, notwithstanding that such action is required under ACA and the proposed regulation. **CMS should allow ACOs to add participants over the course of the contract, or at minimum, allow an ACO to replace ACO participants and ACO provider/suppliers who withdraw from the ACO during the contract term or are terminated from the ACO.**

Furthermore, under the proposed rule, existing organizations cannot add partners even at the beginning of the contract. We believe that existing organizations should not be forced to create whole new bureaucracies at considerable expense just to add ACO participants. CMS should be encouraging ACOs, to forge new partnerships, not to create boundaries. **CMS should allow existing entities to form ACOs and alter their structure to meet the needs of the new care delivery models being implemented.**

Assignment

CMS proposes to assign Medicare beneficiaries to an ACO retrospectively, but provide ACOs with preliminary assignment information at the start of the performance period and annually thereafter. The agency further proposes to assign beneficiaries to an ACO if they received a plurality of their primary care services (allowed charges, not units of service) from primary care physicians (internal medicine, family practice, general practice and geriatric medicine) within that ACO. The test, then, is whether they received more primary care from that ACO than any other provider. **Premier supports CMS' hybrid approach to provide preliminary assignment information to ACOs combined with retrospective reconciliation, which will ensure ACOs are only assigned patients they provide care for during the performance period.**

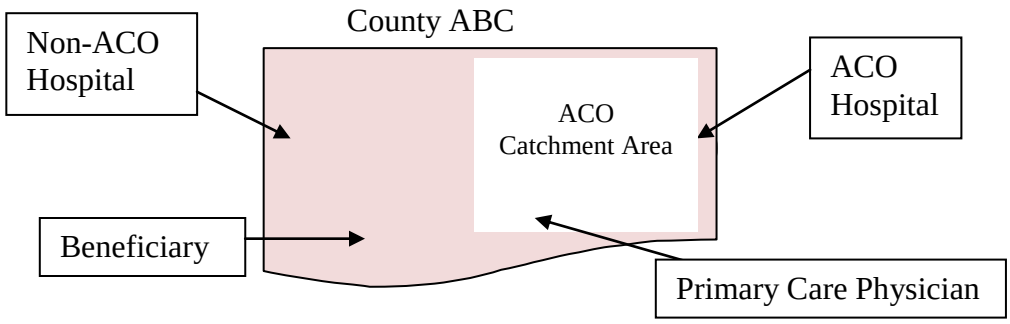
Because enhanced primary care is central to the success of ACOs, it is critical that the beneficiary have a relationship with a primary care practitioner. This connection should drive the inclusion of beneficiaries in particular ACOs. We agree that beneficiaries with at least one visit with a primary care physician (general practice, internists, family medicine or geriatrician as defined by CMS) should be assigned to an ACO based on their utilization of primary care services. However, we further believe that beneficiaries who do not have at least one visit with a primary care professional should be able to be assigned to an ACO based on services received from certain medical specialists (limited to pulmonologists, cardiologists, rheumatologists, nephrologists, neurologists, gastroenterologists and endocrinologists) provided they have received at least two evaluation and management services from such specialists. By relying on primary care services first and a select group of specialists second, more beneficiaries would be able to participate in the program and the ACO would still likely be able to predict the bulk of the patients that would assign to them. **Thus, we recommend that beneficiaries first map to a primary care physician, and if not, based on the plurality of E/M codes to a subset of specialists.**

CMS defines primary care services by Healthcare Common Procedure Coding System (HCPCS) codes 99201 through 99215 (office or other outpatient visits), 99304 through 99340 (nursing facility, domiciliary or rest home visits and related services), and 99341 through 99350 (home visits), as well as the Welcome to Medicare visit (G0402) and the annual wellness visits (G0438 and G0439). These codes are consistent with what many of our members use with their payor partners in private ACO contracts; although, such contracts often include additional codes that are not currently covered by Medicare. **Premier supports the codes proposed by CMS.**

<u>Exclusions</u>
CMS should develop a set of exclusions for certain beneficiaries. These would need to be agreed to in advance to prevent cherry picking. For example, "snow birds" should be removed, as the ACO will have no ability to affect the beneficiaries' health and care while at their alternate home or traveling. **CMS should include a list of exclusions in its final rule.**

<u>Geographic Limitation</u>
Given the lack of a lock-in provision, CMS might also consider a geographic limitation in the beneficiary assignment process. Rural areas in particular draw from great distances. By limiting the distance from the components of the ACO that the beneficiary may reside, ACOs are more likely to be assigned beneficiaries who are able to seek other types of care from the ACO. Below we provide a simple example where assignment based on a primary care physician could result in a beneficiary who is more likely to use services outside the ACO. Within the MA program, there are limits on physician accessibility that may serve as a good model for a geographic limitation. Alternatively, ACOs could conduct analyses on their existing service area prior to the implementation of the ACO. **CMS should allow the ACO to include a geographic limitation**

in its application so long as rules are based on concrete criteria that do not involve risk selection.



Physician Exclusivity

CMS further proposes that ACO professionals within the respective TIN on which beneficiary assignment is based (that is, primary care physicians) will be exclusive to one ACO agreement. All other providers and suppliers would be free to participate in more than one ACO.

We believe CMS should allow more than one ACO in an area. In areas where there are more than one ACO, a physician exclusivity requirement, as proposed by CMS, may cause unintended consequences. In some markets, forcing physicians to choose an ACO will artificially restrain the development of the model. In others it may hasten the hospital systems purchasing physician groups. We recognize that allowing physicians to participate in more than one ACO will complicate the assignment process, but believe workable options exist such as including institutional claims in a two-step assignment process. **CMS will need to monitor the effects of primary care physician exclusivity on the development of the model.**

BENEFICIARIES

Transparency

In the proposed rule, CMS notes that it intends to develop a communications plan, including educational materials and other forms of outreach, to help educate beneficiaries about the program. We believe it is critical for CMS to explain and effectively define the value of the ACO model to beneficiaries, notify them that they may be assigned to an ACO in their area and outline what effect it may have on their care. This should also include a message describing beneficiaries' role and responsibility as part of engaged members of the model. Medicare has had a long-standing history of transparency in programs such as Medicare Advantage, and should continue this exchange of information in the ACO program. The first contact with the beneficiary should be from "Medicare" as the trusted entity, and should explain who may be

contacting them, why and what to expect. This will also help protect beneficiaries against fraudulent schemes. **We support CMS' intention to develop and execute a beneficiary communications plan around the ACO program.**

Opt-Out

CMS also proposes that primary care physicians participating in an ACO make available standardized written information to the Medicare FFS beneficiaries whom they serve notifying them of both the providers' participation in the program and the potential for CMS to share beneficiary identifiable data with ACOs when a beneficiary receives services from a physician on whom assignment to the ACO is based.

What CMS has proposed is the worst of both worlds for both the beneficiary and the providers. If beneficiaries can opt-out of data-sharing but not the program, providers will not have sufficient information to properly care for and manage the beneficiaries. Beneficiaries should be given the opportunity to fully withdraw from the program without having to seek care from another provider. We are concerned that this opt-out policy could prove confusing to beneficiaries or even cause some of them to believe that they must cease receiving care from their regular primary care physician. For example, some beneficiaries may very well be skeptical of the ACO program at first—or at least with respect to the data sharing aspect of the program—and want to wait to determine if they would like to participate. **CMS should structure an opt-out option that prevents both data-sharing and attribution of that beneficiary to an ACO while allowing them to continue seeking care from their usual providers. Premier believes this would be the fairest, most workable approach, from the perspective of both beneficiaries and ACOs.**

Marketing

CMS further proposes that all ACO marketing materials and activities must be approved by CMS prior to use. The regulation text defines "marketing materials and activities" as including, but not being limited to, "general audience materials such as brochures, advertisements, outreach events, letters to beneficiaries, web pages, data sharing opt-out letters, mailings, or other activities conducted by or on behalf of the ACO, or by ACO participants, or ACO providers/suppliers participating in the ACO, or by other individuals on behalf of the ACO or its participating providers and suppliers when used to educate, solicit, notify, or contact Medicare beneficiaries or providers and suppliers regarding the Shared Savings Program."[2] Further, before any changes can be made to any approved materials, the revised materials would first have to be approved by

[2]The regulation text adds that the following beneficiary communications are <u>not</u> marketing materials and activities: information materials customized or limited to a subset of beneficiaries; materials that do not include information about the ACO or providers in the ACO; materials that cover beneficiary-specific billing and claims issues or other specific health-related issues; or educational information on specific medical conditions (for example, flu shot reminders), or referrals for Medicare covered items and services.

CMS. The proposed rule warns that an ACO that fails to adhere to these requirements may be placed under a corrective action plan or terminated at CMS' discretion.

We believe that it is critical that not only CMS, but also the ACO, provide educational materials to beneficiaries on the ACO model, what additional value it will provide beneficiaries, what to expect in this new delivery model, and how to become engaged and empowered as a healthcare consumer. This will serve to introduce the ACO to the beneficiary and begin to build a stronger relationship between the provider and beneficiary. That relationship or partnership is absolutely key to the success of delivering accountable care, particularly because the model does not place any obligations on the beneficiary to remain within the ACO "network." Unlike many of the emerging private sector models with closed ACO networks, knowledge of the CMS ACO program and its goals will facilitate a more effective partnership between providers and beneficiaries that will engage beneficiaries to use the more efficient and high quality services within the ACO. Further, since ACOs will want to engage their beneficiaries in a wide array of care management and care coordination programs to achieve their Triple Aim goals, it will be important for the ACO to have transparent communication with beneficiaries about the ACO objectives and how the delivery of care is evolving to better meet the beneficiaries' needs. These programs could address disease management, wellness to support healthier lifestyles, transitions of care to support changes between settings, preventive health services reminders, decision support around treatment and procedure decisions, and remote monitoring of weight or blood pressure to better activate the beneficiaries' self-management.

Premier is concerned that CMS is drawing extensively from the Medicare Advantage (MA) program marketing requirements when the two models are very different. While CMS may wish to establish consistent policies, it should not apply them in whole. MA plans conduct traditional marketing to induce subscription to a product and employ a sales force of brokers who work on commission. Given the assignment process, ACOs cannot persuade a beneficiary to "enroll" in the program. While improved care and added services may engender loyalty to the ACO providers, the connection to assignment is indirect. **If CMS requires approval of materials similarly to MA, it should directly state that CMS will approve them or allow the use of materials that it chooses not to review within 45 days of submission per the MA program.**

Moreover, it appears that the only potential harm to beneficiaries that could result from improper communications would be the suggestion that beneficiaries are precluded from using certain providers or services. It seems as if CMS is approaching this problem backward: it should be stating what behavior is inappropriate, conducting reviews to ensure compliance, and otherwise allowing the use of the majority of communications without approval, rather than listing a limited scope of appropriate communications. The current definition of approved communications also assumes the same sorts of contacts will occur under the ACO as previously or under the MA program. ACOs should not, for instance, need to get approval to offer

beneficiaries a health risk assessment, notify them of new scheduling options or introduce them to the concept of care navigators.

We question the value of forcing ACOs and CMS to invest significant resources in an approval process when the likelihood of harm is negligible. The proposal is far more prescriptive than necessary and again attempts to regulate what should be considered business operations. The ACO providers have far more to lose by misleading beneficiaries than they would stand to gain by such behavior. Plus, these communications are often time-sensitive and need to be framed specifically to the locality. **We support CMS' proposal to allow ACOs to directly contact beneficiaries, but urge CMS to significantly limit the types of materials that must be pre-approved by CMS prior to use and urge it to focus on monitoring for egregious behavior. Furthermore, it is not appropriate to frame a marketing approval process as part of the patient-centered requirements in the statute punishable by program termination.**

Patient-Centeredness

ACA specifies that an ACO must demonstrate that it meets patient-centeredness criteria specified by the Secretary. The proposed rule notes that a patient-centered orientation could be defined as "care that incorporates the values… of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care" and that patient-centered care "should extend not only to the patient but to the family and caregivers of the patient." The proposed rule states that an ACO would be considered patient-centered if it has all eight (8) of the following:

- A beneficiary experience of care survey;
- Patient involvement in ACO governance;
- A process for evaluating the health needs of the assigned population;
- Systems to identify high-risk individuals and processes to develop individualized care plans;
- A mechanism for the coordination of care;
- A process for communicating clinical knowledge/evidence-based medicine to beneficiaries in a way understandable to them;
- Written standards for beneficiary access and communication; and
- Internal processes for measuring clinical or service performance by physicians across practices and for using these results to improve care and service over time.

Premier generally supports these criteria, but cautions CMS that most prospective applicants are just beginning to set up these capabilities. Each organization is taking a different path to meeting these requirements and using different techniques based on the patients they serve, their existing capabilities and those of their partners. In addition, given that the beneficiary assignment will be retrospective, the ACO will not know all of its respective beneficiaries and thus may not meet all of the criteria, such as individualized care plans, for each and every beneficiary in the ACO.

Providing these services are resource intensive and CMS should not assume that an ACO can or will apply such techniques to all Medicare beneficiaries. This is particularly true of care management and care coordination. Moreover, there may be legal concerns if ACOs communicate with or provide incentives to beneficiaries who are not ultimately assigned to the ACO. **CMS should focus on ascertaining if the ACO has appropriate plans and processes in place to carry out the required activities during the contract in the application and not whether the ACO can demonstrate prior experience or specifically review for compliance in all cases.**

DATA SHARING

CMS proposes to share three separate types of data with ACOs. First, in advance of an ACO's initial performance year (for beneficiaries who would have been assigned to an ACO based on historical data) and at quarterly intervals thereafter, CMS proposes to provide de-identified aggregate data reports with utilization, financial performance, quality scores and other relevant metrics. Second, at the beginning of the agreement period and at the end of each performance period, CMS would, upon the ACO's request, provide four data elements (beneficiary name, date of birth, sex, and Health Insurance Claim Number (HIC)) about each beneficiary who would have been assigned to the ACO based on historic data for the first year or who was assigned during a given performance period. Third, CMS would give ACOs the option of requesting certain beneficiary identifiable claims data on a monthly basis through a data use agreement, in the form of a standardized data set about the beneficiaries currently being serviced by primary care physicians.

The success of ACOs depends on the receipt of timely and comprehensive data. The ACO's own data will not suffice for the required activities. Because ACOs are taking responsibility for an entire population and the healthcare services they incur, it is critical to know what, if any, services the beneficiaries are receiving outside of the ACO provider network. This can only be done if CMS provides data across the continuum to the ACOs. Pharmacy data are also instrumental to the success of an ACO to both improve quality and reduce costs even though they are not included in the shared savings calculations. For example, pharmacy data can be used to identify high-risk cases (e.g., diabetics on insulin); monitor medication compliance (e.g., filling scripts on the right schedule); check appropriate use of medications (e.g., poly-pharmacy interactions); and identify beneficiaries who will hit the "donut hole" in coverage (risking non-compliance). **We applaud CMS for proposing to make available Medicare Parts A, B and D data to ACOs on a routine and timely basis and urge it to finalize the policy.**

Aggregate Data

Not all ACOs will be capable of receiving and processing full claims files. Moreover, all ACOs will need quality data from CMS including measure results such as risk-adjusted readmissions

which cannot be calculated outside of CMS. We concur that ACOs will need baseline data for the three years prior to the start of the program, and then ongoing information like demographics, risk scores, key quality indicators and overall spending for the current period as well as prior periods for trend analysis. At minimum, CMS should include the measures that are in the annual quality performance assessment and measures that an ACO cannot calculate itself like all-facility risk-adjusted readmission rates, total admissions per thousand, emergency department visits per thousand, and Medicare Parts A and B per member per month spending. We also urge CMS to share analyses it conducts in identifying "at-risk" beneficiaries as part of its program monitoring with the ACOs in these quarterly reports to assist in targeting services appropriately. The reports should also include benchmarks and comparisons to the ACO's prior reporting periods to identify trends. **We support CMS' proposal to provide all ACOs with quarterly data reports.**

CMS does not, however, outline how long after the close of a calendar quarter it expects to make the reports available to the ACOs. While CMS will need some time to process the data and calculate the metrics, timeliness is key to the value of the data. The longer the lag, the less useful it will be to the ACO in determining appropriate action steps. **Thus, we urge CMS to clearly state in the final rule its plan for data distribution and ensuring timeliness.**

Furthermore, CMS should make all attempts to move to real time data in the future. While this is not an easy task, it will greatly contribute to the success of programs such as this one. **To that end, CMS should outline what steps it plans to take to improve its data systems to support closer to real-time quality and payment feedback reports.**

Beneficiary Information

While we appreciate CMS' proposal to provide identifying data on the beneficiaries who are assigned to the ACO on an annual basis, we believe CMS should provide this data more frequently. Given the retrospective assignment process, ACOs will need ongoing information on who is likely part of the population. As CMS notes based on experience from the Physician Group Practice (PGP) demonstration, about 25 percent of the population assigned in a prior year will not again match in the next year. Given this turnover, **CMS should provide provisional assignment lists to ACOs with the beneficiary identifying data on a quarterly basis as well as those excluded (due to opt-out, death etc.).**

The regulation text omits sex from the list of beneficiary level identifiers that CMS will provide. **CMS should clarify that the omission of sex from the regulatory text was inadvertent in the final rule.**

Claims Data

In the rule, CMS lists possible data elements for the Medicare Parts A, B and D claims file. This information will be used by ACOs on an ongoing basis to conduct predictive modeling, appropriately target services based on the needs of the specific population, evaluate provider quality performance, establish performance targets and other operations. While the information CMS proposes to provide would be helpful, we believe more is necessary for the effective operation of an ACO. In Attachment I, we provide an example of the data provided to a member ACO as part of its contract with a private payor as similar data elements would be needed to succeed under the Medicare ACO program. **We urge CMS to expand the data elements included in the monthly claims files and clarify that the initial file will include the three-year historic data used to calculate the benchmark.**

CMS also limits this file to those beneficiaries who have received services from participating primary care physicians during the given performance period. This may unnecessarily restrict the file in the first couple of months of the performance period. **CMS should include services in the claims file for beneficiaries that were assigned to the ACO in the prior year as well as beneficiaries receiving care from participating primary care physicians in that year.**

In addition, it is not clear whether the file will contain comprehensive data on all services provided to these beneficiaries whether furnished by ACO participants or not. The rule states that the claims data requested must be for "The patients of its HIPAA covered entity ACO participants as the business associate of these HIPAA covered entities, and the request reflects the minimum data necessary for the ACO to conduct health care operations work." This seems to suggest that the ACO would not be receiving data on *all services* provided to the beneficiaries during the performance period. Having the full picture of services provided is critical to understanding where opportunities exist to improve care. The services that the ACO does *not* furnish may be the most instructive as the ACO would otherwise have no mechanism to track this care. **CMS should also clarify that it will include data on providers outside the ACO furnishing services to beneficiaries who are using the primary care services of the ACO.**

Lastly, CMS does not outline for the claims data how long after the close of the month it expects to make the files available to the ACOs. Since CMS will not be processing this data, but rather simply preparing files, it should be able to provide the files fairly quickly. The longer the lag, the less useful it will be to the ACO in determining appropriate action steps. **Thus, we urge CMS to clearly state its plan for data distribution and ensuring timeliness in the final rule.**

Data Prior to Contract

CMS did not, however, propose to provide ACOs with data in advance of executing a final contract. ACOs will need baseline information before entering into a contract with CMS to determine risk, which if any contract model is appropriate, and the adequacy of their provider

network for beneficiary assignment. This report should include three years worth of data to provide a historical view of the potentially-assigned population and allow for predictive modeling. ACOs cannot be expected to enter into contracts with no information on the total spending of the population that would likely be assigned to it. Sound business practice dictates that such entities should be able to conduct due diligence before entering into the program. ACOs that CMS approves as eligible for the program could sign a letter of intent and limited data use agreement prior to receiving the files. **CMS should provide data to ACOs in advance of executing a contract so that the ACO can determine which if either model is right for them.**

Data Designee

As stated previously, timely and comprehensive data, following all the requirements of HIPAA, is critical to the success of ACOs. It will enable ACOs to target safe and effective care for individual patients most in need and assure care coordination and integration. It will also allow ACOs to benchmark performance and identify performance improvement strategies. In many cases, ACOs will contract with other entities to process, analyze and develop reports from their data. For example, smaller ACOs may not have the infrastructure to carry out these activities that are critical to drive change. In addition, our healthcare system will benefit if groups of ACOs can work together through collaborative arrangements to speed the development of best practices and gain economies of scale in data management functions. It is unclear from the proposed rule whether such vendors will be able to access the ACO claims data provided by CMS under the program, and furthermore whether they would be permitted to use the data in the same way as under HIPAA. We are concerned that the application of data use agreements (DUA) and the Privacy Act to obtaining and using claims data under the program will preclude ACOs from being able to transmit data to vendors to assist ACOs in undertaking the aforementioned tasks and/or co-mingle data from multiple ACOs for use in identifying best practices, developing measures and risk adjustment methodologies, or other such activities.

The current DUA structure is more applicable to independent research projects than quality improvement activities. For instance, under the HIPAA an entity can de-indentify and then reuse the data for other analyses (i,e. development of a risk adjustment methodology), while it is unclear under the DUA whether such activities would be deemed appropriate by downstream users like vendors as opposed to the data custodians. In fact, the use of a DUA may be unnecessary under the program given the pathway for sharing such data under Health Insurance Portability and Accountability Act (HIPAA).

We would also like clarification that data from private sources and CMS can be compiled within the same warehouse from multiple ACOs across multiple DUAs. Data is needed from all sectors to create quality benchmarks, identify areas of practice variation, and develop evidenced-based guidelines. **CMS should explicitly state that ACOs can transmit claims-level Medicare data**

to a vendor, or designate a vendor to receive data from CMS on their behalf, and that it may use the data in all ways permitted under HIPAA.

Availability of Large-scale Datasets

CMS should also make large data sets more easily available to researchers and others to support the ACO program. Organizations like Premier routinely purchase the MedPAR file for the preparation of annual comment letters under the FFS program, but it is more expensive and time consuming to obtain files that cross both Parts A and B and these files do not include Part D data. Making linked datasets, even with de-identification precautions applied, would not only support more informed comments on the construction of the program, but would enable researchers to develop evidenced-based care bundles, risk adjustment models, etc. that would further advance the program. **CMS should, as part of the administration's Open Government Initiative, make robust linked data sets more easily available through a data use agreement process.**

It is unclear how section 10332 of ACA may interact with the ACO program. This provision of the law requires the Secretary to make Medicare Parts A, B and D data available to "qualified entities" at cost. However, it is unclear if the data sets can be used for purposes beyond creating quality and efficiency performance reports, such as developing evidence-based guidelines. It also requires that such reports be made available to the public. While some of the metrics used for quality improvement within an ACO may be appropriate for public display, others may not have the requisite specificity and sensitivity for comparison across healthcare systems and providers, or may not be intuitive for the average consumer. **We urge CMS to include a discussion in the final rule about the availability of large-scale datasets and any constraints of their use.**

Required Infrastructure

According to the proposed rule, the ACO must have "an infrastructure, such as information technology, that enables the ACO to collect and evaluate data and provide feedback to ACO providers/suppliers across the entire organization." As stated above, routine data across the continuum is key to the success of ACOs. However, the way in which ACOs achieve the data collection, analysis and feedback process will vary. For example, some ACOs will use Application Service Providers rather than locally host such capabilities. **CMS should not be concerned with the particulars of the ACO's infrastructure, but rather focus on the way in which it will use the data to transform care as evidenced by materials such as sample provider reports in its application.**

ICD-10

The move from ICD-9 to ICD-10 will occur during the first round of ACO contracts. This will affect the longitudinal data, the quality metrics and likely other aspects of the program. **We urge CMS to consider and discuss the possible implications of this transition for ACOs in the final rule.**

VALUE METRICS

CMS proposes to use 65 performance measures in year one of the ACO program, with ACOs required to report full and accurate data for those measures, but not meet any specific performance target. For subsequent performance periods, ACOs may also be expected to exceed certain minimum performance levels for each ACO performance measure then in use.

We believe that measurement is central to determining the success of the ACO program and monitoring for unintended consequences. However, measurement should be purposeful, meaningful and avoid undue burden on providers. CMS should focus on automated measures that assess the "value" of care. However, we do not have many outcomes-based, population-level measures across the continuum (including post-acute care, long-term care and hospice care) available to us at this time. On the contrary, many of the existing measures focus on process of care and rely on the labor-intensive process of manually-abstracting data from medical charts. **CMS should make it a priority to identify gaps and develop broad-based measures, including electronic specifications, which can be applied on a population basis.**

Initial Measures

The magnitude of the proposed measures in the first year of the program is overwhelming. While we appreciate that CMS has largely used measures with standard definitions that have been tested and are in wide use (including other Medicare programs), the number of measures required is far greater than the initial Physician Group Practice demonstration and Hospital Inpatient Quality Reporting program, both of which have been in operation for more than five years. We recognize that the first year of the program is pay for reporting rather than performance, but this still poses significant burden on newly formed partnerships that are forging new ground in interoperability. **CMS should pare back the initial measure set and only include National Quality Forum endorsed measures.**

Premier bases the following comments on its experience launching and operating its own Accountable Care Collaborative, which currently consists of 27 healthcare systems in its Implementation Collaborative and 62 healthcare systems in its Readiness Collaborative. In choosing measures of performance for its Implementation Collaborative, Premier patterned its framework on the Institute for Healthcare Improvement's Triple Aim™ of improving the health of the population, the experience of care and the efficiency and cost of care. To this extent Premier's framework aligns very well with the five domains of performance that have been chosen by CMS.

In adopting its specific performance metrics the Premier Implementation Collaborative acknowledges three facts: 1) The measures available currently to assess the performance of population health and experience of care fall short of providing optimal information, 2) the

availability of data needed to produce performance metrics is sparse and uneven even in those institutions that utilize electronic medical records, and 3) it is a very rare organization today that can electronically blend administrative claims data with clinical EHR data to efficiently and effectively produce meaningful clinical and efficiency measures.

Because of these realities, Premier has elected to adopt a phased approach to performance metrics, and we encourage CMS to consider adopting a similar approach. A phased approach to performance measurement: 1) serves to encourage and promote maximum participation by eliminating data collection barriers, 2) allows institutions wishing to form an ACO to start now without waiting for the perfect measurement framework, and 3) leaves open the door for continuous refinement and innovation in performance assessment.

Premier's Phase One Measure Set includes by design only those elements that could be captured from survey or claims data. The set specifically excludes metrics that would require use of an EHR. For a number of reasons we specifically wish to avoid the creation of ad hoc data collection methods which reside outside the normal workflow of the provision of care. Investing time, money and energy into systems that will soon become obsolete is not an appropriate use of resources at this time when we are all striving toward the ultimate goal of full electronic interoperability and reduced cost of delivering healthcare.

Premier has compared its Phase One Measures to the 65 proposed CMS measures. We have found partial agreement with 3 of 65, complete agreement with 11 of 65 and no overlap in the remaining 51 of 65. The overlap in the two measure sets is shown in Attachment II. This is chiefly because of CMS' decision to collect data via the Group Practice Reporting Option (GPRO), which we talk about below under "Reporting." We note, however, that while all of our measures would be used for quality improvement purposes, not all of them would be used for payment purposes within the ACO's commercial contracts. **We encourage CMS to adopt a phased approach to ACO performance measurement with Phase I relying solely on measures available from medical and pharmacy claims or surveys, and future phases that will rely on data from the ambulatory EHR and the blending of the two data types.**

Given what CMS has proposed and our specific comments below, we recommend in Attachment III a set of measures to be used in Phase 1 of the program.

<u>Healthcare Effectiveness Data and Information Set (HEDIS)</u>
CMS has proposed a number of the National Committee of Quality Assurance's (NCQA) Healthcare Effectiveness Data and Information Set (HEDIS) measures. While we generally support these measures, we are concerned about the use of the GPRO tool to collect them. Some of the measures can easily be collected via claims according to the HEDIS specifications:

- #28, Breast Cancer Screening;

- #29, Colon Cancer Screening;
- #43, Diabetes– Eye Exam;
- #44, Diabetes– Foot Exam; and
- #64, At Risk Population.

Premier recommends that CMS adopt these measures, but using their claims specifications rather than requiring chart-abstracted data reported through GPRO.

The HEDIS specifications also offer the option of using only claims data for the following measures:

- #30, Cholesterol Management;
- #36, Diabetes – HbA1c Control;
- #37, Diabetes – LDL-C Control;
- #40, Diabetes – HbA1c Poor Control;
- #41, Diabetes – Blood Pressure Control; and
- #42, Diabetes – Microalbumim.

While these measures can be calculated using solely claims data, we recognize that adding medical record information results in much more accurate estimates. **Thus, we recommend that CMS prioritize these measures for electronic exchange of clinical data between ACOs and CMS in the future rather than introduce the manual burden associated with the use of the GPRO tool.**

In terms of #58, Hypertension–Blood Pressure Control, while clinically very important, it is currently highly dependent on medical record data for both the numerator and denominator. We are therefore concerned that it will be particularly difficult for ACOs to collect and report. **Thus, we do not recommend the adoption of this measure in the near term.**

<u>Care Coordination/Transitions of Care</u>
For the Care Coordination/Transition Domain, CMS proposes one readmission measure:

- #8, Risk Standardized, All Condition Readmission;
- #9, 30 Day Post Discharge Physician Visit;
- # 10, Medication Reconciliation; and
- #11, Care Transition Measure (self reported by patients).

Readmissions
The measure is described as the rate of readmissions within 30 days of discharge from an acute care hospital for assigned ACO beneficiary population. However, no further information or specifications are provided for the risk model or measure. It is not clear if the proposed All

Condition Readmission measure is similar to the current 30-day readmission measures used in the Hospital Inpatient Quality Reporting (IQR) Program or the NCQA's HEDIS measure used in MA.

Thus, we caution CMS to pay close attention to possible unintended consequences and consider the complexity associated with establishing a fair and logical readmission measurement policy for ACOs. For example, patients discharged from one hospital may be readmitted to another facility when it is not clear what share of responsibility each facility should have in the readmission. Moreover, we have major concerns about the sufficiency of the readmissions measures currently in use by CMS.

In addition, some level of readmissions is desirable. Clinicians must weigh the risk of subjecting the patient to continued hospitalization with the risk of potential readmission, and faced with this reality, a certain number of readmissions is to be expected. For example, it is sometimes preferable for chemotherapy patients to be discharged early, risking infection and readmission with a community-acquired organism, rather than to prolong hospitalization and risk infection with a much more dangerous hospital-acquired organism.

Until CMS provides detailed measure specifications and risk standardization methodology, Premier does not support inclusion of this measure for scoring, but such a measure would be useful for monitoring purposes.

Physician Visit
CMS notes the 30 Day Post Discharge Physician Visit measure as requiring GPRO for calculation. We question whether chart information is truly necessary or whether CMS can calculate this measure using only claims data. **We suggest CMS consider including this measure using claims data.**

Care Transition Measure
CMS describes the Care Transition Measure as a uni-dimensional self-reported survey measure yet it too suggests the measure must be submitted via GPRO. **CMS should clarify whether this measure requires submission through GPRO, and if not, adopt it into the measure set.**

Medication Reconciliation
The Medication Reconciliation measure requires chart abstraction and cannot be calculated via claims data. This would therefore require a tool such as GPRO until electronic data exchange between the ACOs and CMS is established. **We recommend CMS drop this measure from its proposed measure set.**

<u>Prevention Quality Indicators</u>
The list of proposed AHRQ Prevention Quality Indicators (PQIs):

- PQI #1 All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma), per 100,000 population.
- PQI #14 All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication, per 100,000 population.
- PQI #5 All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for COPD, per 100,000 population.
- PQI #8 All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for CHF, per 100,000 population.
- PQI #10 All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for hypovolemia, per 100,000 population.
- PQI #11 All non-maternal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for bacterial pneumonia, per 100,000 population.
- PQI #12 All discharges of age 18 years and older with ICD-9-CM principal diagnosis code of urinary tract infection, per 100,000 population.

The AHRQ Guide to PQIs notes: "These indicators serve as a screening tool rather than as definitive measures of quality problems. They can provide initial information about potential problems in the community that may require further, more in-depth analysis." We are concerned that PQI measures would be used to assess the quality of care provided by an ACO rather than as a screening mechanism. Below is a table summarizing the sensitivity of the PQI measures (the entries in the table are explained in the notes found immediately below the table):

Indicator Name (Number)	**Risk Adjustment Incorporated**	**Literature Review Findings**
Diabetes Short-term Complication Admission Rate (PQI 1)	Age and sex.	? Proxy ? Confounding bias
Uncontrolled Diabetes Admission Rate (PQI 14)	Age and sex.	? Proxy ? Confounding bias ? Easily manipulated
Chronic Obstructive Pulmonary Disease Admission Rate (PQI 5)	Age and sex.	? Proxy ? Confounding bias ? Easily manipulated ✓Unclear benchmark
Congestive Heart Failure Admission Rate (PQI 8)	Age and sex.	? Proxy ? Easily manipulated ✓Unclear benchmark

Indicator Name (Number)	Risk Adjustment Incorporated	Literature Review Findings
Dehydration Admission Rate (PQI 10)	Age and sex.	? Proxy ? Unclear construct ? Easily manipulated ✓Unclear benchmark
Bacterial Pneumonia Admission Rate (PQI 11)	Age and sex.	? Proxy ? Unclear construct ? Easily manipulated ✓Unclear benchmark
Urinary Tract Infection Admission Rate (PQI 12)	Age and sex.	? Proxy ? Unclear construct ? Easily manipulated ✓Unclear benchmark

Notes under Literature Review Findings:

Proxy – Indicator does not directly measure patient outcomes but an aspect of care that is associated with the outcome; thus, it is best used with other indicators that measure similar aspects of care.

Confounding bias – Patient characteristics may substantially affect the performance of the indicator; risk adjustment is recommended.

Unclear construct – There is uncertainty or poor correlation with widely accepted process measures.

Easily manipulated – Use of the indicator may create perverse incentives to improve performance on the indicator without truly improving quality of care.

Unclear benchmark – The "correct rate" has not been established for the indicator; national, regional, or peer group averages may be the best benchmark available.

? – The concern is theoretical or suggested, but no specific evidence was found in the literature.

✓– Indicates that the concern has been demonstrated in the literature.

CG CAHPS

There is more than one version of the Clinician and Group (CG) Consumer Assessment of Healthcare Providers and Systems (CAHPS):

- **Four-point response scale**: Never, Sometimes, Usually, Always.
- **Six-point response scale**: Adds "Almost never" and "Almost always" to the four options.

Further, there are primary care and specialist versions of the CG CAHPS. **CMS should clarify that it plans to use the six-point scale as it has been field tested and is endorsed by the National Quality Forum. CMS should also clarify if only the primary care CG CAHPS should be used, since we presume the expectation is not to collect data via both survey types. Lastly, CMS should clarify whether CMS or the ACO is responsible for collecting the survey data and what specifically is expected through that data collection process (including the addition of survey-based ACO measures not included in CAHPS).**

Survey-Based Measures

There are three proposed survey-based measures that are not included in the CG CAHPS tool (but could be added), two of which cite the measure as collected through GPRO vs. a survey tool. And there is a fourth measure which may be better served to be a survey-based measure rather than an EHR-based measure through GPRO.

- Health Status / Functional Status (ACO 7) is appropriately cited as being submitted via a survey and it is presumed this measure can be added to the CG CAHPS
- Influenza Immunization (ACO 26) is an NQF endorsed measure (#41) from AMA-PCPI and is also used in the EHR Incentive Program as a Clinical Quality Measure. Given prior comments about the burden of using EHR data to populate the GPRO, CMS should consider the survey-based measure from NCQA HEDIS as an alternative to the proposed measure. By using that approach, this measure could also be added to the CG CAHPS.
- Pneumoccal Vaccination (ACO 27) is an NQF endorsed measure (#33) from NCQA HEDIS. By definition this is a survey-based measure and as such, should not be submitted via the GPRO as indicated in the proposed rule. This measure could also be added to the CG CAHPS.
- Falls: Screening for Fall Risk (ACO 63) is an NQF endorsed measure (#101) from NCQA Medicare Health Outcomes Survey. By definition this is a survey-based measure and as such, should not be submitted via the GPRO as indicated in the proposed rules. This measure could also be added to the CG CAHPS. Further, the description of this measure provided in the proposed rule does not match the description in the 2011 NCQA HEDIS Specifications Volume II and may be outdated.

Meaningful Use Measures

CMS proposes 5 physician meaningful use measures:

- (ACO 19.) Percent of All Physicians Meeting Stage 1 HITECH Meaningful Use Requirements
- (ACO 20.) Percent of PCPs Meeting Stage 1HITECH Meaningful Use Requirements
- (ACO 21. Percent of PCPs Using Clinical Decision Support
- (ACO 22.) Percent of PCPs who are Successful Electronic Prescribers Under the eRx Incentive Program

- (ACO 23.) Patient Registry Use

These are structural measures that assess physicians' ability to meet meaningful use of EHR requirements. We believe that such structural measures are not necessarily accurate indicators of quality performance. Furthermore, as noted earlier, Premier does not believe that CMS should set specific thresholds for meaningful use of EHRs in order to participate in the ACO program. **CMS should remove measures 19-23 from the program, or at minimum collect them only for monitoring purposes.**

Hospital Acquired Conditions (HAC)

In Premier's QUEST improvement collaborative, participants monitor a QUEST "harm score" which is a composite score of 25 individual harm metrics. Premier has found that this score can be very sensitive to the degree of diligence of documentation and coding. In fact, Premier has observed that in the initial period of the measures introduction, the "harm score" of the group actually increased. Premier feels this is an illustration of a general principle in that if one is focused on an event such as harm, one has a greater chance of documenting and recording the event. Because these composite measures of harm can vary with the degree of documentation and coding, these measures may not be suitable for judging relative performance. However such composite measures can be useful measures to monitor changes over time. However such composite measures may not be suitable for judging relative performance.

Premier is confident that even if CMS monitors the HAC measures rather than including them in the scoring, CMS will see improvement in performance. Premier has found that transparency of measurement alone is enough to motivate improvement in this area. As long as these scores are transparent and visible, improvement will follow; it is not necessary to incorporate this into a performance scoring system to ensure improvement.

In addition, the proposed HAC measures, taken as a large composite score, lack clarity and do not provide useful or timely information to improve performance. The lack of risk adjustment is also notable in light of a composite score that will include numerous unrelated measures. **Premier suggests that metrics of patient safety, specifically the HAC Composite, be used for monitoring and not be used as part of the performance score.**

Lastly, the proposed Measure #25, Central-Line Associated Blood Stream Infection (CLABSI) Bundle (listed as NQF #298) is described as a process measure that can be retrieved from either claims data or NHSN. The CLABSI Bundle is in fact the NHSN process measure "adherence to central line insertion practices (CLIP)." We do not understand how it is possible that these process elements could be retrieved from claims data. The information required is very detailed, for example: maximal sterile barriers used (includes sterile glove, sterile gown, cap, mask worn, large sterile drape); skin antisepsis (whether skin is dry before insertion); hand hygiene practice before insertion; type of central line and insertion site; daily review for possible removal. This

measure remains labor intensive and, is therefore not in widespread use even in NHSN, resulting in minimal baseline data. This measure lacks a large volume of baseline data and is labor intensive. **Premier does not recommend including the CLABSI Bundle in the measure set whether for reporting or scoring.**

At-risk Population Measures

In the At Risk Population Domain, CMS has proposed both composite and individual measures for Diabetes and Coronary Artery Disease.

Diabetes

- Diabetes Composite (All or Nothing Scoring**):**
    - Hemoglobin A1c Control (<8%)
    - Low Density Lipoprotein (<100)
    - Blood Pressure <140/90
    - Tobacco Non Use
    - Aspirin Use
- Individual Measures
    - *Diabetes Mellitus: Hemoglobin A1c Control (<8%)*
    - *Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control*
    - *Diabetes Mellitus: Tobacco Non Use*
    - *Diabetes Mellitus: Aspirin Use*
    - Diabetes Mellitus: Hemoglobin A1c Poor Control(>9%)
    - *Diabetes Mellitus: High Blood Pressure Control <140/90*
    - Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients
    - Diabetes Mellitus: Dilated Eye Exam in Diabetic
    - Diabetes Mellitus: Foot Exam

Coronary Artery Disease

- Coronary Artery Disease (CAD) Composite: (All or Nothing Scoring)
    - Oral Antiplatelet Therapy Prescribed for Patients with CAD
    - Drug Therapy for Lowering LDL-Cholesterol
    - Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction
    - LDL Level <100 mg/dl
    - Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)
- Individual Measures
    - *Oral Antiplatelet Therapy Prescribed for Patients with CAD*
    - *Drug Therapy for Lowering LDL-Cholesterol*
    - *Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction*

- *LDL level < 100 mg/dl*
- *Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)*

The Diabetes Composite includes five of the individual Diabetes measures, and the Coronary Artery Disease Composite includes all of the individual CAD measures (duplicate measures in italics). Thus, it appears that these measures will be double counted for calculating the quality performance standard. **CMS should select either the composite or the individual measures for these conditions. Premier supports using the individual measures, which allow the ACOs to specifically target a process for improvement.**

Alternative Measures

Given that we have recommended that CMS monitor the major composite measure of hospital-performance rather than using it as the scoring system, CMS might want to consider including process measures that are a part of the inpatient value-based purchasing program as an alternative. These measures are already in wide-use and would not contribute to provider burden in terms of reporting requirements. While they may be applied to underlying FFS payments beginning in FY 2013, this would consistently apply similar measures to the ACO bonus payments until true population-based outcomes measures are available.

Measure Changes

CMS says it expects to refine and expand the list of ACO performance measures in subsequent program years through additional rulemaking and to expand measure reporting mechanisms to include those that are directly EHR-based. The agency also expects that the ACO quality measures will evolve over time with the goal of developing a single measure set that could be used by ACOs operating across a wide variety of payors. Per above, we support the evolution toward EHR-based measures and the goal to create a set of core measures for use across a variety of programs and payors. However, we have some reservations about the lack of a methodical, reliable process to integrate new or altered measures into the program.

CMS also indicates that it will make the specifications for the proposed measures available on its website prior to the start of the program and warns that the specifications for some of the measures will need to be refined to apply to an ACO population. It is important for the ACOs to know exactly what measures (including their specifications and the populations to which they apply) in advance of finalizing a contract. **CMS should immediately post the final measure specifications so that ACO applicants can begin preparing for reporting such measures and being held accountable for the ability to report the measures, the accuracy of the measures and their performance on the measures.**

Moreover, we are concerned that the measures against which the ACO will be judged are not yet final. CMS states that in terms of the initial measures (absent rulemaking), the agency will not consider measures "that do not substantially cover the same patient populations, processes, or outcomes addressed by the existing measures outlined in the proposed rule," but this only provides modest comfort. **The Premier alliance urges CMS to establish a measure transition plan in the final rule, and not to modify or add whole new measures during the first three-year contract period.**

At minimum, CMS should institute a system similar to the final value-based purchasing system where measures must be reported for a year (without specification changes) before they are eligible to be added to the scoring system and standards against which the ACO will be measured. Material modifications to a measure should require it to be reported for a year prior to use in the scoring system similarly to new measures. If the modifications result in less challenging measures or are otherwise immaterial to scoring (i.e. routine code splits), then such changes could be made through quarterly specification updates. For example, if a measure states that a diabetic's Hemoglobin A1C levels should be "below 7 percent") and CMS wants to change this to "below 8 percent"), then the measure could be retained; but, if CMS wanted to change this to below 6 percent, it would need to give ACOs time to make modifications to their practice before it is scored as part of the program. **CMS should ensure that all measures, even significant re-specifications, are reported for a year prior to establishing a benchmark and including them in scoring.**

Reporting

The ACA requires that ACOs "submit data in a form and manner specified by the Secretary on measures the Secretary determines necessary for the ACO to report in order to evaluate quality of care furnished by the ACO." In the rule, CMS proposes measures with various submission methods such as survey instruments, claims, or the Group Practice Reporting Option (GPRO) data collection tool. While claims-based measures do not require effort on the part of the ACO, survey data and measures using the GRPO tool will carry a heavy burden on providers. Much needs to be worked out in terms of the form and timing, as well as transmission of the data from ACOs to CMS (and in reverse).

<u>GPRO</u>

Premier discourages the use of the GPRO for several reasons:

1) Inasmuch as this mechanism does not provide a long-term solution to the collection of clinical data elements needed for quality measurement, Premier fears that creating this pathway will actually serve to hinder the creation of robust solutions that are based on clinical data in an ambulatory EMR. Creation of this alternate pathway removes the incentive for EMR vendors to develop innovative solutions for the creation of these metrics. Rather, CMS should establish its intent to collect these measures in a subsequent phase of measurement and allow market-based competition to supply an innovative

solution. CMS should by no means engage in the creation of ad hoc data collection tools that will ultimately impede progress in this important area.

2) The population of the CMS GPRO with data from the clinical practice relies entirely on a manual data collection process. Such processes are expensive, prone to error and divert staff away from providing care to patients. Premier has heard from its membership that reliance on manual data collection processes imposes high barriers to participation.

3) The collection of data through the GPRO takes place outside the normal workflow of providing patient care. It is therefore a non-value adding activity, and in a sense, serves only to create waste. Rather than establishing processes that reside outside the workflow, CMS should establish its intentions for metrics to be collected in a subsequent phase, and allow market-based solutions to provide a true integration with the ambulatory patient record.

4) Under the GPRO data reporting option, a sampling methodology is proposed for data validation, with the requisite data submitted for a sample of beneficiaries. It describes an audit process under which the medical records of a small sample of beneficiaries would be examined (first, 8 records to check for mismatches, then another 22 records if mismatches were found in phase 1, and finally corrective action if mismatches are found in more than 10 percent of the medical records in phase 2). Validation of these measures will be more difficult than CMS might expect. These patients may have been seen across a host of providers and thus the data reported from the actions of multiple providers. This validation process would need to be tested before actual implementation.

We specifically discourage CMS from creating ad hoc data collection tools like GPRO that reside outside the normal workflow of care delivery and instead recommend that it work with vendors to incent the development of informatics solutions that will facilitate electronic submission of clinical data to CMS in the near future.

Benchmarks

CMS proposes to set benchmarks for each proposed measure using Medicare FFS, Medicare Advantage or ACO performance data (depending on availability). ACOs would be required to report completely and accurately on all measures within all domains to be deemed eligible for shared savings consideration. Each measure would have a minimum attainment level. ACOs would have to exceed the minimum attainment level (generally set at 30 percent or the 30^{th} percentile of the Medicare FFS or Medicare Advantage rate) for each measure in a domain for the domain to be eligible for shared savings. Further, all domains must have a score above the minimum attainment level in order for the domain to be eligible for shared savings, and an ACO is eligible for shared savings only if it has satisfied the quality performance requirements for each domain.

We are concerned about the creation of benchmarks based on various data sources against which the ACOs will be measured to determine the portion of savings each is able to retain. While national benchmarks may be easily created for the measures based on claims data, we have some reservations about applying Medicare Advantage benchmarks to ACOs without testing the applicability, and are unclear how CMS will establish benchmarks for many of the other measures. This is especially the case for benchmarks that may attempt to homogenize data from disparate sources or extrapolate from a subset of providers. If, for instance, CMS establishes benchmarks solely on the participating ACOs, the scoring system may need modification. It would be unfair to assume the bottom 30 percent of participants should receive no credit toward retaining savings when they may very well be performing well above the rest of the nation.

Furthermore, we are concerned about the proposal that all measures within a domain must exceed the threshold in order for the domain to be eligible for shared savings. Measures within a domain are not all directly related and performance on one measure may not have any relationship to scores on another. This is especially troublesome at the beginning of a new program where ACOs may not have experience with the measures, the specifications may have been modified, and the thresholds setting methodology is new and untested. We have received unconfirmed reports that this is not the policy CMS intended to specify. In any event, in the final rule, **CMS should give ACOs credit for measures on which the ACO scored well, even if it does not meet the threshold for other measures within the domain. This could be achieved by setting the threshold at the domain level rather than the measure level.**

Scoring

CMS further proposes to use a sliding scale measure scoring approach for performance above the minimum attainment level, with better performance receiving more points, thereby qualifying better performing ACOs to receive a greater share of any savings. Under the proposed scoring methodology, each of the five domains would be worth a pre-defined number of points (for a total of 130 possible points). All domains would be equally weighted regardless of the number of measures within the domain. The aggregated domain scores would determine an ACO's eligibility for sharing up to 50 percent of the total savings generated by the ACO under the one-sided model or up to 60 percent of the total savings under the two-sided model.

Premier bases its comments on the proposed scoring methodology on its experience in launching and operating a multi-centered national improvement collaborative of over 200 Premier Members known as QUEST. The goal of QUEST was to accelerate improvement among hospitals in five broad dimensions of care by using a collaborative execution framework. Premier has already shared with CMS the remarkable success these 200-plus hospitals have achieved in a short period of time.

Premier agrees with CMS' approach to "set the quality performance standard of the first program year at the reporting level and to raise the standard to reflect performance in subsequent years." Using the first year of the program to establish a baseline makes sense and is consistent with the best practices we have learned from our own improvement collaborative. **We support pay-for-reporting in the first year of the program to establish a baseline.**

CMS then proposes to use a sliding scale measure scoring approach, with each metric assigned 0-2 points according to the percentile ranking of relative performance. CMS seeks comment on this approach, whether to use a threshold approach, or whether to use a blended approach. **Premier strongly discourages any approach which bases potential reward on relative percentile rankings (i.e. 90 + percentile, 80+ percentile, etc)**.

This type of approach has several problems: 1) It sets up an anti-collaborative environment in which by definition each member of the cohort can only succeed as others fail. In this type of forced ranking, there is no motivation to share learning and best-practices so that others in the group can also improve. 2) The use of percentile rankings establishes arbitrary performance strata that in some cases can differ only by a small amount that may lack any real significance. 3) If the number of participants in the ACO program is small, as may be true at the start of the program, then the above two problems are magnified.

Premier has found in its own QUEST collaborative that by establishing a fixed target that does not vary over three years and which (though initially may be based on a relative ranking) does not vary from year to year based on relative percentile can accomplish the following: 1) it provides the motivation for all to achieve excellence by reaching an agreed upon, fixed target, 2) it encourages the participants to share best practices because one organization's win does not require another's loss. **Establishing fixed performance targets that do not vary over three years motivates all participants to do well while encouraging a spirit of collaboration. CMS should adopt this approach, which promotes collaboration.**

Premier agrees with CMS that the above approach, which in some ways is closer to a "threshold" approach, may result in lack of motivation for further improvement once the goal is achieved. To mitigate this, CMS may wish to adopt a more blended approach to performance-based payment. For example, CMS could set a minimum "threshold" level of achievement, scoring below which would result in no shared savings, a "target" level which would result in an increased level of shared savings, and a "stretch" level which would result in the highest level of shared savings. The important thing is that the levels be fixed, agreed to in advance and not subject to fluctuation as the group as a whole improves. Furthermore, the ACOs should know what the targets are in advance of executing contracts to figure into their decision to participate in the program and begin planning to meet these goals. **CMS should establish and announce in advance the measure targets as it does as part of the inpatient Value-Based Purchasing program.**

Premier has found through its own performance improvement collaboratives that transparency of results is an essential feature of accelerating improvement and is itself a strong motivator for achieving excellence. **Premier supports CMS in its proposal to encourage transparency of performance metrics.**

Meaningful use

CMS proposes to require that at least 50 percent of an ACO's primary care physicians be meaningful users of EHRs by the beginning of the second year of the ACO's agreement with Medicare (that is, by the beginning of calendar year 2013). CMS also seeks comments on whether a similar requirement should apply to an ACO's hospitals. We are concerned that this requirement may inadvertently preclude a number of otherwise eligible applicants from becoming ACOs under this program; especially prospective ACOs in areas where physicians tend to practice in solo or small groups. In many cases, hospitals and physicians are newly working together in unprecedented collaborations in their markets to share information. In some cases, the information technology connection is just beginning and has been somewhat slow due to a lack of capital –now being addressed by HITECH—and legal concerns.

Moreover, having EHRs does not guarantee that the information is being used to transform care. Again, CMS should not establish a prescriptive bar that must be reached to participate, but rather focus on capabilities and outcomes. This is especially true given that CMS cannot yet accept electronically quality measures generated from EHRs. The existing penalties associated with an inability to meet meaningful use requirements should provide appropriate incentive on its own. Lastly, it is unclear when or if CMS would expect ACOs to meet stage II requirements. Our assumption is that for providers entering the program in 2013 with the second year of the contract beginning 2014, that stage I and not II would still apply. **CMS should remove the physician meaningful use of EHRs requirement and should not implement such a requirement for hospitals.**

PAYMENT

ACA gives CMS the authority to allow different payment models within the ACO program. ACOs that meet the quality performance standards established by the Secretary, as discussed in the previous section, and that achieve savings compared to a benchmark of expected average per capita Medicare fee-for-service (FFS) expenditures, will share in a portion of the Medicare savings. The proposed rule creates two tracks. Under the first track, ACOs can participate in a one-sided, shared savings-only model for the first two years of the three year agreement and not be responsible for any portion of losses above the expenditure target. In the third year of the agreement, however, these ACOs would be automatically transitioned to the two-sided model and payments would be reconciled as if the ACO was in the first year of the two-sided model. Track 2 offers a two-sided model for all three years of the agreement period, and participating

ACOs would be eligible for higher sharing rates than would be available under the one-sided model.

Based on simulation of the CMS payment model using Dartmouth Atlas data from 2005–2007,[i] Premier is concerned that the proposed rule will result in many high spending areas, arguably those who most need to participate, being precluded from the program. Although these areas have more costs to cut, the expectation for how fast they would be able to do so is unreasonable. Even using a very aggressive assumption of a 10 percent reduction in costs in a single year and assuming CMS does not retain the 2 percent threshold proposed under track 1, 29 percent of hospital service areas (HSAs) would lose under the model. Once you add in the 2 percent threshold below which CMS retains 100 percent of the savings, the proportion grows to 37 percent of HSAs that would be unable to generate enough savings to receive compensation. Among 1,332 of the largest HSAs, we believe 13 - 23 percent would be unable to generate savings sufficient to receive a bonus, including markets such as Northern Little Rock, AR; Ventura, CA; Newark, NJ; and Fort Worth, TX.

If this magnitude of areas cannot win even at the outer bound of a realistic reduction in costs, then CMS will only attract a fraction of the markets it could have with the design changes suggested in this letter. **CMS should seek a combination of payment terms, as suggested below, that seek to draw in ACOs from across the country to result in the largest overall improvement in health, healthcare and affordability.**

Up-Front Capital

We are disappointed that CMS did not propose to provide advance capital to ACOs through this program. We know from the PGP demonstration sites that the investment required to be successful under this model is significant. We are, however, pleased that CMS has signaled that it may provide capital through the Advanced Payment ACO Initiative. **CMS should offer grants and/or loans to encourage ACOs to form in areas they might not otherwise be able to.**

ACO Payment Models

We appreciate CMS' inclusion of two payment models. In some areas, particularly where managed care is prevalent, prospective ACO applicants are prepared to accept risk. However, in many other areas ACOs are just beginning to function as collaborative groups of providers and are not yet prepared to take on risk. Thus, we are concerned about the inclusion of down-side risk in the third year of Track I.

A shared-savings-only model is perfectly consistent with section 3022 of ACA and arguably the option that the Congress expected CMS would make available. First, section 3022 is entitled the Shared Savings program, not the Shared Savings and Shared Loss Program. Second, among the statutory requirements for organizations to become ACOs is one requiring the organization to

have a formal legal structure that would allow it to receive and distribute payments for shared savings with no mention of shared losses. Similarly, the law provides detailed instructions for calculating shared savings with no similar instructions for calculating shared losses. Thirdly, the law precludes administrative and judicial review with respect to the determination of whether an ACO is eligible for shared savings, the percent of shared savings specified by the Secretary or any limit on the total amount of shared savings established by the Secretary (among other things) with no mention of such a preclusion with respect to shared loss-related matters.

Section 1899(d) of the statute envisioned a pure one-sided shared savings approach, with entities assuming no risk in the event expenditures exceed the benchmark. Section 1899(i) separately gives the Secretary authority to create a risk-based option. The clearly statute envisioned one model based purely on shared savings as evidenced by the risk models being outlined in the subsection of the law indicating "optional other payment models" (see e.g. 1899(i)(2)).Taken together, we believe that section 3022 provides ample evidence that, in enacting section 3022, the Congress was not expecting that the Medicare Shared Savings Program would fail to provide an option under which only the potential for shared savings was at issue. Otherwise, we believe that section 3022 would have provided explicit Congressional guidance regarding shared loss issues.

As additional insight into the development of section 3022 we point to the December 2008 report, *Budget Options, Volume 1: Health Care*, the Congressional Budget Office (CBO). This report identified an option under which "Bonus-Eligible Organizations" (BEOs) would receive performance-based payments if they reported certain quality measures and if spending was below a benchmark. In that report, CBO noted that the concept of BEOs is "similar to the accountable care organization models proposed by some researchers." As is evident from the BEO term used by CBO, this budget option identified for the Congress did not involve shared losses, although it nonetheless was projected to produce five-year savings (FY 2010-2014) of $320 million. We mention this report here because we believe it provides a relevant indication of how the Congress ended up incorporating provisions for a Medicare Shared Savings Program into ACA, and because we believe this history provides a useful indication of what the Congress was expecting.

Similarly, in a Senate Finance Committee document titled "Description of Policy Options: Transforming the Health Care Delivery System: Proposals to Improve Patient Care and Reduce Health Care Costs," dated April 29, 2009, the option "Medicare Shared Savings Program (i.e., Accountable Care Organizations)" is described in considerable detail (on pages 17 and 18). Among other things, the committee's document states the following:

> Under this option, the Medicare program would allow groups of providers who voluntarily meet quality thresholds to share in the cost-savings they achieve for the Medicare program. Beginning in 2012, groups of providers — such as

> individual physician practices, physician group practices, networks of physician practices, hospital/physician joint ventures, hospitals employing physicians, etc. — would have the opportunity to qualify for sharing of the cost savings they achieve for Medicare…To earn the incentive payment the organization would have to meet certain quality thresholds [emphases added].

While this Senate Finance Committee document goes on to list a wide range of design features under consideration for the Medicare Shared Savings Program, no mention is made of a shared loss component for this option. Once again, we believe this document provides further relevant evidence regarding the evolution of section 3022 of ACA and related Congressional expectations.

The risk of shared losses in the third year of Track 1 is the single feature of CMS' proposal most likely to deter applicants according to our membership. CMS' haste to get to more advanced models may backfire in such a way that the program never gets off the ground. From an ACO perspective, even "shared savings" with no "down-side" risk, still includes significant risk. These organizations are making capital investments and restructuring to meet the needs of this new approach to care. If they fail, they stand to lose their up-front investments, the reduced revenue from fewer services (for example, fewer hospital admissions) and the intangible but real costs of potentially soured relationships with ACO partners, effects on market share and public perception. **CMS should include a payment track that relies solely on a shared savings model with no down-side risk for the first three-year contract.**

Benchmark

The law directs CMS to establish benchmarks that are updated each year by the absolute growth in the national adjusted per capita spending across Medicare Parts A and B for the associated beneficiaries. Specifically, it notes that the benchmark should be adjusted by beneficiary characteristics, but also gives the Secretary latitude to make other appropriate adjustments.

The ACOs will need benchmark-related information in advance of the performance period to conduct financial modeling, plan operational changes and educate employees about the goals. The benchmark is also critical to an ACO determining their opportunity and risk under the program to make an informed decision about whether to participate in the program and if so, which payment track. **We urge CMS to establish the estimated benchmarks and notify the ACO applicants prior to the deadline for contract execution.**

CMS needs to strike a delicate balance in crafting the benchmark and expenditure calculations. Each methodological decision affects the ability of an ACO to succeed under the model, including the growth rate used to bring historical data to the first benchmark and what adjustments are made to the benchmarks. Below we suggest some adjustments CMS should make to the benchmark calculation methodology.

Population

CMS proposes two options for calculating the benchmarks: 1) conduct the calculations on beneficiaries who would be assigned to the ACO based on the historical data and 2) conduct the calculation on the population actually assigned retrospectively to the ACO. Premier believes that these two options should not be considered mutually exclusive. Similarly to the assignment process overall, we think there is value in calculating the benchmarks both ways. The initial calculation is needed to provide ACOs with estimated benchmarks in advance of the performance period, while the second calculation would determine the final benchmark based on the actual assigned population. **CMS should calculate estimated benchmarks on the historically assigned population and then on the actual population to conduct the final payment reconciliation.**

Growth Rate

The combination of a national rate of per-capita spending growth applied to the historical data to build the initial benchmark and the absolute growth in the national per-capita spending applied to the performance period benchmark growth results in a distinct disadvantage for high spending areas. If the goal of the program is to rein in national healthcare spending, this proposal starts off on the wrong foot for targeting the areas with greatest opportunity. In establishing the initial benchmark, the goal should be to accurately predict the actual growth of the particular ACO and establish a reasonable starting point, not to immediately penalize certain areas for past spending trends without giving them the opportunity to transform care. **CMS should apply the higher of a local and national growth rate to trend historical data forward and increase participation in high-spending areas.**

Payment adjustments

CMS does not propose to adjust the spending calculations for wage and practice cost differences or add-on payments such as disproportionate share hospital (DSH) and indirect medical education (IME). The proposed rule does not specifically discuss the treatment of direct medical education (GME), so it is unclear if CMS plans to include them in the ACO benchmark and shared savings/shared loss calculations. There has been significant volatility in the DSH factor recently due to changes in the data and methods used to calculate the adjustment. This instability will persist with the implementation of ACA payment reductions and will be unrelated to the effectiveness of an ACO's operations. Including such payments in the calculation of spending will add variability that will be difficult to parse from true cost savings and will make it challenging for hospitals to predict risk, identify opportunity and gauge progress.

In either the case of add-ons or pass-throughs, efficiency gains will not affect the costs associated with these activities, and thus are not amenable to the objectives of the ACO model. For instance, better coordinated care may avoid a beneficiary needing a transplant, which would be captured in the savings calculations; but, if a transplant is necessary, the organ acquisition costs will not change. In fact, teaching costs are likely to go up as reorienting teaching programs to a

new way of thinking and practice will be resource intensive. In addition, if such costs are included in the national data used to set the targeted reductions, they may unduly influence the result. To arrive at an appropriate spending reduction target, CMS should look at the costs that are common to all hospitals for the services provided.

While CMS contends that it does not have the authority to make such adjustments to the expenditure calculation, rather only the benchmark calculation, we respectfully disagree and refer CMS to American Association of Medical College's legal analysis of the issue. We believe that such action is permitted by section 1899(i) of ACA and will create an equal playing field that ensures the broadest group of beneficiaries has access to critical services and the ACO model. **CMS should wage and practice cost adjust its spending calculations as well as exclude DSH, IME and GME.**

The reduction in hospital admissions under the ACO philosophy will result in lower add-on payments and distinctly disadvantage hospitals that provide substantial care to low-income patients and house residency programs. These DSH and IME payments, while paid on a per case basis, are in large part intended to reimburse hospitals for costs unrelated to the particular case. For example, according to Mark McClellan, then Administrator of CMS:

> *The original intent of DSH payments was to reimburse hospitals for increases in their Medicare costs that were associated with treating a large share of low-income patients. Since that time, several changes to the statutory formula have increased the likelihood that DSH payments also compensate hospitals for the costs of treating uninsured patients.*[i]

These obligations will remain even if Medicare admissions decrease. **CMS should consider including a policy to mitigate this disincentive for a key constituency of the program.**

CMS proposes to truncate spending at the 99th percentile to account for outlier cases. Outlier payments are necessary even within the ACO construct. This proposal prevents extraordinary cases from skewing the spending for a particular ACO and aligns incentives to ensure that difficult cases are not avoided. In analyzing the data, CMS may also realize that certain services or conditions should be routinely removed, such as transplant surgeries or end-stage renal disease. **We support CMS' proposal to truncate spending for the shared savings calculations at the 99th percentile.**

<u>Patient Adjustments</u>

Changes in the case mix of assigned patients stemming from changes in the health status of assigned patients or changes in the ACO's organizational structure could affect expenditures. CMS considered alternative risk-adjustment options to account for this impact. While CMS considered adjusting solely for demographic factors, it proposes to incorporate diagnostic

information based on the CMS Hierarchal Condition Category (CMS-HCC) prospective risk adjustment model that is used in the MA program and is annually calculated for all Medicare beneficiaries. Risk-adjustment is of paramount importance for the ACO program, as the enhanced benefits will inherently draw a higher-acuity patient population. **We support the application of the HCC risk adjustment methodology to ACO calculations, but we urge CMS to continue investigating risk adjustment methods that will capture more of the unexplained variation in spending and include additional variables such as socio-economic status.**

Incorporating adjustments based on diagnostic information in the program carries the potential for changes in coding completeness and intensity that affects payments. Based on experience in MA and with the PGP demonstration, CMS concluded that ACOs' HCC scores are likely to increase significantly due to more complete coding rather than patient acuity. Therefore, CMS proposes to calculate a single benchmark risk score for each ACO. The same risk score will be applied throughout the agreement period. The Premier healthcare alliance is very concerned that this will unduly penalize ACOs who treat a high-risk population with severe conditions that will naturally progress in acuity even under the best possible care. To assert that the acuity of the assigned patients will remain constant and the entire increase will be due to coding does not seem justified. The ACOs may well end up attracting the sickest and hardest to treat patients that are most in need of care coordination and their conditions will likely, through no fault of the ACO, continue to decline.

The ACO population is fundamentally different than MA where plans can market to beneficiaries who may enroll in plans product. Some of these beneficiaries may use relatively few services, especially early on. In contrast, ACOs will be assigned beneficiaries based on service utilization and this will likely result in the heaviest of users with declining conditions matching to the ACO. In addition, ACOs will not have the same ability to maximize coding accuracy as MA plans, given the differences in the structures of the models. MA plans have a process to go back and add codes that will not, in all likelihood, be available to ACOs. Moreover, a blanket adjustment will be inappropriate when ACOs have varied backgrounds in coding for risk score purposes. This would unfairly penalize certain ACOs. **CMS should devise a system that creates an ACO-specific cap on risk growth during the performance period.**

Underlying Payment

CMS proposes to apply FFS payments without modification to underlying claims payment. For instance, under the Medicare inpatient prospective payment system (PPS), a national value-based purchasing program and a readmissions penalty will both begin in fiscal year (FY) 2013, while a HAC policy will begin in FY 2015. Conceptually, we embrace tying payment to quality, as it is the foundation underpinning ACOs. Based on our current understanding of these policies, we believe they should apply to underlying ACO payment. These policies are consistent with the goals of an ACO and will further encourage improvements even if bonus payments under the

ACO are not made. **CMS should apply quality-related payment policies to underlying FFS ACO payment.**

There are, however, other payment rules that run counter to the goals of an ACO. For example, post-acute care transfer policies reduce payments if the beneficiary is moved to certain other providers prior to reaching the geometric mean average length of stay for that diagnosis-related group. Also, under current policy, in order for Medicare patients to have skilled-nursing facility stays covered, they must first have a qualifying inpatient stay. Under the physician fee schedule, echocardiograms cannot be performed on the same day as a new patient visit, which is inconvenient and unnecessarily delays care. In Attachment III, we provide examples of such policies that should not apply under the ACO model. Within an ACO, the goal is to treat the patient in the right setting regardless of payment policies that micromanage care and restrict innovation. As long as the ultimate outcome is high-quality, cost-effective care, the ACOs should be able to direct patients to the appropriate setting without reduced payment. ACOs will be mindful of care patterns that ultimately result in higher Medicare spending, as it will reduce the annual bonus, and the quality measurement process will ensure that the quality of care is maintained. **Accordingly, CMS should not apply payment policies that penalize providers for directing the setting of care.**

Shared Savings

The ACA requires CMS to measure the "estimated average per capita Medicare expenditures under the ACO for Medicare fee-for-service beneficiaries for Medicare Parts A and B services, adjusted for beneficiary characteristics." If actual spending is below the benchmark by more than the minimum savings rate set by the Secretary, then the ACO is able to share in a certain portion of the savings (for example all savings greater than 2 percent below the benchmark in the case of the one-sided model.

Minimum Savings Rate

Even in a bonus-only model, ACOs will have to invest significant resources in order to transform the delivery of care. We believe that the potential amount of savings shared by an ACO does not provide enough incentive to undertake the expensive and robust change to the delivery of care required by a move to accountable care. It will take significant funds for providers to transform their structures and processes to focus on value, and they should be compensated for their dramatic effort and risk. While this model does not explicitly include downside risk in the form of shared losses in the first two years, ACOs will still be investing substantial capital and human resources that have considerable opportunity costs. The cost of failure will be felt not only in terms of money and resources expended to implement ACOs; adverse results could also include damage to physician and patient loyalty, loss of market share or other consequences.

Given these costs, the potential savings available through the program (specifically Track 1) as currently proposed are low. If CMS retains the first 2 percent of savings and then shares 50

percent thereafter, the ACO would not be able to achieve savings even approaching the level of first dollar savings that would accrue to CMS. As an example, in Track 1, an ACO that achieves 3 percent savings can, at best, only receive 33 percent of the actual first dollar savings, and that is assuming the provider is rewarded with 100 percent of the savings after the 2 percent threshold. Only after the savings rate grows high enough (our calculations show a rate greater than 4 percent is required) will the ACO and CMS obtain an equal share of the savings if the ACO received 100 percent of the second dollar savings.

Premier believes that once CMS has established that the savings are not due to chance variation, and that actual costs are below what CMS calls the minimum savings, the ACOs should be able to participate in all savings realized, not just a portion of those savings. The rationale is that once the comparative savings are judged sufficient to reject the null hypothesis of no savings (i.e., that actual adjusted costs are below the CI around the cost target and therefore statistically significant), then the most accurate measure of savings is the difference between the target and actual costs, not the difference between the lower CI and actual costs. Reducing the savings by the cost buffer would misrepresent true savings. **Once an ACO demonstrates costs that are below the lower bound of the CI, then CMS should allow ACOs to share in first dollar savings in Track 1 and 2. At minimum, CMS should increase the savings shared with ACOs if it retains the 2 percent threshold in Track 1.**

CMS should establish a rolling CI option for small ACOs that need to satisfy savings rate thresholds in each year that are as high as 3.9 percent (for under 5,000 beneficiaries). The idea is allow them to cumulate cost experience (and savings) over time, giving them an effectively larger beneficiary base, which would reduce the size of the CI accordingly. For example a 5,000-member ACO would have the CI of a 15,000-member ACO over three years; so that its CI boundary would drop from 3.9 percent to 2.7 percent. That way a small ACO that consistently saves over three years (say, 3 percent each year) will ultimately be eligible for a share of that savings, even though in each year separately it did not exceed the single-year threshold of 3.9 percent.

Another way to reduce the CI is to allow ACOs to include their entire beneficiary base, not just Medicare, but privately insured members as well. The same logic from the above paragraph applies. For example, if an ACO's beneficiaries are 40 percent Medicare, then including the other 60 percent of private-payor beneficiaries in the shared-savings calculation will effectively increase the base by 150 percent, so that an ACO with 6,000 Medicare beneficiaries will have 15,000 total beneficiaries, driving the CI boundary down from 3.6 percent to 2.7 percent.

Combining payor populations in this way, moreover, provides an incentive for alignment between the private payor contracts and the CMS contracts.

<u>Application of Quality Score</u>

It is important that CMS allow ACOs to grow into the program over time given the significant resources that are needed to transform the system as described above. Even those few organizations that participated in the PGP demonstration will need to continue to invest in their quality infrastructure to prepare for broader, more outcomes-oriented measures that will be developed for this program. At first, the improvements are likely to be a result of increased efficiency that then will diminish over time, while it will take longer to achieve quality gains that result in savings. Similarly to the PGP demonstration, a transition that splits the bonus pool into an efficiency payment and quality payment, with a heavier emphasis on quality over time, is appropriate. We recognize that CMS has proposed that the quality score not apply in the first year, which we support, but this is really due to a lack of time, data and infrastructure. Notwithstanding this, in the second and third years of the programs, CMS should transition in the application of the quality score to the portion of the savings shared with the ACO. For example, the efficiency pool could be weighted 60 percent in year 2 and 40 percent in year 3, while quality is weighted 40 percent in year 1 and 60 percent in year 3. Then, in the ACO's second contract the quality score could transition to 100 percent. **CMS should establish an efficiency pool and a quality pool in years 2 and 3 of the contract with the quality portion weighted more heavily over time (See below for additional details about this recommendation).**

Efficiency Pool

In order to obtain the efficiency pool, the ACO first would have to demonstrate savings above the target and the CI. As discussed above, if the CI is exceeded, then all of the savings should be shared at whatever rate is set by CMS. In the first year, the pool would be available to the ACO if it properly and successfully reports the required metrics to CMS. However, in the second year the ACO would also need to meet a minimum quality threshold to obtain the efficiency pool. This would be to ensure that the savings did not come at the expense of quality as measured by a subset of key metrics such as mortality and patient safety. This requirement would be a floor to ensure that there is no diminution in quality. **If this minimum quality threshold is met, CMS would distribute the entire efficiency pool to the ACO.**

Quality Pool

CMS would apply a composite quality score to the quality pool to determine which portion of the pool would be distributed back to the ACO. As discussed earlier, this composite should not be composed of an overwhelming number of measures at first, but transition over time and should initially focus on measures derived from survey and claims data. Ultimately, the goal would be to transition to more outcomes oriented, population-based measures that cross the continuum once available. See the "Value Metrics" section above for our specific recommendation on the scoring of the quality metrics for application to the payment share.

Shared Losses

CMS proposes that a flat 25 percent withholding rate be applied annually to an ACO's earned performance payment under both payment tracks. Noting that the 25 percent withhold may be

inadequate to cover the total amount of shared losses, the proposed rule establishes several additional requirements. In general, an ACO must establish a self-executing method for repaying losses greater than 1 percent of per capita expenditures for its assigned beneficiaries to the Medicare program by indicating that funds may be recouped from Medicare payments to the ACO's participants, obtaining reinsurance, placing funds in escrow, obtaining surety bonds, establishing a line of credit as evidenced by a letter of credit that the Medicare program can draw upon, or establishing another repayment mechanism. CMS further proposes to carry forward unpaid losses into subsequent performance years.

If CMS removes the down-side risk included in Track 1, this withhold will no longer be necessary. Under the two-sided model, we remain concerned that the withhold will further diminish the resources available to the ACO to support the model and care transformation. Rather than withhold 25 percent of any funds received from CMS related to the shared savings program or force the ACO to put funds in an escrow account, CMS could require ACOs to show, up to twice a year and subject to audit verification, that it has such funds on deposit in a nationally registered bank. **CMS should remove the 25 percent withhold, and rely on the ACO demonstrating that it has funds on hand to repay CMS in the event of losses under the program.**

Claims Run Out

For purposes of evaluating shared savings, CMS proposes to use a six-month claims run-out period. This would be expected to produce a completion percentage of about 99.5 percent for physician services and 99 percent for Part A services. We are concerned that a six-month claims run-out period means that final decisions about shared savings (and losses) would not occur until many months after the end of each performance period. Timely feedback on spending performance is needed to make adjustments to operations and increase the likelihood of success in the subsequent years. Timely payments are needed to continue investing in the model. **To minimize the time lag, CMS should not wait more than 60 days after the close of the year or when CMS estimates 90 percent of the claims have been received, whichever is sooner.**

APPLICATIONS

The proposed rule includes a long list of information that a prospective ACO would need to submit to CMS as part of its application. Among other things, the ACO would need to provide documentation describing its plans to: (1) promote evidence-based medicine; (2) promote beneficiary engagement; (3) report internally on quality and cost metrics; and (4) coordinate care. The proposed rule includes considerable requirements for what must be included in the ACO application. It is imperative that CMS release the application in time for ACOs to have adequate time to prepare them for a January 1 start date. This means that the application cannot require voluminous or overly detailed responses. **We urge CMS to release a streamlined application as soon as possible that focuses on assessing whether the applicant meets the**

legal requirements, not on assessing business operations such as governance and administrative systems. We also request that CMS hold an open door forum shortly thereafter to go through application requirements with interested parties.

CMS proposes to adopt an annual ACO application period during which a cohort of ACO applicants would be evaluated and further proposes that the performance years be based on the calendar year. This presumably means that the first cohort of ACOs would be approved for a start date of January 1, 2012. CMS also invites comments on alternative start dates and notes that one option might be to add an additional start date of July 1, 2012 (with a 3.5 year agreement period and the first performance year defined as 18 months). Given the final rule will not be out until mid-summer at the earliest, we are concerned that neither CMS nor many applicants will be ready in time for a January 1 start date. While a few ACOs may want to apply for January 1, and should be able to, a July 1, 2012, start date is more realistic for the majority of applicants. This will allow CMS to focus on a few applications and the necessary advance work on its part to support those successful applicants (i.e., conducting assignment analyses, preparing data files etc.). **CMS should include a July 1 start date option in addition to January 1 for 2012 in the final rule.**

MEDICAID ACOs

CMS said remarkably little about Medicaid in its proposed rule. CMS should consider how Medicaid and safety net providers can contribute to the development of the Medicare Shared Savings program. Developing multi-payor ACOs, including Medicaid, early on is critical given dual eligible care costs and the substantial expansion of Medicaid – 10 million new enrollees are expected in 2019 and 16 million total in 2019. This will help the Medicare program determine how best to manage care and contain costs on a *population* basis. In order to implement such programs, however, CMS will have to clearly illustrate how it will determine savings attributable to Medicare versus Medicaid. **CMS should clearly delineate the interaction between the Medicare and Medicaid programs, and consider providing a bonus payment similar to the proposed FQHC bonus to those that serve a high proportion of dual eligible beneficiaries to encourage inclusion of this population in the model.**

State Capacity

States must play a critical role in developing ACOs that include the Medicaid population. However, as state resources are considerably stretched, it is difficult to foresee that any states that have not already initiated this activity will begin doing so without assistance from CMS. As such, many multi-payor ACOs may not include Medicaid and an opportunity for Medicaid to be "on the cutting edge" of delivery system reform may be lost. This is tremendously important given that the success of the health reform statute in large measure rests on a successful Medicaid expansion and ensuring those beneficiaries have access to care.

Given the potential lack of capacity in many states to engage in the Medicaid reforms necessary to participate in a multi-payor ACOs, we urge CMS to provide guidance to states wishing to file waivers and/or initiate demonstrations. This could take the form of technical assistance, template applications or convening all the state Medicaid directors for educational programs. CMS could also provide states with the basic specifications for the creation of ACO models that focus all, or in part, on dual eligible beneficiaries (in collaboration with the Center for Medicaid, CHIP and Survey & Certification and the newly created Federal Coordinated Health Care Office). **At minimum, CMS should immediately provide states with guidelines on establishing Medicaid ACO demonstrations. Ideally, CMS should structure the Medicare application process such that states could rely on Medicare ACO status to determine eligibility for Medicaid ACO programs, whether through a demonstration or a waiver.**

Pediatric Demonstration

Section 2706 of ACA authorizes the Medicaid Pediatric ACO demonstration. Given that the pediatric demonstration is to begin January 1, 2012, we are concerned that CMS has not yet released a request for information (RFI) or request for applications (RFA). Section 2706(a)(1) places a duty on CMS to establish the demonstration as it states that CMS "...shall establish the Pediatric Accountable Care Organization Demonstration Project." It further indicates this requirement in 2706(a)(2) where it states that the project "...shall begin January 1, 2012...". Thus, CMS should be actively preparing for this demonstration. This section of the law does not note that its implementation is subject to the availability of appropriations as is the case with sections 4102, 4304, 6703 of ACA. In order to meet this requirement, CMS could use funds from the newly created Innovation Center that is already taking steps to implement other ACO models through projects such as the Pioneer program. The Innovation Center has $1 billion a year available to it to operate demonstrations such as this. **We urge CMS to immediately release an RFI, or at minimum an RFA, launching a pediatric ACO demonstration.**

INTERACTION WITH OTHER PROGRAMS

The ACA precludes ACOs from participating in other Medicare shared savings demonstration projects. However, CMS proposes that the prohibition against duplicate participation not be extended to individual providers and suppliers. More specifically, CMS proposes that an ACO provider or supplier who submits claims under multiple Medicare-enrolled TINs may participate in both the Medicare Shared Savings Program and another shared savings program if the patient population is unique to each program and the relevant Medicare-enrolled TINs do not participate in both programs. **We support CMS proposal to allow providers and suppliers to participate in more than one shared savings program.**

However, ACO participants should also be able to participate in more than one program if the beneficiary populations are unique. For instance, in the pediatric demonstration discussed above

in the "Medicaid" section of the letter. The preclusion in the statute is intended to ensure that providers do not accrue savings in two programs for the same beneficiaries or "double dip." **CMS should allow ACO participants to participate in more than one shared savings program if the populations included are mutually exclusive.**

Premier is also concerned that this restriction may affect participation in some medical home programs. The Premier collaborative members are constructing their ACOs with "health homes," sometimes called medical homes, to support the people at the center of the healthcare system. It is our belief that these are core components to successfully enhance primary care and reorienting care around wellness and care management of both acute episodes and chronic illness. Because of the up-front capital needed to restructure, CMS should to the extent possible allow ACOs to receive medical home payments through demonstration programs. Participation in these programs will better prepare ACOs for success as they work to meet the programs' requirements. It will also increase their short-term cash flow, allowing ACOs to reinvest those dollars in their transformation. **CMS should allow ACOs to also participate in the various medical homes demonstrations, whether through Medicare or Medicaid, that do not include shared savings or include shared savings but for a different patient population.**

Furthermore, ACOs need to weigh possible preclusions in considering which programs to submit applications. Specifically, CMS should clarify whether ACOs can also participate in the medical home, bundling and gainsharing demonstrations. **CMS should clearly state in its rulemaking the demonstrations already in existence or being developed based on legislative requirements in which the ACO program participants cannot participate.**

CLOSING

In closing, Premier appreciates the opportunity to submit these comments on the ACO program. Please do not hesitate to contact Danielle Lloyd, senior director for reimbursement and policy analysis, at 202.879.8002 or Danielle_Lloyd@Premierinc.com if you would like to discuss further.

Sincerely,

Blair Childs
Senior vice president, Public Affairs

cc: Ms. Nancy-Ann DeParle
Deputy Assistant to the President and
Director of Office of Health-Care Reform
The White House

Ms. Kathleen Sebelius
Secretary, Department of Health and Human Services

Mr. Daniel R. Levinson
U. S. Department of Health and Human Services
Office of the Inspector General

Mr. Eric H. Holder Jr.
United States Attorney General
U.S. Department of Justice

Mr. Jon Leibowitz
Chairman, Federal Trade Commission

Attachment I

Recommended Data Elements for Claims Files

Data Type Key:

- A = Alpha only field
- N = Numeric only field
- A/N = Alphanumeric field
- **NOTE:** Some fields will be marked as an alphanumeric field even though only numbers are expected, e.g. phone and ZIP. Such fields will be noted in the comment field
- D = Date field, format MMDDCCYY
- T = Time field, format HH24MISS
- S = Space(s)
- Asterisks = *

Data Requirements:

R (Required) – These are the data elements that ACO participants need sent from CMS monthly
O (Optional) – These data elements would be helpful for ACO participants if CMS has access to them to send

Header Record

Field Name	Field Size	Position	Data Type	Description	Data Requirement
HEADER RECORD				Header record will be the first record on every file sent. This record will be used to verify security and validate the file sent	R
Header Identifier	10	10-Jan	Asterisks	Asterisks	R
User Sys ID	8	18-Nov	A/N	User ID Number	R
Processed Date	8	19-26	D	Date file was generated. Date will be used to verify that the file sent was not already processed Format: MMDDCCYY	R
Process Time	6	27-32	T	Time file was generated. Time will be used to verify that the file sent was not already processed Format: HH24MISS	R
Data Source	3	33-35	A	Default value =’INS’	R
File Type	1	36	A	Type of File P = Production T = Test	R

Trailer Record

Field Name	Field Size	Position	Data Type	Description	Data Requirement
Trailer RECORD				Trailer record will be the last record on every file sent. This record will be used to verify security and validate the file sent	R
Trailer Identifier	10	10-Jan	Asterisks	Asterisks	R
User Sys ID	8	18-Nov	A/N	User ID Number.	R
Processed Date	8	19-26	D	Date file was generated. Date will be used to verify that the file sent was not already processed Format: MMDDCCYY	R

Attachment I

Field Name	Field Size	Position	Data Type	Description	Data Requirement
Process Time	6	27-32	T	Time file was generated. Time will be used to verify that the file sent was not already processed Format: HH24MISS	R
Data Source	3	33-35	A	Default value =’INS’	R
File Type	1	36	A	Type of File P = Production T = Test	R

Attachment I

Provider File
Description: This table is an example of a Provider File. There is one record for each provider
Primary Key: Provider_ID
Foreign Key: none

Field No.	Element	Field Name	Type	Size	Start	End	Comment	Required
1	Provider ID	Provider_ID	N	5	1	5	This number will be used as the identifier of the provider throughout the system	R
2	Provider Type Code	Prov_type_cd	A/N	5	6	10		R
3	Provider Type	Prov_type_desc	A	30	11	40		R
4	Provider Last Name	Prov_last_name	A	25	41	65		R
5	Provider First Name	Prov_first_name	A	25	66	90	Can place Provider Last Name or full facility name	O
6	Provider Middle Initial	Prov_mi_initial	A	1	91	91		O
7	Specialty Code	Prov_spec_code1	A/N	5	92	96		R
8	Specialty	Prov_spec1	A	30	97	126		R
9	Second Specialty Code	Prov_spec_code2	A/N	5	127	131		O
10	Second Specialty	Prov_spec2	A	30	132	161		O
11	Address Line1	Prov_addr1	A/N	50	162	211		R
12	Address Line2	Prov_addr2	A/N	50	212	261		O
13	City	Prov_city	A	30	262	291		R
14	State	Prov_state	A	2	292	293		R
15	Zip	Prov_zip	A/N	5	294	298	NOTE: 5 numbers expected	R
16	Phone	Prov_phone	A/N	10	299	308	NOTE: 10 numbers expected	O
17	UPIN	Prov_upin	A/N	6	309	314	NOTE: 6 numbers expected	O
18	NPI	Prov_npi	A/N	10	315	324	NOTE: 10 numbers expected	R
19	DEA	Prov_dea	A/N	9	325	333	NOTE: 2 letters + 6 numbers	O
20	Run Date	Run Date	D	10	334	343	Format CCYYMMDD	R

Attachment I

Membership File
Description: This table is an example of demographic information file for each policy holder and his/her insured dependents. There is one record for each member.

Primary Key: Subscriber_id / Dep_no
Foreign Key: none

Field No.	Element	Field Name	Type	Size	Start	End	Comment	Required
1	Subscriber ID	Subscriber_ID	A	20	1	20		R
2	Dependent Number	Dep_no	N	3	21	23	0 = Subscriber 1-999 = Dependent	R
3	Last Name	mem_last_name	A	25	24	48		R
4	First Name	mem_first_name	A	25	49	73		R
5	Middle Initial	mem_mi_initial	A	1	74	74		O
6	Suffix	mem_suffix	A	5	75	79		O
7	Birth Date	mem_dob	D	8	80	87	Format CCYYMMDD	R
8	Gender (Sex)	mem_gender	A	1	88	88	M = Male; F = Female	R
9	SSN	mem_ssn	A/N	9	89	97	NOTE: 9 numbers expected Format: xxxxxxxxx	R
10	Relationship Code	mem_relat_code	N	1	98	98	1 = Cardholder 2 = Spouse 3 = Child 4 = Other	R
11	Address Line1	mem_addr1	A/N	50	99	148		R
12	Address Line2	mem_addr2	A/N	50	149	198		O
13	City	mem_city	A	30	199	228		R
14	State	mem_state	A	2	229	230		R
15	Zip	mem_zip	A/N	5	231	235	Note: 5 numbers expected	R
16	Phone	mem_phone	A	10	236	245	Note: 10 numbers expected Format: xxxxxxxxxx	O
17	Run date	run_date	D	9	246	254	Format CCYYMMDD	R

Enrollment History
Description: This table provides an example of a file for history of enrollee's groups. There is one record for each group associated with an insured life at a given time.

Primary Key: Subscriber_id / Dep_no / Group_no / Plan_name / Eh_eff_date
Foreign Key: Subscriber_id / Dep_no combination must have a match in the Membership table

Field No.	Element	Field Name	Type	Size	Start	End	Comment	Required
1	Subscriber ID	Subscriber_ID	A	20	1	20		R
2	Suffix Number	Dep_no	N	3	21	23		R
3	Group Number	Group_no	A	15	24	38	ID assigned to Cardholder Group or Employer Group	R
4	Sub Group	Sub_group	A	10	39	48		R
5	Plan Name	Plan_name	A	50	49	98		R
6	Product Code	Prod_code	A	4	99	102	Suggested values: EPO HMO IND -Indemnity MCR - Medicare MDC -Medicaid POS PPO	R
7	Benefit_Type	Benefit_type	A	2	103	104	M – Medical R – RX MR - Medical & RX	R
8	Effective Date	eh_eff_date	D	8	105	112	First day member is has coverage. Format CCYYMMDD	R
9	End Date	eh_end_date	D	8	113	120	First day member do NOT have coverage Format CCYYMMDD	O
10	Run Date	run_date	D	8	121	128	Format CCYYMMDD	R

Attachment I

MedClaims
Description: This table provides an example of a claims file for all non-pharmacy claims.
Primary Key: Subscriber_id / Dep_no / Claim_no / Serv_line_no
Foreign Key: Subscriber_id / Dep_no combination must have a match in the Membership table
Rendering_prov_id must have a match in Providers table
Payto_prov_id must have a match in Providers tab

Field No.	Element	Field Name	Type	Size	Start	End	Comment	Required
1	Subscriber ID	Subscriber_ID	A	20	1	20		R
2	Suffix Number	Dep_no	N	3	21	23		R
3	Claim No	Claim_no	A	20	24	43		R
4	Service Line	Serv_line_no	A	3	44	46		R
5	Primary or Secondary Flag	Prim_flag	A	1	47	47	Type of Payment P=Primary; S=Secondary; T=Tertiary; O = Other	R
6	Discharge Disposition	discharge_disp	A	3	48	50		R
7	In/Out Patient Flag	in_out_flag	A	1	51	51	Y = yes ; N = no	R
8	ER Flag	er_flag	A	1	52	52	Y = yes ; N = no	R
9	Mental Health Claim	mental_flag	A	1	53	53	Y = yes ; N = no	R
10	UB_1500	UB_1500_flag	A	1	54	54	U – UB 1 -1500	R
11	Claim Type	Claim_type	A	1	55	55	C = Claim; E = Encounter	R
12	HCPCS or CPT4 Procedure Code	cpt4_code	A	6	56	61		O
13	HCPCS or CPT4 Procedure Modifier	cpt4_mod	A	3	62	64		O
14	Units	units	N	3	65	67		O
15	Provider ID	Rendering_prov_ID	N	5	68	72	Rendering Provider Provider ID must match a record in the	R

Field No.	Element	Field Name	Type	Size	Start	End	Comment	Required
							Provider Table	
16	Payto Provider ID	payto_prov_id	N	5	73	77	Payto Provider Provider ID must match a record in the Provider Table	R
17	Taxid	taxid	A	9	78	86	format: xxxxxxxxx	R
18	Rendering Provider Par / Not par	ren_par	A	1	87	87	Y = par; N = not par	R
19	Rendering Provider In / Out Network	ren_in	A	1	88	88	Y = in-network; N = out of network	O
20	Location Code	loc_code	A	3	89	91		R
21	Location Code Description	loc_code_desc	A	50	92	141		R
22	Service Code	serv_code	A	3	142	144		R
23	Service Code Description	serv_code_desc	A	5	145	149		R
24	Beginning Date of Service	from_date	D	8	150	157	Format: CCYYMMDD	R
25	End Date of Service	to_date	D	8	158	165	Format: CCYYMMDD	R
26	Admit Date	admit_date	D	8	166	173	Format: CCYYMMDD	R
27	Discharge Date	discharge_date	D	8	174	181	Format: CCYYMMDD	R
28	Paid Date	paid_date	D	8	182	189	Format: CCYYMMDD	R
29	Charge Amount	charge_amt	N	12	190	201	(10,2) Do not include commas. Minus sign for negative numbers	R
30	Ineligible Amount	inel_amt	N	12	202	213	(10,2) Do not include commas. Minus sign for negative numbers	R

Attachment I

Field No.	Element	Field Name	Type	Size	Start	End	Comment	Required
31	Paid Amount	paid_amt	N	12	214	225	(10,2) Do not include commas. Minus sign for negative numbers	R
32	Ineligible Code	inel_code	A	10	226	235		O
33	Ineligible Code Description	inel_code_desc	A	60	236	295		O
34	Claim Status	status	A	1	296	296	P -Paid / V-Void	R
35	ICD9 Diag1	diag1	A	6	297	302	Primary Diagnosis	R
36	ICD9 Diag2	diag2	A	6	303	308	Secondary Diagnosis	O
37	ICD9 Diag3	diag3	A	6	309	314	Tertiary Diagnosis	O
38	ICD9 Diag4	diag4	A	6	315	320	Diagnosis 4	O
39	ICD9 Diag5	diag5	A	6	321	326	Diagnosis 5	O
40	ICD9 Diag6	diag6	A	6	327	332	Diagnosis 6	O
41	ICD9 Diag7	diag7	A	6	333	338	Diagnosis 7	O
42	ICD9 Diag8	diag8	A	6	339	344	Diagnosis 8	O
43	ICD9 Diag9	diag9	A	6	345	350	Diagnosis 9	O
44	ICD9 Diag10	diag10	A	6	351	356	Diagnosis 10	O
45	ICD9 Procedure	icd9_proc	A	6	357	362		R
46	Allowed Amount	allow_amt	N	12	363	374	(10,2) Do not include commas. Minus sign for negative numbers	O
47	Coinsurance	coins_amt	N	12	375	386	(10,2) Do not include commas. Minus sign for negative numbers	O
48	Co-Pay	copay_amt	N	12	387	398	(10,2) Do not include commas. Minus sign for negative numbers	O
49	Deductible	deduct_amt	N	12	399	410	(10,2) Do not include commas.	O

Field No.	Element	Field Name	Type	Size	Start	End	Comment	Required
							Minus sign for negative numbers	
50	Cob	cob_amt	N	12	411	422	(10,2) Do not include commas. Minus sign for negative numbers	O
51	Run date	run_date	D	8	423	430	Format: CCYYMMDD	R

RxProviders
Description: This table provides an example for information on DEA prescribing/ordering providers and pharmacies. There is one record for each provider
Primary Key: Provider_id
Foreign Key: na

Field No.	Element	Field Name	Type	Size	Start	End	Comment	Required
1	Provider ID	Prov_id	N	5	1	5	This number will be used as the identifier of the provider throughout the system	R
2	Provider Type	Prov_type	A	1	6	6	D = DEA prescribing or ordering provider P = Pharmacy	R
3	Provider Last Name	Prov_last_name	A	25	7	31		R
4	Provider First Name	Prov_first_name	A	25	32	56	Can place Provider Last Name or full Pharmacy Name	O
5	Provider Mi Name	Prov_mi_initial	A	1	57	57		O
6	Address Line1	Prov_addr1	A/N	50	58	107		R
7	Address Line2	Prov_addr2	A/N	50	108	157		O
8	City	Prov_city	A/N	30	158	187		R
9	State	Prov_state	A/N	2	188	189		R
10	Zip	Prov_zip	A/N	5	190	194	NOTE: 5 numbers expected	R
11	Phone	Prov_phone	A/N	10	195	204	NOTE: 9 numbers expected	O
12	DEA	prov_dea	Text	9	205	213	NOTE: 2 letters + 7 numbers	R
13	Pharmacy Number	pharm_no	Text	12	214	225	ID assigned to Pharmacy (NABP)	O
14	Run Date	run_date	Date	10	226	235	Format: CCYYMMDD	R

Attachment I

Table: RxClaims
Description: This table provides an example of line-by-line drug prescriptions and their associated dollar amount for all pharmacy claims.
Primary Key: Subscriber_ID / Dep_no / Claim_no
Foreign Key: Subscriber_id / Dep_no combination must have a match in the Membership table
Pharm_prov_id must have a match in RXProviders table
Prescriber_id must have a match in RXProviders table

Field No.	Element	Field Name	Type	Size	Start	End	Comment	Required
1	Subscriber ID	Subscriber_ID	A	20	1	20		R
2	Suffix Number	Dep_no	N	3	21	23		R
3	Claim Number	claim_no	A	20	24	43		R
3	Pharmacy Number	pharm_prov_id	A	12	44	55	ID assigned to Pharmacy (NABP)	R
4	Prescription Number	Prescription Number	N	15	56	70	Prescription Number	R
5	Date Filled	date_filled	N	8	71	78	Dispensing date for Rx YYYYMMDD	R
6	Quantity	Quantity	N	5	79	83	Number of Metric Units of Medication Dispensed	R
7	Day Supply	day_supply	N	3	84	86	Estimated number of days the prescription will last	R
8	NDC Number	ndc_number	N	11	87	97	National Drug code	R
9	Drug Description	drug_descrip	A	30	98	127	Drug Name	
10	New/Refill Code	refill_code	N	2	128	129	00 = New Prescription 01-99 = Number of Refills	R
11	Number of Refills Authorized	no_refills_authorized	N	2	130	131	Number of refills authorized by prescriber	O
12	Prescriber ID	Prescriber_id	A	10	132	141	Identification assigned to the prescriber	R

Field No.	Element	Field Name	Type	Size	Start	End	Comment	Required
13	Ingredient Cost	ingredient_cost	N	12	142	153	(10,2) Do not include commas. Minus sign for negative numbers	O
14	Dispensing Fee	dispensing_fee	N	12	154	165	(10,2) Do not include commas. Minus sign for negative numbers	O
15	Co-pay Amount	copay	N	12	166	177	(10,2) Do not include commas. Minus sign for negative numbers	R
16	Sales Tax	sales_tax	N	12	178	189	(10,2) Do not include commas. Minus sign for negative numbers	O
17	Amount Billed	amount_billed	N	12	190	201	(10,2) Do not include commas. Minus sign for negative numbers	R
18	Amount Allowed	amount_allowed	N	12	202	213	(10,2) Do not include commas. Minus sign for negative numbers	R
19	Amount Paid	amount_paid	N	12	214	225	(10,2) Do not include commas. Minus sign for negative numbers	R

Attachment II

Metric Description	Owner	Data Source
HEDIS: Colorectal Screening, adults 50 - 75	NCQA	Claims and Ambulatory (optional)
HEDIS: Breast Cancer Screening, females 40 - 69	NCQA	Claims
HEDIS: Flu Shot for Older Adults, adults 65+	NCQA	Medicare Advantage CAHPS Survey
HEDIS: Pneumonia Vaccination Status for Older Adults, adults 65+	NCQA	Medicare Advantage CAHPS Survey
HEDIS: Comprehensive Diabetes Care – HbA1c control (<8%), 18-75	NCQA	Claims and Ambulatory (optional)
QUEST: Prevention of Harm (composite)	Premier	Discharge Abstract
QUEST: Risk Adjusted mortality / 1000	Premier	Discharge Abstract
QUEST: Composite Score of Evidence Based Care for Hospitalized Cases	Premier	Premier
HEDIS: Global Rating of All Health Care	NCQA	Health Plan CAHPS Survey
HEDIS: Global Rating of Personal Doctor	NCQA	Health Plan CAHPS Survey
HEDIS: Global Rating of Specialist Seen Most Often	NCQA	Health Plan CAHPS Survey
HEDIS: Composites Score of Getting Needed Care	NCQA	Health Plan CAHPS Survey
HEDIS: Composite Score of Shared Decision Making	NCQA	Health Plan CAHPS Survey
AHRQ: Hospital Admissions for Ambulatory Care Sensitive Conditions (ACSC), risk adjusted: Measures for 14 Adult Conditions	AHRQ	Claims and Discharge Abstract
Total Cost PMPM (e.g. medical and Rx)	TBD	Claims (Medical, Rx) Eligibility
Total Cost PMPM Trend	TBD	Same as previous
Admits per 1000 members / year (risk adjusted)	TBD	Claims and Discharge Abstract
30 day readmit (all cause) rate (risk adjusted)	TBD	Claims
ED Visits/1000	TBD	Claims

Measure	Number	Owner	Data Submission Source
Preventive Health (26-34) 9 Measures	1 Measure	AMA-PCPI	GPRO Data Collection Tool
	4 Measures	NCQA HEDIS	GPRO Data Collection Tool
	2 Measures	CMS	GPRO Data Collection Tool
	2 Measures	AMA-PCPI	GPRO Data Collection Tool
At Risk Population (35-65) 31 Measures	15 Measures	AMA-PCPI	GPRO Data Collection Tool
	3 Measures	CMS	GPRO Data Collection Tool
	1 Measure	CMS	Claims
	10 Measures	NCQA HEDIS	GPRO Data Collection Tool
	1 Measure	AMA-PCPI/ NCQA / TBD	GPRO Data Collection Tool
	1 Measure	TBD	GPRO Data Collection Tool
Patient/Care Giver Exp (1-7) 7 Measures	6 Measures	AHRQ	Clinician Group CAHPS Survey
	1 Measure	AHRQ	Medicare Advantage CAHPs Survey
Care Coordination (8-23) 16 Measures	1 Measure	CMS	Claims
	2 Measures	CMS	GPRO Data Collection Tool
	1 Measure	NCQA HEDIS	GPRO Data Collection Tool
	1 Measure	Univ of CO Hlth Sci. Cntr.	Survey or GPRO Data Collection Tool
	7 Measures	AHRQ ACSC	Claims
	3 Measures	CMS	GPRO Data Collection Tool / EHR Incentive Prog Reporting
	1 Measure	CMS	GPRO Data Collection Tool / eRx Incentive Prog Reporting
Patient Safety (24-25) 2 Measures	1 Measure	CMS/ CDC / AHRQ	Claims/ CDC National Healthcare Safety Network
	1 Measure	IHI	Claims/ CDC National Healthcare Safety Network
Shared Savings			

Attachment III

AIM	ACO #	Domain	Measure Title & Description	Premier Comments	CMS Program EHR Incentive	CMS Program PQRS	NQF #	Method of Data Submission	Measure Type
Better Care for Individuals	1	Patient/Care Giver Experience	**Clinician/Group CAHPS:** Getting Timely Care, Appointments, and Information	**Recommend with 6 point scale**	NA	NA	5	CG CAPH Survey	Patient Experience of Care
Better Care for Individuals	2	Patient/Care Giver Experience	**Clinician/Group CAHPS:** How Well Your Doctors Communicate	**Recommend with 6 point scale**	NA	NA	5	CG CAPH Survey	Patient Experience of Care
Better Care for Individuals	3	Patient/Care Giver Experience	**Clinician/Group CAHPS:** Helpful, Courteous, Respectful Office Staff	**Recommend with 6 point scale**	NA	NA	5	CG CAPH Survey	Patient Experience of Care
Better Care for Individuals	4	Patient/Care Giver Experience	**Clinician/Group CAHPS:** Patients' Rating of Doctor	**Recommend with 6 point scale**	NA	NA	5	CG CAPH Survey	Patient Experience of Care
Better Care for Individuals	5	Patient/Care Giver Experience	**Clinician/Group CAHPS:** Health Promotion and Education	**Recommend with 6 point scale**	NA	NA	5	CG CAPH Survey	Patient Experience of Care
Better Care for Individuals	6	Patient/Care Giver Experience	**Clinician/Group CAHPS:** Shared Decision Making	**Recommend with 6 point scale**	NA	NA	5	CG CAPH Survey	Patient Experience of Care
Better Care for Individuals	7	Patient/Care Giver Experience	**Medicare Advantage CAHPS:** Health Status/Functional Status	**Recommend as Part of CG CAHPS**	NA	NA	6	Survey	Patient Experience of Care
Better Care for Individuals	8	Care Coordination/Transitions	**Risk-Standardized, All Condition Readmission:** The rate of readmissions within 30 days of discharge from an acute care hospital for assigned ACO beneficiary population.	**Monitoring Only**	CMS	CMS	NA	Claims	Outcome
Better Care for Individuals	9	Care Coordination/Transitions	**30 Day Post Discharge Physician Visit**	**Recommend with Claims Data, not GPRO**	CMS	CMS	NA	Group Practice Reporting Option (GPRO) Data Collection	Process

Attachment III

AIM	ACO #	Domain	Measure Title & Description	Premier Comments	CMS Program EHR Incentive	CMS Program PQRS	NQF #	Method of Data Submission Tool	Measure Type
Better Care for Individuals	10	Care Coordination/Transitions	**Medication Reconciliation:** Reconciliation After Discharge from an Inpatient Facility Percentage of patients aged 65 years and older discharged from any inpatient facility (eg, hospital, skilled nursing facility, or rehabilitation facility) and seen within 60 days following discharge in the office by the physician providing on-going care who had a reconciliation of the discharge medications with the current medication list in the medical record documented.	**Do Not Recommend**	NA	NA	554	GPRO	Process
Better Care for Individuals	11	Care Coordination/Transitions	**Care Transition Measure:** Uni-dimensional self-reported survey that measures the quality of preparation for care transitions. Namely: 1. Understanding one's self-care role in the post-hospital setting 2. Medication management 3. Having one's preferences incorporated into the care plan	**Recommend as Part of CG CAHPS**	NA	NA	228	Survey or GPRO	Patient Experience of Care
Better Care for Individuals	12	Care Coordination	**Ambulatory Sensitive Conditions Admissions: Diabetes, short-term complications** (AHRQ Prevention Quality Indicator (PQI) #1) All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for short-term complications (ketoacidosis, hyperosmolarity, coma), per 100,000 population.	**Recommend**	NA	NA	272	Claims	Outcome
Better Care for Individuals	13	Care Coordination	**Ambulatory Sensitive Conditions Admissions: Uncontrolled Diabetes** (AHRQ Prevention Quality Indicator (PQI) #14) All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for uncontrolled diabetes, without mention of a short-term or long-term complication, per 100,000 population.	**Recommend**	NA	NA	638	Claims	Outcome

Attachment III

AIM	ACO #	Domain	Measure Title & Description	Premier Comments	CMS Program EHR Incentive	CMS Program PQRS	NQF #	Method of Data Submission	Measure Type
Better Care for Individuals	14	Care Coordination	**Ambulatory Sensitive Conditions Admissions: Chronic obstructive pulmonary disease** (AHRQ Prevention Quality Indicator (PQI) #5) All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for COPD, per 100,000 population.	**Recommend**	NA	NA	275	Claims	Outcome
Better Care for Individuals	15	Care Coordination	**Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure** (AHRQ Prevention Quality Indicator (PQI) #8) All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for CHF, per 100,000 population.	**Recommend**	NA	NA	277	Claims	Outcome
Better Care for Individuals	16	Care Coordination	**Ambulatory Sensitive Conditions Admissions: Dehydration** (AHRQ Prevention Quality Indicator (PQI) #10) All discharges of age 18 years and older with ICD-9-CM principal diagnosis code for hypovolemia, per 100,000 population.	**Recommend**	NA	NA	280	Claims	Outcome
Better Care for Individuals	17	Care Coordination	**Ambulatory Sensitive Conditions Admissions: Bacterial pneumonia** (AHRQ Prevention Quality Indicator (PQI) #11) All non-maternal discharges of age 18 years and older with ICD-9-CM principal diagnosis code for bacterial pneumonia, per 100,000 population.	**Recommend**	NA	NA	279	Claims	Outcome
Better Care for Individuals	18	Care Coordination	**Ambulatory Sensitive Conditions Admissions: Urinary infections** (AHRQ Prevention Quality Indicator (PQI) #12 All discharges of age 18 years and older with ICD-9-CM principal diagnosis code of urinary tract infection, per 100,000 population.	**Recommend**	NA	NA	281	Claims	Outcome
Better Care for Individuals	19	Care Coordination/Information Systems	**% All Physicians Meeting Stage 1 HITECH Meaningful Use Requirements**	**Monitoring Only**	NA	NA	NA	GPRO/ EHR Incentive Program Reporting	Process

Attachment III

AIM	ACO #	Domain	Measure Title & Description	Premier Comments	CMS Program EHR Incentive	CMS Program PQRS	NQF #	Method of Data Submission	Measure Type
Better Care for Individuals	20	Care Coordination/Information Systems	**% of PCPs Meeting Stage 1HITECH Meaningful Use Requirements**	**Monitoring Only**	CMS	CMS	CMS	GPRO/ EHR Incentive Program Reporting	Process
Better Care for Individuals	21	Care Coordination/Information Systems	**% of PCPs Using Clinical Decision Support**	**Monitoring Only**	Core Measure	NA	NA	GPRO/ EHR Incentive Program Reporting	Process
Better Care for Individuals	22	Care Coordination/Information Systems	**% of PCPs who are Successful Electronic Prescribers Under the eRx Incentive Program**	**Monitoring Only**	Core Measure	NA	NA	GPRO/ eRx Incentive Program Reporting	Process
Better Care for Individuals	23	Care Coordination/Information Systems	**Patient Registry Use**	**Monitoring Only**	Core Measure	NA	NA	GPRO	Process

Attachment III

AIM	ACO #	Domain	Measure Title & Description	Premier Comments	CMS Program EHR Incentive	CMS Program PQRS	NQF #	Method of Data Submission	Measure Type
Better Care for Individuals	24	Patient Safety	**Health Care Acquired Conditions Composite:** • Foreign Object Retained After Surgery • Air Embolism • Blood Incompatibility • Pressure Ulcer, Stages III and IV • Falls and Trauma • Catheter-Associated UTI • Manifestations of Poor Glycemic Control • Central Line Associated Blood Stream Infection (CLABSI) • Surgical Site Infection • AHRQ Patient Safety Indicator (PSI) 90 Complication/Patient Safety for Selected Indicators (composite) o Accidental puncture or laceration o Iatrogenic pneumothorax o Postoperative DVT or PE o Postoperative wound dehiscence o Decubitus ulcer o Selected infections due to medical care (PSI 07: Central Venus Catheter-related Bloodstream Infection) o Postoperative hip fracture o Postoperative sepsis	**Monitoring Only**	HIQRP uses mos	NA	531	Claims or CDC National Healthcare Safety Network	Outcome
Better Care for Individuals	25	Patient Safety	**Health Care Acquired Conditions: CLABSI Bundle**	**Do Not Recommend**	NA	NA	298	Claims or CDC National Healthcare Safety Network	Process

Attachment III

AIM	ACO #	Domain	Measure Title & Description	Premier Comments	CMS Program EHR Incentive	CMS Program PQRS	NQF #	Method of Data Submission	Measure Type
Better Care for Populations	26	Preventive Health	**Influenza Immunization:** Percentage of patients aged 50 years and older who received an influenza immunization during the flu season (September through February).	**Recommend as Part of CG CAHPS**	Clinical Quality Measure	110	41	GPRO	Process
Better Care for Populations	27	Preventive Health	**Pneumococcal Vaccination:** Percentage of patients aged 65 years and older who have ever received a pneumococcal vaccine.	**Recommend as Part of CG CAHPS**	Clinical Quality Measure	111	44	GPRO	Process
Better Care for Populations	28	Preventive Health	**Mammography Screening:** Percentage of women aged 40 through 69 years who had a mammogram to screen for breast cancer within 24 months.	**Recommend with Claims Data, not GPRO**	Clinical Quality Measure	112	31	GPRO	Process
Better Care for Populations	29	Preventive Health	**Colorectal Cancer Screening:** Percentage of patients aged 50 through 75 years who received the appropriate colorectal cancer screening.	**Recommend with Claims Data, not GPRO**	Clinical Quality Measure	113	34	GPRO	Process
Better Care for Populations	30	Preventive Health	**Cholesterol Management for Patients with Cardiovascular Conditions:** • The percentage of members 18–75 years of age who were discharged alive for AMI, coronary artery bypass graft (CABG) or percutaneous coronary interventions (PCI) of the year prior to the measurement year, or who had a diagnosis of ischemic vascular disease (IVD) during the measurement year and the year prior to the measurement year, who had each of the following during the measurement year.LDL-C screening • LDL-C control (<100 mg/dL)	**Postpone and Prioritize for Electronic Clinical Data Exchange**	Clinical Quality Measure	NA	75	GPRO	Process & Outcome

Attachment III

AIM	ACO #	Domain	Measure Title & Description	Premier Comments	CMS Program EHR Incentive	CMS Program PQRS	NQF #	Method of Data Submission	Measure Type
Better Care for Populations	31	Preventive Health	**Adult Weight Screening and Follow-up**: Percentage of patients aged 18 years and older with a calculated BMI in the past six months or during the current visit documented in the medical record AND if the most recent BMI is outside parameters, a follow-up plan is documented. Parameters: Age 65 and older BMI ≥ 30 or < 22; Age 18-64 BMI ≥ 25 or < 18.5	**Do Not Recommend at this Time**	Clinical Quality Measure	128	421	GPRO	Process
Better Care for Populations	32	Preventive Health	**Blood Pressure Measurement:** Percentage of patient visits with blood pressure measurement recorded among all patient visits for patients aged > 18 years with diagnosed hypertension.	**Do Not Recommend at this Time**	Clinical Quality Measure	TBD	13	GPRO	Process
Better Care for Populations	33	Preventive Health	**Tobacco Use Assessment and Tobacco Cessation Intervention:** Percentage of patients who were queried about tobacco use. Percentage of patients identified as tobacco users who received cessation intervention.	**Do Not Recommend at this Time**	Clinical Quality Measure	TBD	28	GPRO	Process
Better Care for Populations	34	Preventive Health	**Depression Screening:** Percentage of patients aged 18 years and older screened for clinical depression using a standardized tool and follow up plan documented.	**Do Not Recommend at this Time**	NA	134	418	GPRO	Process
Better Care for Populations	35	At Risk Population - Diabetes	**Diabetes Composite (All or Nothing Scoring):** • Hemoglobin A1c Control (<8%) • Low Density Lipoprotein (<100) • Blood Pressure <140/90 • Tobacco Non Use • Aspirin Use	**Use Individual Measures not Composite**	NA	NA	575*, 64* 61*, 28* TBD	GPRO	Process & Outcome
Better Care for Populations	36	At Risk Population – Diabetes	**Diabetes Mellitus: Hemoglobin A1c Control (<8%)** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c less than 8.0%.	**Postpone and Prioritize for Electronic Clinical Data Exchange**	Clinical Quality Measure	NA	575	GPRO	Outcome

Attachment III

AIM	ACO #	Domain	Measure Title & Description	Premier Comments	CMS Program EHR Incentive	CMS Program PQRS	NQF #	Method of Data Submission	Measure Type
Better Care for Populations	37	At Risk Population – Diabetes	**Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent LDL-C level in control (less than 100 mg/dl).	**Postpone and Prioritize for Electronic Clinical Data Exchange**	Clinical Quality Measure	2	64	GPRO	Outcome
Better Care for Populations	38	At Risk Population - Diabetes	**Diabetes Mellitus: Tobacco Non Use** Tobacco use assessment and cessation	**Do Not Recommend at this Time**	Clinical Quality Measure	TBD	28	GPRO	Process
Better Care for Populations	39	At Risk Population - Diabetes	**Diabetes Mellitus: Aspirin Use** Daily aspirin use for patients with diabetes & cardiovascular disease	**Do Not Recommend at this Time**	NA	NA	TBD	GPRO	Process
Better Care for Populations	40	At Risk Population - Diabetes	**Diabetes Mellitus: Hemoglobin A1c Poor Control(>9%):** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent hemoglobin A1c greater than 9.0%.	**Postpone and Prioritize for Electronic Clinical Data Exchange**	Clinical Quality Measure	1	59	GPRO	Outcome
Better Care for Populations	41	At Risk Population - Diabetes	**Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus:** Percentage of patients aged 18 through 75 years with diabetes mellitus who had most recent blood pressure in control (less than 140/90 mmHg).	**Postpone and Prioritize for Electronic Clinical Data Exchange**	Clinical Quality Measure	3	61	GPRO	Outcome
Better Care for Populations	42	At Risk Population - Diabetes	**Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients** Percentage of patients aged 18 through 75 years with diabetes mellitus who received urine protein screening or medical attention for nephropathy during at least one office visit within 12 months.	**Postpone and Prioritize for Electronic Clinical Data Exchange**	Clinical Quality Measure	119	62	GPRO	Process
Better Care for Populations	43	At Risk Population - Diabetes	**Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients** Percentage of patients aged 18 through 75 years with a diagnosis of diabetes mellitus who had a dilated eye exam.	**Recommend with Claims Data, not GPRO**	Clinical Quality Measure	117	55	GPRO	Process

Attachment III

AIM	ACO #	Domain	Measure Title & Description	Premier Comments	CMS Program EHR Incentive	CMS Program PQRS	NQF #	Method of Data Submission	Measure Type
Better Care for Populations	44	At Risk Population - Diabetes	**Diabetes Mellitus: Foot Exam** The percentage of patients aged 18 through 75 years with diabetes who had a foot examination.	**Recommend with Claims Data, not GPRO**	Clinical Quality Measure	163	56	GPRO	Process
Better Care for Populations	45	At Risk Population - Heart Failure	**Heart Failure: Left Ventricular Function (LVF) Assessment** Percentage of patients aged 18 years and older with a diagnosis of heart failure who have quantitative or qualitative results of LVF assessment recorded.	**Do Not Recommend at this Time**	NA	198	79	GPRO	Process
Better Care for Populations	46	At Risk Population - Heart Failure	**Heart Failure: Left Ventricular Function (LVF) Testing** Percentage of patients with LVF testing during the current year for patients hospitalized with a principal diagnosis of heart failure (HF) during the measurement period.	**Do Not Recommend at this Time**	NA	228	NA	GPRO	Process
Better Care for Populations	47	At Risk Population - Heart Failure	**Heart Failure: Weight Measurement** Percentage of patient visits for patients aged 18 years and older with a diagnosis of heart failure with weight measurement recorded.	**Do Not Recommend at this Time**	NA	227	85	GPRO	Process
Better Care for Populations	48	At Risk Population - Heart Failure	**Heart Failure: Patient Education** Percentage of patients aged 18 years and older with a diagnosis of heart failure who were provided with patient education on disease management and health behavior changes during one o more visit(s) within 12 months.	**Do Not Recommend at this Time**	NA	199	82	GPRO	Process
Better Care for Populations	49	At Risk Population - Heart Failure	**Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD)** Percentage of patients aged 18 years and older with a diagnosis of heart failure who also have LVSD (LVEF < 40%) and who were prescribed beta-blocker therapy.	**Do Not Recommend at this Time**	Clinical Quality Measure	8	83	GPRO	Process

Attachment III

AIM	ACO #	Domain	Measure Title & Description	Premier Comments	CMS Program EHR Incentive	CMS Program PQRS	NQF #	Method of Data Submission	Measure Type
Better Care for Populations	50	At Risk Population - Heart Failure	**Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD** Percentage of patients aged 18 years and older with a diagnosis of heart failure and LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.	**Do Not Recommend at this Time**	Clinical Quality Measure	5	81	GPRO	Process
Better Care for Populations	51	At Risk Population - Heart Failure	**Heart Failure: Warfarin Therapy for Patients with Atria Fibrillation** Percentage of all patients aged 18 and older with a diagnosis of heart failure and paroxysmal or chronic atrial fibrillation who were prescribed warfarin therapy.	**Do Not Recommend at this Time**	Clinical Quality Measure	200	84	GPRO	Process
Better Care for Populations	52	At Risk Population – Coronary Artery Disease	**Coronary Artery Disease (CAD) Composite: All or Nothing Scoring** • Oral Antiplatelet Therapy Prescribed for Patients with CAD • Drug Therapy for Lowering LDL-Cholesterol • Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI) • LDL Level <100 mg/dl • Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)	**Do Not Recommend at this Time**	NA	NA	67, 74, 70 64, 66	GPRO	Process & Outcome
Better Care for Populations	53	At Risk Population – Coronary Artery Disease	**Coronary Artery Disease (CAD): Oral Antiplatelet Therapy Prescribed for Patients with CAD** Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed oral antiplatelet therapy.	**Do Not Recommend at this Time**	Clinical Quality Measure	6	67	GPRO	Process

Attachment III

AIM	ACO #	Domain	Measure Title & Description	Premier Comments	CMS Program EHR Incentive	CMS Program PQRS	NQF #	Method of Data Submission	Measure Type
Better Care for Populations	54	At Risk Population – Coronary Artery Disease	**Coronary Artery Disease (CAD): Drug Therapy for Lowering LDL-Cholesterol** Percentage of patients aged 18 years and older with a diagnosis of CAD who were prescribed a lipid-lowering therapy (based on current ACC/AHA guidelines). The LDL-C treatment goal is <100 mg/dl. Persons with established coronary heart disease (CHD) who have a baseline LDLC 130 mg/dl should be started on a cholesterol-lowering drug simultaneously with therapeutic lifestyle changes and control of nonlipid risk factors (National Cholesterol Education Program (NCEP).	**Do Not Recommend at this Time**	Clinical Quality Measure	197	74	GPRO	Process
Better Care for Populations	55	At Risk Population – Coronary Artery Disease	**Coronary Artery Disease (CAD): Beta-Blocker Therapy for CAD Patients with Prior Myocardial Infarction (MI)** Percentage of patients aged 18 years and older with a diagnosis of CAD and prior MI who were prescribed beta-blocker therapy.	**Do Not Recommend at this Time**	Clinical Quality Measure	7	70	GPRO	Process
Better Care for Populations	56	At Risk Population – Coronary Artery Disease	**Coronary Artery Disease (CAD): LDL level < 100 mg/dl**	**Do Not Recommend at this Time**	Unknown	NA	NA	GPRO	Outcome
Better Care for Populations	57	At Risk Population – Coronary Artery Disease	**Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD)** Percentage of patients aged 18 years and older with a diagnosis of CAD who also have diabetes mellitus and/or LVSD (LVEF < 40%) who were prescribed ACE inhibitor or ARB therapy.	**Do Not Recommend at this Time**	NA	118	66	GPRO	Process
Better Care for Populations	58	At Risk Population – Hypertension	**Hypertension (HTN): Blood Pressure Control** Percentage of patients with last BP < 140/90 mmHg	**Do Not Recommend at this Time**	Clinical Quality Measure	TBD	18	GPRO	Outcome

Attachment III

AIM	ACO #	Domain	Measure Title & Description	Premier Comments	CMS Program EHR Incentive	CMS Program PQRS	NQF #	Method of Data Submission	Measure Type
Better Care for Populations	59	At Risk Population – Hypertension	**Hypertension (HTN): Plan of Care** Percentage of patient visits for patients aged 18 years and older with a diagnosis of HTN with either systolic blood pressure ≥ 140 mmHg or diastolic blood pressure ≥ 90 mmHg with documented plan of care for hypertension.	**Do Not Recommend at this Time**	NA	TBD	17	GPRO	Process
Better Care for Populations	60	At Risk Population – COPD	**Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation** Percentage of patients aged 18 years and older with a diagnosis of COPD who had spirometry evaluation results documented.	**Do Not Recommend at this Time**	NA	51	91	GPRO	Process
Better Care for Populations	61	At Risk Population – COPD	**Chronic Obstructive Pulmonary Disease (COPD): Smoking Cessation Counseling Received**	**Do Not Recommend at this Time**	Unknown	NA	NA	GPRO	Process
Better Care for Populations	62	At Risk Population – COPD	**Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy based on FEV1** Percentage of patients aged 18 years and older with a diagnosis of COPD and who have an FEV1/FVC less than 70% and have symptoms who were prescribed an inhaled bronchodilator.	**Do Not Recommend at this Time**	NA	52	102	GPRO	Process
Better Care for Populations	63	At Risk Population – Frail Elderly	**Falls: Screening for Fall Risk** Percentage of patients aged 65 years and older who were screened for fall risk at least once within 12 months	**Recommend as Part of CG CAHPS**	NA	NA	101	GPRO	Process
Better Care for Populations	64	At Risk Population – Frail Elderly	**Osteoporosis Management in Women Who had a Fracture** Percentage of women 65 years and older who suffered a fracture and who had either a bone mineral density (BMD) test or prescription for a drug to treat or prevent osteoporosis in the 6 months after the date of fracture	**Recommend with Claims Data, not GPRO**	NA	NA	53	GPRO	Process
Better Care for Populations	65	At Risk Population – Frail Elderly	**Monthly INR for Beneficiaries on Warfarin** Average percentage of monthly intervals in which Part D beneficiaries with claims for warfarin do not receive an INR test during the measurement period	**Do Not Recommend at this Time**	NA	NA	555	Claims	Process

Attachment IV

FFS Payment Rules to Waive

INPATIENT RULES

RULE	REFERENCE and LINK	RATIONALE FOR ELIMINATION
Transfer Policy		• Beneficiaries will be able to move to the right level of care when they are ready rather than when supported by arbitrary payment policies. • The incentive to discharge inpatients to increase post-acute care payments is counter to the incentive to generate shared savings. • The quality measurement component will protect against inappropriately early discharges.

PHYSICIAN RULES

RULE	REFERENCE and LINK	RATIONALE FOR ELIMINATION
Bundled code pairs		• Allowing beneficiaries to receive multiple services on the same day will improve the chances of patient compliance with needed care. • The ACO model reduces the incentive to provide unnecessary services.
Diagnostic tests that preclude payment for an office visit		• Allowing payment for diagnostic tests and office visits will provide higher payment for services appropriately provided. • Given the annual savings reconciliation, there is not an incentive to provide unnecessary services.

IRF RULES

RULE	REFERENCE and LINK	RATIONALE FOR ELIMINATION
60 Percent Rule **CMS 13** **IRF** **Co-Morbidity Inclusion**	42 CFR Part 412 Medicare Program; Inpatient Rehabilitation Facility Prospective Payment System for Federal Fiscal Year 2009; Final Rule Page 46388 http://edocket.access.gpo.gov/2008/pdf/e8-17797.pdf Statutory	• Under ACOs there is an inherent incentive to treat the patient at the most cost-effective setting of care, thus an admission rule is not necessary. • Elimination of these regulations would be advantageous, as patients would be discharged to a post-acute setting based on their basic needs and not on an arbitrary percentage of patients in certain diagnostic categories. • Elimination would result in significant reduction in the burden of providers managing the complex and ever-changing rules related to which patient qualifies under the CMS 13 or a qualifying co-morbid condition. • Patients benefit with the elimination of these regulations by being able to receive services in a post-acute setting at the time of their specific need. For example, currently a patient may be admitted to an IRF in one month, but that same patient could be denied admission in any other given month if the IRF is nearing their 60% compliance threshold.
3-Hour Rule	Medicare Benefit Policy Manual Chapter One, Section 110.4.3	• Conditions of participation require therapy to be delivered at a high level of intensity interpreted by Medicare as being at least three hours of therapy per

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RULE	REFERENCE and LINK	RATIONALE FOR ELIMINATION
	http://www.cms.hhs.gov/manuals/Downloads/bp102c01.pdf Regulatory	day. • Monitoring this unsubstantiated provision serves no purpose if the goal is to return the patient to his or her home in an efficient, quality-oriented manner while reducing re-hospitalizations.
IRF-PAI CMG	42 CFR § 412.614 Inpatient Rehabilitation Facility Patient Assessment Instrument Case Mix Group http://law.justia.com/us/cfr/title42/42-2.0.1.2.12.15.51.8.html Regulatory	• Currently, there are numerous setting-specific post-acute assessment tools that are required for reimbursement purposes (MDS, OASIS and IRF-PAI). A common assessment tool under an ACO model eliminates the need for multiple assessment tools. Post-acute bundling would in essence require one standardized assessment instrument. Currently a post-acute assessment instrument is in demonstration with CMS. • Standardization of assessment instruments across the post-acute continuum would be cost-effective for CMS and providers. ○ Future rule making relative to updates would be required for one instrument rather than the current three. ○ Providers would have a significantly reduced burden in maintaining compliance with the complicated and ever-changing rules with only one standardized assessment instrument. • Patients would benefit by having a single assessment tool that could be part of the electronic health record, reducing error rates when attempting to incorporate multiple assessment documents.

SNF RULES

RULE	REFERENCE and LINK	RATIONALE FOR ELIMINATION
SNF PPS **3-Day Hospitalization** **30-Day Transfer Rule**	Medicare Benefit Policy Manual Chapter 8 - Coverage of Extended Care (SNF) Services Under Hospital Insurance § 20 and 20.2 http://www.cms.hhs.gov/manuals/Downloads/bp102c08.pdf Statutory	• Under an ACO model, compliance with regulations such as qualifying three-day hospitalization and 30-day transfer becomes irrelevant. • Elimination of these regulations would be advantageous to both patients and providers. Patients would be discharged to the post-acute setting based on their immediate clinical need and not based on an arbitrary acute stay requirement.
SNF Resource Utilization Groups **MDS Consolidated Billing**	42 CFR Part 413 Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities for FY 2009; Final Rule http://edocket.access.gpo.gov/2008/pdf/e8-17948.pdf Statutory	• Similar to the rationale above for IRF-PAI, the Resource Utilization Group payment policies would be unnecessary under a single post-acute assessment tool. • Compliance with a rigid and complicated MDS assessment schedule that raises administrative costs would be eliminated. • Consolidated billing regulations requiring the provider to bill for all services would be irrelevant in a post-acute model, as all services would be bundled in one payment.

LTCH RULES

Attachment IV

RULE	REFERENCE and LINK	RATIONALE FOR ELIMINATION
25% Threshold Rule **Short Stay Outlier Payment** **Six Month Demonstration Requirement**	42 CFR § 412.534 Special payment provisions for long-term care hospitals within hospitals and satellites of long-term care hospitals. http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr412.534.pdf 42 CFR § 412.529 http://edocket.access.gpo.gov/cfr_2005/octqtr/pdf/42cfr412.529.pdf 42 CFR §412.23 http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr412.23.pdf Statutory	• Under an ACO model, all of these admission policies, payment requirements and pre-qualifying requirements become obsolete. • Elimination of admission criteria based on arbitrary percentages would be beneficial to patients as their immediate needs would not be hamstrung to regulatory admission restrictions.
25 Day Length Of Stay	42 CFR §412.23 http://edocket.access.gpo.gov/cfr_2004/octqtr/pdf/42cfr412.23.pdf Statutory	• Compliance with regulations such as maintenance of an arbitrary average length of stay would be irrelevant. Elimination of these regulations would be advantageous as patients would be discharged to the post-acute setting based on their immediate clinical need without being required to remain in a setting for a specified period of time, further escalating costs. • Patients benefit by not being subjected to post-acute settings' compliance percentages. For example, a patient may easily be admitted due to medical necessity criteria one month, but that same patient could be denied admission if that LTCH is encroaching the 25% threshold.

OTHER ADMINISTRATIVE RULES

RULE	REFERENCE and LINK	RATIONALE FOR ELIMINATION
Recovery Audit Contractor (RAC)	Tax Relief and Healthcare Act of 2006 §302 http://www.cms.hhs.gov/RAC/Downloads/Legislation%20for%20Permanent%20RACs.pdf Statutory	• The costly ($4.4B over 10 years) and complicated Recovery Audit Contractor (RAC) project would need refinement in an ACO model. • Under a FFS model, the underlying payment is only temporary until the annual reconciliation process. If payments are higher on a claim by claim basis, it ultimately reduces the shared savings available to the ACO. • Under a capitation model, ACOs should be able to provide the care deemed appropriate and underlying payment edits should be disregarded.

Endnotes

[i] Statement by Mark B. McClellan, MD, Ph.D., Administrator, Centers for Medicare and Medicaid Services on Tax Exemption for Hospitals and Federal Payment for Uncompensated Care before the U.S. House of Representatives Committee on Ways and Means, Thursday, May 26, 2005.