Statement by Blair Childs, senior vice president of Public Affairs, Premier healthcare alliance, on ACO proposed rule

The Premier healthcare alliance supports CMS in its efforts to develop people-centered, sensible regulations for accountable care organizations (ACOs). This new model of care delivery represents one of our best hopes for overcoming fragmentation in care delivery. In forming ACOs, we believe that we will achieve 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, as well as select ACOs and structure the program to maximize the potential for success. With this in mind, Premier offers reactions to several key provisions in the rule.

Beneficiary opt-out, transparency and inducements

Requiring that beneficiaries are made aware of their participation in the ACO will ensure transparency and provide consumers with appropriate, fact-based information on their healthcare choices. We also support CMS' decision to allow ACOs to not only contact, but also provide additional benefits and services to beneficiaries, including disease management programs and condition-specific education. These services will provide tremendous value to beneficiaries, and will give the ACO the flexibility needed to direct and improve care. However, in the final rule, we will urge CMS to be more expansive in allowed communication and services provided to beneficiaries to include pay for travel, technologies, seminars, co-pay waivers, etc. These services do not serve a marketing function, and are essential to improve care quality, provide convenient choices and enhance overall compliance with recommended care.

Timely access to A, B & D claims data and beneficiary list

Since ACOs can't effectively manage and improve care without timely access to relevant data, we are extremely pleased that CMS will make data from Medicare Parts A, B and D available. As we learned in the Physician Group Practice demo, it is essential that providers know the services beneficiaries are receiving outside the ACO, in order to customize care and avoid duplicative work with other providers. However, in its final rule, we urge CMS to provide this data monthly, rather than quarterly. Without monthly access to this data, providers may not have adequate information to ensure they are meeting targets and appropriately directing care.

Payment models

We are extremely pleased that CMS will allow multiple payment models within the ACO program from the start. As we have learned from members of the Accountable Care Collaboratives, different ACOs are at different points in their journey to deliver accountable care, with some prepared to participate in a one-sided shared savings program, while others are able to accept downside risk. As ACOs are local and subject to regional market conditions, multiple payment models will allow a variety of approaches to be tested, as well as a broader scope of learnings for CMS. However, noticeably absent from the rule are partial and full capitation payment models. We hope such options will be considered either in the final rule or through the CMS Innovation Center.

Measures

As we have learned through the Hospital Quality Incentive Demonstration (HQID) and the QUEST: High Performing Hospitals Collaborative, measures are the key to assessing performance and evaluating improvements over time. Given that the measurement requirement for ACOs is a significant undertaking, and one that should not be discounted due the need for sophisticated informatics capabilities, CMS has taken a wise step in structuring year 1 of the program as a pay for reporting year. This will give providers adequate time to demonstrate capacity to improve care and health of their ACO population. We are also pleased that CMS has chosen population-based quality measures that are standardly-defined, tested and in use today, as well as those that overlap with other requirements, including patient experience, hospital and physician quality, and meaningful use of electronic health records. This will support efficiencies, as providers will be able to collect and submit data once, avoiding duplicative or conflicting reporting obligations.

Savings splits

CMS should reconsider its savings split with providers and instead share back at least 70 to 80 percent of the total in preliminary years of the program. In addition, we are concerned about CMS's application of a payment withhold. Shared savings payments are critical, and are necessary to make the technology and other infrastructure investments needed to transform care delivery and processes. Without adequate investment capital, accountable care organizations will struggle to provide care and services needed to appropriately manage the health of the population. Short changing ACOs now will make the program less attractive to applicants and could stifle future innovations.

Legal (anti-trust, anti-kickback….) "safe harbors"

Legal barriers traditionally have prevented innovative care delivery models from taking root. We believe CMS's decision to grant waivers for the division of shared savings bonuses and a "safe harbor" for other payments provides a greater level of legal assurance, and will allow a variety of ACO models to be tested over time, both in the Medicare program and among private payors. We also strongly agree that ACOs that meet CMS' criteria for clinical integration are in compliance with antitrust laws overseen by the Department of Justice and the Federal Trade Commission. Assuming that the final rule is substantially similar to the proposed regulations, providers will have confidence in the legality of ACOs, and an efficient, expedited review process for antitrust questions. This should permit hospitals to collaborate with non-owned providers, share data across the continuum and financially reward physicians for improved outcomes and reduced costs. These new abilities are foundational to the ACO, and will allow for improved care coordination, greater provider cooperation and enhanced services for consumers.

Medicaid ACOs

We were disappointed that the regulation did not adequately address the interaction between the Medicare and Medicaid programs. Our initial impression is that shared savings will only be determined based on Medicare savings, although savings to the Medicaid program may also be attained due to efforts of the ACO. We would encourage CMS to provide states with specific guidance for establishing Medicaid ACO programs and demonstrations, and ideally, that CMS will structure the Medicare application process in such a way that states could rely on it to determine eligibility for Medicaid ACO program.

Payment adjustments

We believe that a critical fix that CMS must make in the final rule is to exclude disproportionate share hospital (DSH), indirect medical education (IME) and direct graduate medical education from the calculation of spending and the associated targets. These payments are made to account for higher program costs that are outside of the services provided to ACO beneficiaries, such as teaching residents or higher proportions of uncompensated care. These costs will not affected by care improvements or other quality interventions initiated by the ACO. Hospitals with a higher proportion of these payments will be at a disadvantage, because their spending will look artificially higher than others, yet they have no ability to affect these costs. As these are both key constituencies for the ACO program, CMS should consider including a policy to mitigate this disincentive for participation among teaching hospitals, as well as those that serve low-income patients.

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