

## **Statement by Premier healthcare alliance, on ACO final 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 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 accountable care, Premier offers reactions to several key provisions in the rule.

### Payment models

We are extremely pleased that CMS will allow multiple payment models within the ACO program from the start, including an option that does not involve downside risk, and will allow first dollar savings once the minimum savings rate is achieved. As we have learned from members of the Premier collaboratives, different ACOs are at different points in their journey to deliver accountable care, with some prepared to accept shared savings, while others are able to accept risk. These two changes to the model will provide an enhanced business case for organizations to enter the program. Particularly in the early years when providers are still developing and testing effective strategies for coordinated, cost-effective care, a no-risk option that mimics agreements already in place in the private sector will be important to encourage provider participation, and a broader set of learnings for CMS.

### EHR requirements

Members of the Premier alliance are very pleased that CMS opted to waive its initial requirement that at least 50 percent of all primary care physicians in the ACO would be considered meaningful users of electronic health records (EHR) in order to participate in the program. As we stated in comments to CMS, existing penalties associated with an inability to meet meaningful use requirements should provide appropriate incentive on its own, and such a duplicative policy would only serve to limit the inclusion of innovative physicians who are seeking to improve their patients' care.

### 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 phasing in the number of quality measures in the shared savings program. This will give providers adequate time to demonstrate capacity to improve care and health of their ACO population.

### Management and governance

We strongly commend CMS for relaxing many of the proposed rule's excessively prescriptive requirements for Board and leadership structures, as well as overall governance. These

micromanaging policies were one of the chief outcries from the provider community, many of whom have already established effective leadership teams to manage the transition to accountable care. By allowing for flexibility, providers now will be able to evolve their governance structures to meet a new need and experiment with novel approaches that work in their individual communities to share with others. However, we continue to believe there is room for improvement in this regard, and look forward to working with CMS to resolve outstanding issues.

#### Savings splits

While we are pleased that proposals to impose a payment withhold have been abandoned, we continue to believe that CMS' decision to limit its savings split with providers to 50-60% will limit participation in the program. Shared savings payments are critical to make the technology and other infrastructure investments needed to transform care delivery and processes.

#### Beneficiary opt-out, transparency and incentives

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. However, we are troubled that the agency has chosen to move forward with an unworkable plan to allow beneficiaries to participate in the ACO, but also opt-out of sharing the data. Without access to beneficiary data, ACOs will be hamstrung in efforts to target interventions that are essential to improve care quality, provide convenient choices and enhance overall compliance with recommended care. CMS's rigidity around beneficiary data could have the unintended consequence of limiting necessary services that would enhance compliance with treatment plans, and compromise the ACO's ability to achieve the goals of better health, better healthcare and reduced expenses.

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

As we learned in the Physician Group Practice demo, it is essential that providers know who is covered in the ACO, as well as the services beneficiaries are receiving outside the ACO on a timely basis. CMS' commitment to provide monthly data files is a step in the right direction, but we remain concerned that the process to obtain these data may be too cumbersome and outdated to truly use the data for ongoing care improvement. For instance, it may be challenging for providers to target interventions to specific beneficiaries before they increase in severity, which compromises the providers' ability to address health issues with primary care, as opposed to the more costly hospital setting.

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