National Business Group on Health

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Creative Health Benefits Solutions for Today, Strong Policy for Tomorrow

June 6, 2011

The Honorable Donald Berwick, M.D.
Administrator
Centers for Medicare and Medicaid Services (CMS)
Room 314 G
U.S. Department of Health and Human Services (HHS)
7500 Security Boulevard
Baltimore, MD 21244–1850

Attention: CMS–1345–P, RIN 0938-AQ22

Dear Dr. Berwick:

The National Business Group on Health appreciates the opportunity to comment on the proposed rule implementing Section 3022 of the Patient Protection and Affordable Care Act (ACA) establishing the Medicare Shared Savings Program and Accountable Care Organizations (ACOs).

The National Business Group on Health (Business Group) represents approximately 332, primarily large, employers (including 64 of the Fortune 100) who voluntarily provide health benefits and other health programs to over 50 million American employees, retirees, and their families.

Our members, America's largest employers, have long advocated for fully integrated and organized health care systems that are patient-centered and focused on improving the health care of populations. The Business Group believes that if CMS implements ACOs correctly they have the potential to truly reform health care by incentivizing and rewarding networks of providers (hospitals, primary care physicians, specialists and potentially other health care professionals) who succeed in coordinating patients' care, controlling costs and improving quality to move us all towards an effective and efficient health care delivery system.

While ACOs have great potential, they could also be a wasted opportunity if they merely repackage or relabel the existing ineffective and inefficient provider arrangements and ways of delivering care or shift costs to patients and private payers.

A successful ACO program will have a strong foundation in primary care; include consensus-approved quality measures; engage patients to participate in their own care; provide increased payments (rewards) for better performance and penalties for failure to

meet quality or savings standards; maintain an openness to innovative payment methods and avoid overvalued, unnecessary and potentially harmful care.

While the Business Group generally supports CMS' considerable efforts to set the bar high for quality standards in the proposed rule, we offer the following recommendations to ensure ACOs truly deliver on the promise of better care and better health at lower costs. Specifically, we recommend that CMS:

- Deny or reduce shared savings payments to ACOs that demonstrate evidence of increased "cost shifting" to private payers and non-Medicare beneficiaries;
- Deny points to ACOs that incur preventable healthcare-acquired conditions (HACs);
- Improve many of the positive provisions in the proposed rule by:
    - Setting maximum loss limits where ACOs' financial risk equals their shared savings;
    - Adopting a phased approach to quality measure selection by initially limiting measures to a reasonable number of evidence-based, validated measures;
    - Updating the quality measures on an annual basis taking into account any updates by the National Quality Forum (NQF), new information garnered from the comparative effectiveness research of the Patient-Centered Outcomes Research Institute (PCORI), and removing any measures that are no longer supported by the evidence;
    - Using measures endorsed by the NQF, indicating broad consensus;
    - Adding quality measures that address misuse and overuse of medical services;
    - Including emerging Quality Alliance Steering Committee (QASC) cost and efficiency measures;
    - Adding quality measures promoting patient responsibility and accountability for health and wellness;
    - Adding patient safety indicators or additional evidence-based outcomes measures endorsed by the NQF;
    - Deeming ACOs that meet NCQA's medical home certification to have met the ACO primary care standards and make them eligible for increased shared savings;
    - Assigning Medicare beneficiaries to ACOs where they receive a majority rather than a plurality of primary care services;
    - Publicly reporting quality performance standard scores to rank ACOs and creating a public, searchable database for Medicare beneficiaries to compare ACOs based on quality;
    - Creating a public, searchable database of ACOs' shared savings and losses that is easy-to-understand and use;
    - Requiring ACOs to utilize the PCORI's comparative effectiveness research and the Agency for Healthcare Research and Quality's (AHRQ)

evidence-based practice centers (EPC) program's findings, endorsed by the NQF, to promote evidence-based care;
- Incorporating NCQA's Patient-Centered Medical Home standards to track and coordinate tests, referrals, and transitions of care and providing technical assistance to assist in coordinating care between rural and urban ACO providers;
- Publicly reporting ACOs' results on the patient and caregiver experience quality measures; and
- Ensuring that ACOs' governance boards include an equal number of primary care and specialty physicians as well as local employers and multi-state large employer plan sponsors with experience in quality improvement.

The Business Group also sent a separate comment letter on the Department of Justice/Federal Trade Commission's proposed statement of antitrust enforcement policy on ACOs participating in the Medicare shared savings program, which emphasized our first point above. It also recommended that the agencies err on the side of caution to prevent harm to consumers, the Medicare program, and private payers by lowering the safe harbor for anti-trust reviews from 30% to 20% of a patient service area (PSA) and the threshold for mandatory reviews from 50% to 40%.

Again, thank you for the opportunity to comment. You are doing a commendable job steering the Medicare program to become more effective and efficient. Please contact me or Steven Wojcik, the National Business Group on Health's Vice President of Public Policy, at (202) 558-3012, if you want to discuss our comments in further detail. We look forward to continuing our work with you to ensure the successful implementation of the ACO program.

Sincerely,

Helen Darling
President

cc: The Honorable Kathleen Sebelius, Secretary, HHS
Ms. Marilyn B. Tavenner, Principal Deputy Administrator, CMS
Dr. Richard Gilfillan, Acting Director, CMS Innovation Center
Mr. Peter Lee, Deputy Director, CMS Innovation Center

Recommendations to Improve the Proposed ACO Rule

CMS Should Deny or Reduce Shared Savings Payments to ACOs that Demonstrate Evidence of Increased "Cost Shifting" to Private Payers and Non-Medicare Beneficiaries

CMS will collect cost, quality, and utilization data to determine whether the program is meeting its goals.

Producing "savings" for the Medicare program and then making up for lost revenues by charging non-Medicare payers and patients more should not be mistaken as evidence for more efficient provision of care and CMS should not reward it.

The Business Group recommends that CMS:

- Determine, as part of its data gathering, baseline levels of "cost shifting" by calculating the ratio of public to private payments to ACOs for the same services and recalculate these ratios annually;
- At a minimum, reduce ACOs' shared savings by any amount of "cost shifting";
- Remove ACOs who participate in "cost shifting" from the Medicare shared savings program; and
- Share relevant data and analyses of "cost shifting" with the Department of Justice and the Federal Trade Commission to alert them of any anti-trust concerns.

CMS Should Not Award any Points to ACOs if they Incur Any Preventable Healthcare-acquired Conditions (HACs) (II, E, 4, b, 2)

Under the proposed rule, ACOs can earn up to two points on each of the 65 quality performance measures. CMS scores most of the measures, including Healthcare-acquired Conditions (HACs), on a sliding scale: an ACO receives 1.10 points for achieving the "minimum attainment level" (30% of Medicare Fee-for-Service (FFS) or the Medicare Advantage (MA) rate) for a measure and up to two points for achieving the higher "performance benchmark" for that measure. CMS has not yet established the benchmarks. However, CMS only awards points for the diabetes and coronary artery disease composite measures on an "all or nothing" basis.

The Centers for Disease Control (CDC) found that nearly two million Americans suffer from hospital acquired infections every year. These infections result in as much as $45 billion in extra hospital care. Patients who develop hospital infections and other complications often require longer stays in the hospital or end up being readmitted for further treatments. The CDC also reports that hospitals readmit almost one in five Medicare patients who are discharged within 30 days.

The Business Group recommends CMS:

- Only award ACOs points for the HAC composite measures (foreign object retained after surgery; central-line associated blood infections; fall and trauma; catheter associated urinary tract infections; and others) on an "all or nothing" basis to eliminate rewards for preventable medical errors.

CMS Should Set Maximum Loss Limits Where ACOs' Financial Risk Equals their Shared Savings (II, G, d, 5)

The proposed rules offer two shared savings tracks: Track 1) A one-sided shared savings-only model for the first two years of the three-year agreement with no risk which converts to the two-sided risk model in the third year; and, Track 2) A two-sided risk model for all three years.

The proposed rule caps ACOs' maximum losses at 5% in the third year that ACOs bear risk under Track 1 (the less risky/less mature ACO model) and 5% in the first year, 7.5% in the second year and 10% in the third year under Track 2 (the more risky/more mature ACO model).

A bonus-only, or shared savings model for ACOs meeting quality and cost growth targets would not fully incentivize ACOs to become more effective and efficient. ACOs that share financial risk for losses as well as savings have an incentive to lower excessive costs and share the burden with Medicare if they fail to meet their cost and quality targets.

The Business Group recommends CMS:

- Set the ACO payment models' maximum loss limits so that ACOs' financial risk equals their potential gains in shared savings—at the same time, CMS should ensure that ACOs' shared savings are budget-neutral and that ACO do not shift any cost overruns onto private payers (see our recommendations on treating "cost shifting").

CMS Should Adopt a Phased Approach to Quality Measure Selection by Initially Limiting Measures to a Reasonable Number of Evidence-based, Validated Measures (II, E, 2)

The proposed rule requires ACOs to meet 65 quality measures under 5 domains (patient and caregiver, care coordination, patient safety, preventive health and at-risk population measures (diabetes, heart failure, coronary artery disease, hypertension, chronic obstructive pulmonary disorder, frail/elderly) in order to receive maximum shared savings. Of the 65 proposed measures, 50+ impose a significant data collection burden on ACO providers.

CMS based the proposed rule's quality of care measures on the Physician Group Practice Demonstration. While all of the ten leading health care systems' participating in the demonstration met many of the quality requirements and it fostered innovation in care, only four of the ten systems decreased Medicare spending enough to qualify for a performance bonus in 2010. Only two systems decreased Medicare spending enough to qualify for bonuses in all five years of the project, and three systems never qualified for bonuses.

The Business Group recommends CMS:

- Adopt a phased approach to quality measure selection by initially limiting measures to a reasonable number of evidence-based, validated measures. CMS should choose measures that provider organizations already have extensive experience and exposure. CMS should initially limit measures to performance data that rely mostly on claims or survey data rather than new data gathered through additional manual collection processes that take place outside the normal workflow of providing patient care. CMS should focus on high value measures. Adopting this approach will reduce ACOs' administrative burden. CMS could refine the measures as the program progresses.

CMS Should Annually Update the quality measures on an Annual Basis Taking Into Account any Updates by the NQF, Review Quality Measures to Take into Account any Updates by the NQF and Remove Any Measures No Longer Supported By the Evidence (II, E, 2)

The Business Group recommends CMS:

- Review the quality measures on an annual basis and take into account any new scientific evidence published in peer-reviewed medical literature, new information garnered from the comparative effectiveness research of the PCORI, and remove any measures that are no longer supported by the evidence.

CMS Should Not Use Measures that the NQF Has Not Yet Endorsed (II, E, 2)

CMS and NQF have a long tradition of collaboration on quality measures.

The Business Group recommends CMS:

- Not use measures that the NQF, a consensus building group representing diverse stakeholders, has not yet endorsed. For example, NQF has not yet reviewed the 4 information system measures and 2 transition measures under the care coordination domain scheduled for implementation in the first year of the ACO program.

CMS Should Annually Add Quality Measures that Address Misuse and Overuse of Medical Services (II, E, 2)

The proposed rule's patient safety domain contains the few proposed measures focused on misuse by providers (foreign objects left in patients after surgery and infections), but none of the proposed measures focus on overuse.

The Business Group recommends CMS:

- Focus on misuse and overuse as much as underuse when measuring ACOs' performance on the quality measures; and
- Target the areas for misuse identified by the National Priorities Partnership including:

    - **Inappropriate medication use:** *Antibiotic use***;** *Polypharmacy (for multiple chronic conditions; of antipsychotics)*;
    - **Unnecessary laboratory tests:** *Panels (e.g., thyroid, SMA 20); Special testing (e.g., Lyme Disease with regional considerations)*;
    - **Unwarranted maternity care interventions:** *Cesarean section*;
    - **Unwarranted diagnostic procedures:** *Cardiac computed tomography (noninvasive coronary angiography and coronary calcium scoring); Lumbar spine magnetic resonance imaging prior to conservative therapy, without red flags; Uncomplicated chest/thorax computed tomography screening; Bone or joint x-ray prior to conservative therapy, without red flags; Chest x-ray, preoperative, on admission, or routine monitoring; Endoscopy;*
    - **Inappropriate nonpalliative services at end of life:** *Chemotherapy in the last 14 days of life***;** *Aggressive interventional procedures - More than one emergency department visit in the last 30 days of life;*
    - **Unwarranted procedures:** *Spine surgery; Percutaneous transluminal coronary angioplasty (PTCA)/Stent Knee/hip replacement; Coronary artery bypass graft (CABG); Hysterectomy; Prostatectomy*;
    - **Unnecessary consultations**;
    - **Preventable emergency department visits and hospitalizations:** *Potentially preventable emergency department visits; Hospital admissions lasting less than 24 hours; Ambulatory care-sensitive conditions*; and
    - **Potentially harmful preventive services with no benefit:** *BRCA mutation testing for breast and ovarian cancer– female, low risk; Coronary heart disease screening using electrocardiography (ECG), exercise treadmill test (ETT), electronbeam computed tomography (EBCT) – adults, low risk; Carotid artery stenosis screening – general adult population; Cervical cancer screening – female over 65, average risk and female, posthysterectomy; Prostate cancer screening – male over 75.*

CMS Should Include the Emerging QASC Cost and Efficiency Measures (II, E, 2)

QASC is working with key stakeholders to make consistent and useful information about the quality and cost and efficiency of health care widely available to patients, physicians, hospitals, health insurers, and others who need information about health care delivery.

The Business Group recommends CMS:

- Include the emerging QASC cost and efficiency measures, once endorsed by the NQF, in any updated list of quality performance measures.

CMS Should Add Quality Measures Promoting Patient Responsibility and Accountability for Health and Wellness (II, E, 2)

ACOs need to view patients as partners for improving the quality of care. Recent surveys from the National Business Group on Health found that employees want health communications targeted to their needs; employees want to reduce their costs and get more value out of their care; and employees are trying to live healthier. People are more and more willing to take personal responsibility for their health. We know from our own research that employees understanding of health care cost challenges and individual accountability are greater at the best performing companies. The best performing companies also believe that employees can become better health care consumers, provide information to their employees and support choice. ACOs should follow our nation's best performing companies by partnering with their patients to lower costs and improve care.

The Business Group recommends CMS:

- Add quality performance measures promoting patient responsibility and accountability for health and wellness such as providing cost and wellness information to beneficiaries so they have a greater understanding of health care cost challenges and individual accountably.

CMS Should Add Patient Safety Indicators and Additional Evidence-Based Outcomes Measures, Endorsed by the NQF (II, E, 2)

We support CMS' efforts to add additional measures from AHRQ's list of 20 total Hospital-level Patient Safety Indicators (PSIs) and outcome measures in the future to its Value-Based Purchasing Program (VBP) as long as CMS (1) provides hospitals with adequate notice about the set of measures and performance thresholds and benchmarks to be used for the financial incentive payment; (2) accrues baseline performance data on all VBP measures required for determining improvement scores; and (3) establishes benchmarks and thresholds for computing attainment scores. Continually raising the bar

to increase patient safety and health care quality for ACOs as well will lead to lower costs and direct improvements in our nation's health care system.

The Business Group recommends CMS:

- Follow the lead of the Value-Based Purchasing Program (VBP) and add any additional measures from AHRQ's list of Hospital-level PSIs or evidence-based outcome measures (mortality, etc.), endorsed by the NQF, in addition to the current outcome, structure and process measures, which would clearly improve patient care, reduce unnecessary costs and save lives (see our recommendations on HACs).

CMS Should Deem NCQA Certified Medical Homes to Meet ACO Primary Care Standards and Consider them for Increased Shared Savings (II, B, 7)

The proposed rule assigns Medicare beneficiaries to ACOs retrospectively at the end of each performance period from primary care physicians whom they received a plurality of their primary care services. CMS defines primary care services to include services provided by doctors of medicine and osteopathy in general practice, family practice, internal medicine, and geriatrics medicine. The proposed rule also requires participating ACOs to include primary care ACO professionals that are sufficient for the number of Medicare beneficiaries (minimum of 5,000) assigned to ACOs.

The current health care system emphasizes specialist care rather than primary care, despite the fact that money spent on basic primary care is money well spent. Adults (age 25 and older) with a primary care physician rather than a specialist as their personal physician had 33% lower cost of care. Primary care can dramatically reduce the long-term cost burden and health care demands of chronic conditions. According to the Health Resources and Services Administration (HRSA), only 37% of physicians practice primary care medicine, and only 8% of the nation's medical school graduates go into family medicine.

ACOs will likely provide incentives for primary care providers to participate and the ACA provides a 10% Medicare bonus to primary care/general surgery doctors in health professional shortage areas, beginning in 2011. However, CMS' current proposed rule does not clearly state that primary care providers will receive increased payments for providing preventive care services and participating in patient-centered medical homes and does not address the current shortage of primary care physicians.

The Business Group recommends CMS:

- Deem NCQA certified medical homes to meet ACO primary care standards and consider them for increased shared savings.

CMS Should Assign Medicare Beneficiaries to ACOs Where they Receive a Majority of Primary Care Services (II, B, 7)

Seniors may receive a plurality of services from one primary care physician, but the same seniors may have 20 other doctors or receive most of their primary care services from nurse practitioners, clinical nurse specialists, or physician assistants. CMS should ensure that seniors are assigned to the correct providers that actually handle the majority of their primary care needs.

The Business Group recommends CMS:

- Assign Medicare beneficiaries to ACOs based on where seniors receive a simple majority of their primary care services, rather than a plurality.

CMS Should Use the Public Reporting of Quality Performance Standard Scores to Rank ACOs and Create a Public, Searchable Database for Medicare Beneficiaries to Compare ACOs Based on Quality (II, E, 6)

The proposed rule requires ACOs to publicly report their quality performance standard scores. As part of the patient-centeredness criteria, ACOs must have internal processes in place for measuring clinical or service performance by physicians across the practices, and using these results to improve care and service over time.

CMS should make meaningful disclosure of performance results to the public, which will reinforce the value of ACOs and value-based purchasing by improving the stability of Medicare and rewarding superior performers with additional demand for their services while eliminating waste, fraud and abuse.

The Business Group recommends that CMS:

- Publicly rank ACOs based on quality and cost and inform Medicare patients of high and low quality ACOs. Making this information public will encourage ACOs to manage the cost and care of patient populations; and
- Create a public, searchable database to compare CMS' quality rankings of ACOs.

CMS Should Create a Public, Searchable Database of ACOs' Shared Savings and Losses that is Easy to Understand and Use (II, E, 6)

The proposed rule requires ACOs to provide a description in their applications of the criteria they plan to use for distributing shared savings among ACO participants and ACO providers/suppliers, and to publicly report the total proportion of shared savings invested in infrastructure, redesigned care processes and other resources to support the

three-part aim goals of better health for populations, better care for individuals and lower growth in expenditures.

Public reporting of ACOs shared savings will allow other ACOs, Medicare and private payers to benchmark against successful practices that improved care and reduced costs. Public reporting will also aide patients in choosing high-performing ACOs and avoiding low-performers. Public reporting of ACO losses will also allow stakeholders to avoid any potential financial pitfalls from contracting with more expensive ACOs who failed to achieve the proposed rule's minimum savings rate (MSR).

The Business Group recommends CMS:

- Create a public, centralized, searchable database with electronic results of the distribution of shared savings, investments in redesigned care processes and losses of ACOs that is easy for the public to access, understand and use.

CMS Should Require ACOs to Utilize the PCORI's Comparative Effectiveness Research and AHRQ's EPC Program's Findings to Promote Evidence-Based Care (II, B, 9)

The proposed rule requires ACOs to provide documentation to CMS on how they plan to promote evidence-based medicine (including establishment, implementation and periodic updates to evidence-based guidelines) in order to receive shared savings. The proposed rule also makes ACOs' governance boards responsible for the processes to promote evidence-based medicine.

Estimates of the amount of unnecessary, duplicative, and inefficient care run as high as one-third of total annual health care spending. Evidence-based medicine will improve quality and patient outcomes, help control costs and reduce the use of unproven and/or ineffective treatments.

The Business Group recommends CMS:

- Require ACOs' physician-directed quality assurance and process improvement committees' to utilize comparative effectiveness research from the PCORI and findings from AHRQ's EPC Program to promote evidence-based medicine in determining their processes to implement the quality of care, process and outcome improvement measures; and
- Incorporate any new information from credible, scientific evidence published in peer-reviewed medical literature in ACO quality measure benchmarks and remove measures that are no longer supported by the evidence.

CMS Should Incorporate NCQA's Patient-Centered Medical Home Standards to Track and Coordinate Tests, Referrals, and Transitions of Care and Provide Technical Assistance to Assist in Coordinating Care Between Rural and Urban ACO Providers (II, B, 9, d)

The proposed rule requires ACOs to document how they plan to coordinate care, such as through the use of case managers in primary care offices, telehealth, remote patient monitoring, and other such enabling technologies such as health information technology (HIT), including electronic health records and electronic health information exchanges, to enable ACOs to submit electronic transition of care summaries both within and outside of ACOs to be eligible for shared savings. The proposed rule includes 16 care coordination quality measures divided between transitions and information systems.

With well-coordinated patient-centered care, patients transition between providers easily and their medical histories are available to all of their health care providers. Poorly coordinated care often leads to medical errors, higher costs, and unnecessary pain for patients. Medicare wastes upwards of $15 million each year treating patients who are discharged and, because of poor care coordination, suffer an adverse event and must be readmitted within 30 days.

HIT has the potential to improve the quality of care, improve patient safety, control costs, enhance affordability and increase efficiency. HIT is necessary for providers to successfully participate in ACOs (track and report proficiency on quality and cost measures and outcomes; coordinate care between providers; identify at-risk populations; create and share beneficiary-specific care plans; and facilitate care transitions).

The Business Group recommends CMS:

- Incorporate NCQA's Patient-Centered Medical Home standards to track and coordinate tests, referrals, and transitions of care; and
- Provide technical assistance to ACO providers to assist them in coordinating care between large, urban providers and small, rural providers (primary care (physicians, nurse practitioners, clinical nurse specialists, or physician assistants), specialty and mental health).

CMS Should Make ACOs' Results on the Patient and Caregiver Experience Quality Measures Available to the Public (II, B, 10, a)

The proposed rule requires ACOs to have a beneficiary experience of care survey in place (using the Clinician and Group (CAHPS) survey, including an appropriate functional status survey module) and describe in their applications how they will use the results to improve care over time. CMS proposes 7 CAHPs ACO quality performance measures under the domain of Patient and Caregiver Experience to determine shared savings. The ACO quality performance measures include 3 measures not currently publicly reported

on the Hospitalcompare.hhs.gov website, including patients' ratings of doctors; shared decision making; and health status or functional status.

Studies have shown that shared decision making between patients and providers can reduce the number of patients opting for invasive procedures anywhere from 21 to 44 percent.

Patient survey results help the government, patients and private payers indentify high and low value providers based on patient experience.

The Business Group recommends CMS:

- Make all of the ACOs' results on the patient and caregiver experience quality measures available to the public on the Hospitalcompare.hhs.gov website.

CMS Should Ensure that ACOs' Governance Boards Include an Equal Number of Primary Care and Specialty Physicians as well as Local Employers and Multi-State Large Employer Plan Sponsors with Experience in Quality Improvement (II, B, 2, c)

The proposed rule states that ACOs must demonstrate a mechanism of shared governance that provides all ACO participants with an appropriate "proportionate" control over ACOs' decision making processes. ACOs leadership and management structure must also have physician-directed quality assurance and process improvement committees to establish internal performance standards for quality of care and services, cost effectiveness, and process and outcome improvements, and hold ACOs' providers/suppliers accountable for meeting the performance standards. The committees must also identify and correct poor compliance with approved standards and promote continuous quality improvements. Fulltime, physically present, board-certified physicians, in the States where the ACOs operate will manage their clinical management and oversight.

The proposed rule also requires that 75% of ACOs' governing boards must include ACO participants. The proposed rule identifies experience with non-Medicare payer initiatives as critical to improving quality and the opportunity for shared savings in the leadership and management structure of ACOs.

ACOs should lead efforts to transform our current health care system's emphasis away from expensive specialist care toward primary care (including the medical home concept) to promote prevention, care coordination and disease management to lower cost and improve quality. If ACOs have minimal representation of primary care physicians, then the ACOs quality assurance and process improvement committees will have little incentive to request evaluations of potentially overvalued procedures and may undervalue primary care, prevention, care coordination and disease management.

In addition, employers and health plan sponsors have years of experience in integrating care, lowering costs, improving quality and reporting and providing timely information to

consumers. Many of our members have taken the lead in promoting pay-for-performance, health care quality and transparency by participating in initiatives such as the Leapfrog Group Hospital Rewards Program, Bridges to Excellence (BTE) and the pay-for-performance programs of the Integrated Healthcare Association (IHA) to make true health care transparency and quality a reality. Today, most large insurers and health plans already have a provider incentive program based on performance.

The Business Group recommends that CMS:

- Ensure that ACOs' governance boards include an equal number of primary care and specialty physicians to guarantee that ACOs' leadership structures focus on primary care, prevention, care coordination and disease management; and
- Include local employers and multi-state large employer plan sponsors with experience in quality improvement and reporting and providing timely information to consumers on ACOs' governance boards to successfully improve quality, reduce unnecessary costs and drive through transformational change.