June 6, 2011

Donald Berwick, M.D., Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D.C. 20201

**Re: CMS-1345-P Brookings-Dartmouth Comments on Proposed Rulemaking for the Medicare Shared Savings Program**

Dear Dr. Berwick:

The Engelberg Center for Health Care Reform at the Brookings Institution and the Dartmouth Institute for Health Policy & Clinical Practice have long advocated for the development of new payment models – including the concept of accountable care organizations (ACOs) – in order to support provider efforts to deliver better care to patients. As when we first advocated for a Medicare ACO program several years ago, the goal remains a simple one: to help physicians, hospitals, and other health care providers – whether in the public sector or private sector – deliver higher-value care by providing support to allow them work together to improve quality while lowering costs. Currently, many steps that improve care and lower overall costs are reimbursed either poorly or not at all by Medicare, making it difficult for providers to sustain steps to improve their delivery of care.

The path toward implementing accountable care will not be easy for health care organizations or Medicare, Medicaid, and private payers. The transition toward integrated, coordinated and accountable care requires investments in health information technology (HIT) that supports measurement for both improvement and accountability; the development of care management programs that allow teams comprised of nurses, pharmacists and other health professionals to deliver the right care to the right patient and maintain health while preventing costly complications of chronic diseases; the effective coordination of care – especially for the frail elderly or for those with multiple chronic conditions – across clinicians and sites of care; and governance and leadership structures that can strategically deploy the resources and project management required to implement these new models of care. These activities take considerable time, effort, and money. In addition, the steps must be implemented in a way that, over time, achieves reductions in health care costs. Thus, effective payment reforms must provide both new financial support for effective investments to improve care, and lead to evidence of meaningful cost savings and quality improvement. Further, these efforts must occur in a way that promotes beneficiary involvement. Though these changes are not easy, the ACO program and related – hopefully reinforcing – Medicare payment reforms are essential for supporting needed steps by providers to continue to improve care.

We believe the Notice of Proposed Rulemaking (NPRM) for the Medicare Shared Savings Program ("Shared Savings Program") released by CMS on April 7th represents a comprehensive and thoughtful effort to identify and address a wide range of key issues for Medicare ACOs. These comments are intended to help the Shared Savings Program achieve those goals as effectively as possible.

Our comments reflect experience with ACO implementation. Over the past several years, we have worked closely with our own ACO pilot sites[1], which have been implementing ACO payment models with private sector partners. In addition, we lead an ACO Learning Network that includes over 125 members. We have held multiple meetings to bring together major stakeholders to discuss challenges and opportunities in the

[1] Over the past two years, the Engelberg Center for Health Care Reform and the Dartmouth Institute have worked closely with these five sites to prepare a shared savings contract with private payer(s), including Anthem, UnitedHealth and Humana.

ACO model. We also have a long history of developing empirical research on this subject. Most recently, with support from the Commonwealth Fund and the involvement of other collaborators, we have begun to develop an evaluation framework for understanding the development of ACOs.

A number of insights have emerged from this work. First, it is increasingly clear that the transition to becoming an ACO cannot be seen as a simple, one-time contracting process – an "on-off" switch. To the contrary, even for relatively integrated systems, the development can best be seen as a process that extends over years through several phases: the decision to explore the transition toward payment models that provide better support for reforms to improve care; the identification of a payer partner (or partners) and initial exploratory discussions; identification of specific opportunities to improve care and development of an implementation plan; a decision to begin to work together to implement reinforcing payment changes (such as medical homes or episode payments) and to acquire and effectively use data to improve care delivery and population management; and finally, implementing reforms, usually with a relatively long-term contract to enable it to work.

Second, the ACO model requires ongoing commitments and adjustments from both providers and payers. The ACO is transforming care, but receives substantial support from the payer to make success more likely, including timely provision of data, recognition of the need to have the payer manage insurance risk and, perhaps, sharing of performance risk.

Finally, it appears critically important to distinguish risk from uncertainty. Many health care organizations are already bearing risk and have built an infrastructure allowing them to monitor that risk. Indeed, in Medicare, providers bear substantial risk on an ongoing basis when they provide care over the phone, implement care coordination programs, work together on managing patient transitions, and take many other steps that are currently reimbursed poorly – if at all – by Medicare. But few organizations are willing to bear new risk in the face of serious uncertainty about the relationship between the payer and ACO, the costs of implementing changes, knowledge of how they are now performing, and expectations for both quality and cost performance (i.e., their likelihood of success).

As CMS considers a wide-variety of comments and perspectives on the necessary components of a shared savings program, we suggest serious consideration be given to the following general principles:

1. **Increase early rewards relative to costs.** Providers are deeply concerned about whether the costs of participation will exceed the benefits. Costs include raising the necessary start-up capital (e.g., HIT costs, governance formation), incremental operating expenditures (e.g., analytics, quality reporting, personnel, consumer engagement), and the potential loss of revenue loss from improved care coordination in the face of uncertainty about the potential financial rewards from participation. Additional assurance is needed that the cost and quality benefits of the Medicare Shared Savings program exceed these direct and indirect costs. Deepening the shared savings opportunities available to ACOs is one lever at CMS's disposal. So too is making Medicare's shared savings easier to implement alongside existing and incipient efforts by other payers, including commercial payers and states, whose participation in multi-stakeholder models can help ACOs increase the number of participating patients and the magnitude of the rewards. Our detailed comments suggest a number of ways to incentivize such multi-payer collaboration, such as reducing the minimum savings rate (MSR) and demonstration of capital requirement for multi-payer ACOs undertaking two-sided risk and reducing the minimum savings rate to 1%.

2. **Reduce uncertainty by providing predictive data and a longer window before risk-bearing is required.** Provider organizations interested in participating in the Shared Savings program should be able to submit their list of TINs and NPIs and receive standardized reports that allow them to understand their recent performance and the opportunities for savings and care improvement that may exist. Once enrolled in the program, we suggest that providers be able to stay in the one-sided,

bonus-only program for up to three years (with lower potential savings), but then be eligible to shift to risk bearing in either year 4 or 5 (analogous to the Pioneer 3+1+1 program).

3. **Reduce administrative burden and implementation costs, and offer greater flexibility to allow existing organizations to participate**. We recognize the tough challenge CMS is facing in attempting the balance the need for clear standards and structural integrity of ACOs with the flexibility that will be necessary to ensure ACOs can fiscally and organizationally sustain implementation. As written, we believe there are a number of opportunities to refocus governance requirements away from burdensome administrative and reporting tasks and towards the more central objective of ensuring the ACO organization can improve quality while reducing costs. Our specific comments focus on streamlining entry for existing ACO organizations, providing clearer support and leveraging sub-regulatory guidance both during the application process and throughout ACO implementation, and generally minimizing burdensome governance changes that may inhibit participation without offering clear beneficiary protections – particularly for smaller ACOs.

4. **Better leverage and align with other private and public initiatives.** CMS should build off and be reinforced by other federal payment reforms (e.g., meaningful use, Center for Medicare and Medicaid Innovation (CMMI), Physician Quality Reporting System (PQRS), pay-for-performance, and particularly primary-care initiatives like medical homes) but also off the state and private-sector reforms that are already demonstrating progress, including the development of a process that allows organizations already engaged in multi-payer ACOs to avoid costly changes or poorly coordinated incentives. Our detailed comments discuss opportunities to refocus structural requirements to reflect existing current private or state initiatives, to align performance measures across programs, and to provide better guidance for Medicare ACO participants and participants of other potential shared savings programs.

5. **Optimize data-sharing, assignment, notification and benchmarking to support patient-centered care.** The aims of the assignment, notification and benchmarking elements of the program are to: (1) inform patients as effectively as possible to support engagement and ensure choice; (2) support providers efforts to improve and manage care of their Medicare patients; (3) avoid a double-standard of care; (4) hold providers accountable for what they have the greatest capacity to influence; (5) make sure that as many as possible of the Medicare beneficiaries who receive their primary care from the ACO professionals within the provider organization are eligible for inclusion. The latter can be achieved by allowing beneficiaries to be attributed to additional clinicians, including nurse-practitioners and PAs supervised by the ACOs primary care physicians and selected medical specialists (e.g. cardiologists within the ACO), if the patients are not being seen by primary care physicians. The former aims can be achieved, we believe, through a combination of data support, modified prospective notification of both beneficiaries and ACO providers on a regular basis, more clear and flexible legal guidance and waiver processes, and timely modified prospective attribution for performance measurement and financial benchmarking. Alternatively, CMS should consider using its demonstration authority to achieve these goals.

6. **Build a sustainable pathway to improving quality**. We believe in a virtuous cycle for improving quality that links meaningful quality reforms to improved quality and outcome measures, and ultimately to shared savings that will be reinvested to promote continuous quality improvement. We commend the proposed regulation's recognition of the need for carefully defined performance measures, and believe the regulation can further be strengthened by providing ACOs with an achievable ramp-up pathway to executing quality measurement. Some options described more fully in our comments include: increasing the significance of quality for payment over program years; adopting measures in use for other payment and delivery reform initiatives across the public and private sectors; and, phasing clinically-enriched and other advanced measures over time, with an initial phase of measurement based largely on survey and claims-based measures. We also advocate

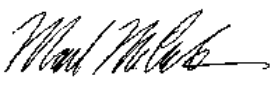
that CMS further create a quality scoring approach that reinforces financial rewards for ACOs undertaking greater levels of accountability and continuous quality improvement.

7. **Create a clear path forward and reinforce support for accountable care.** One reason that provider organizations may be holding back on committing to participating in the Shared Savings program is their uncertainty about what other programs will be emerging (e.g., Pioneer ACOs, additional medical home programs, etc.) and whether the benefits of participating in these future programs could be greater than what is available through the earlier programs. It will therefore be important for CMS to try to create as much clarity as possible about where the various programs are going, and that they reinforce each other rather than being alternatives or competing choices. For example, CMS could consider: clarifying that the transition toward value-based payment is inexorable, with an expectation that incentives will include some degree of global cost accountability and patient-centered performance measures; and emphasizing that all value-based payment programs will be increasingly based on a common set of advancing quality measures.

In each of these focal areas – and throughout the final regulation and other payment reforms – CMS has an opportunity to both learn from and build upon private and Medicaid models. Indeed, as the CMMI has already shown in its patient-centered medical home pilots, multi-payer collaboration can provide much greater support for health care reform than actions by individual payers alone, even Medicare. Throughout our comments, we attempt to identify lessons from other payer-provider collaborations throughout the country. These examples emphasize shared risk and the use of sound actuarial principles to make sure that the provider groups bear reasonable risk for things that they can control; quality measurement with increasingly robust measures; and, financial incentives structured so as to support care changes that lower costs by improving quality, with some models making any share of savings fully contingent upon demonstrable improvements in quality.

From the onset of our work to help build out the ACO concept, we asserted that an ACO program alone is unlikely to be a silver bullet to improve quality or lower costs. Rather, ACOs are likely to work best when implemented along with other reforms in payment and benefits to promote better care. We are optimistic that by addressing the core concerns above – as well as some of the more specific comments we have provided – the Medicare ACO program can have a substantial positive impact on the cost and quality of care in our health system.

We appreciate your consideration of our comments and look forward to providing further assistance to CMS in the continued development and implementation of this important program.



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*FULL COMMENTS ENCLOSED*

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## The Need for Multi-Payer and Multi-Initiative Alignment

Before turning to comments on specific sections of the regulation, we highlight one critical area where the proposed regulation is largely silent: the need for alignment between Shared Savings Program and similar programs supported by other payers. The Affordable Care Act intended for such an alignment in statute: "The Secretary may give preference to ACOs who are participating in similar arrangements with other payers." While we realize that the priority of this proposed rule is around the Shared Savings Program, it is important for CMS to recognize that the goals of this program will be much easier to achieve if this initiative is aligned with other efforts to promote accountable care – support for better care at a lower cost.

It is especially important that participation in the shared savings program not preclude participation in other initiatives that support investments and activities that traditionally are not well-supported by Medicare's fee-for-service payment system. Rather, CMS should promote such participation and make it easier for providers to participate in reinforcing payment reform initiatives. Payers have generally implemented ACO reforms in conjunction with other steps to redirect resources toward supporting ACO goals, such as implementing ACOs along with medical home payments, and new data support initiatives. CMS has begun to take steps in this direction, such as through efforts to align ACO performance measures with physician and hospital quality reporting payments, and with meaningful-use payments. All of this can be done while sustaining – indeed promoting – the overall goal of accountability for shared savings and quality improvement. We return to this issue throughout our comments.

We want to place particular emphasis on alignment with reforms supporting the patient-centered medical home. Primary care providers in medical homes receive additional payments for implementing steps to promote care coordination, and for achieving improvements in care and reductions in costs based on those steps. This is a very important complement to a more integrated, shared savings model as proposed by the Shared Savings Program NPRM. ACO applicants should be supported and encouraged to implement medical-home reforms both within Medicare and outside of Medicare, in conjunction with the implementation of the shared savings program.

Medical specialist efforts in ACOs could also be supported more effectively if Medicare implemented and promoted alternatives to fee-for-service payments for specialists, such as reforms that redirect some of their fee-for-service payments toward steps to improve quality and lower costs that are currently not reimbursed well by Medicare for specialists. CMS faces a particular statutory restriction on its ability to implement certain specific payment reforms in conjunction with the shared savings program. It is important to remember that the Shared Savings Program is not an experimental or pilot program, but an integral part of Medicare that is intended to help achieve the goal of better care and lower costs for beneficiaries. So long as participating organizations are able to meet the overall performance goals of quality improvement and cost trend reduction (with appropriate inclusion of additional payments in both benchmark and target setting and assessment of cost performance), they should be supported and encouraged by allowing participation in complementary reforms that help achieve these performance goals.

Similarly, we strongly encourage CMS to seek mechanisms and opportunities to align initiatives and regulations with other public and private payers. This will require CMS to exhibit flexibility at each of the critical junctures of care – governance structures, quality measures, payment mechanisms, reporting strategies – to promote the alignment of these goals with initiatives already underway and expanding in the private sector and state-based programs. Doing so will enable CMS to do much more to chart a pathway towards the three-part aim, assuring that beneficiaries receive better care at the right place at the right time.

This includes ACO initiatives already being implemented by many private plans. As we note below, these initiatives not only have goals that align with the Medicare shared savings program; they have also already addressed many of the same issues raised in the proposed rule. They are implementing measures of quality and cost that could and should align with Medicare measures of accountability. CMS should provide a pathway for organizations already committed to such measures to participate in the shared savings program without having to make costly short-term changes in the measures. These initiatives also provide important, direct evidence that organizations applying for participation in the ACO program have the infrastructure, support, provider and patient involvement, and other features necessary for ACO success.

Organizations that are undertaking such initiatives should be able to use them as direct evidence of capabilities intended to be covered in the NPRM requirements. For example:

- The current Shared Savings Program governance requirements may prevent many existing ACO-ready organizations from applying. Although the NPRM specifies that "if the ACO is comprised of a single entity . . . the ACO governing body may be the same as the governing body of that entity, provided it satisfies the other requirements of this section," we find the shared governance requirements at odds with many current governance practices. We believe that CMS should adjust the governance requirements to enable those organizations already operating as ACOs with private sector contracts to participate in the Shared Savings Program.
- The management and leadership requirements laid out in the NPRM have the potential to create costly and redundant structures for ACOs already successfully working with private sector contracts. We believe that CMS can modify these requirements so that these ACOs can leverage their infrastructure for private sector contracts into the Shared Savings Program.
- Many organizations currently have the ability to report some of the quality measures that are proposed in the NPRM; this capability is most advanced in organizations that have contracts with private payers. Even these organizations, however, will be significantly challenged to meet all of the current measurement and reporting requirements in the NPRM. We believe that there is a significant opportunity for CMS to phase in measures over time in a manner that considers and leverages the measurement capabilities that currently exist among those organizations best positioned to participate in the Shared Savings Program.
- CMS is appropriately concerned that savings may appear as a result of chance, and has structured a MSR that reflects the higher levels of uncertainty that attend observations in smaller ACOs. But confidence that estimates of savings reflect ACO operation (rather than chance) can be enhanced by considering savings achieved not only among Medicare beneficiaries, but among private enrollees in ACOs with private payer contracts. So we believe that CMS has an opportunity to leverage insight gained from private sector operations into the Shared Savings Program, in a manner that strengthens the program and offers value to ACOs.

Finally, the alignment we describe also includes ACO initiatives being undertaken by states, including in Medicaid programs as well as across multiple payers. The same recommendations we have described for promoting alignment with private initiatives should apply to these programs as well. As a more general matter, CMS should enhance its efforts to collaborate on its ACO performance measures for both quality and cost with those being used in Medicaid.

***Recommendations***

- Allow providers participating in private sector ACO initiatives to participate in the Shared Savings Program without requiring major changes to their current governance structures.

- Promote participation in programs such as the Patient Centered Medical Home, (with the exception of those that are already excluded due to participation in Section 1115 waivers or other Medicare Shared Savings Programs) and in innovative strategies to reimburse specialists that promote high quality, cost-effective care, as components of infrastructure that are expected to enable ACOs to succeed under the Shared Savings Program.
- Adapt the Shared Savings Program so that functioning governance, and leadership and management, structures that have evolved in the private sector can be used as evidence to demonstrate relevant ACO capabilities.
- Phase quality measurement and reporting requirements into the Shared Savings Program, in a manner that explicitly considers and leverages quality measurement and reporting infrastructure that is already in place in private sector and Medicaid ACOs. Establish a clear pathway that will assist organizations that have, or are committed to build, components of that infrastructure to achieve (over time) the full complement of measurement and reporting capability that CMS seeks.
- Use private sector and Medicaid experience to inform judgments about ACO savings.

## 425.5 Governance & Eligibility

### Overview

Governance and eligibility requirements should adhere to and support the goals of lowering costs, raising quality, and maximizing value. The following comments make recommendations on how CMS can balance the need for confidence in the governance model with the flexibility to allow high-performing organizations with strong governance models to join the program. As a general theme, these comments recognize that more stringent and specific requirements beyond those of current well-coordinated, high-performing provider organizational arrangements would increase costs, discourage participation, discourage innovation, and reduce the impact of ACOs on quality and cost to our health system. On the other hand, too few meaningful structural requirements could create additional payouts by Medicare in the absence of real care improvements. These comments outline a governance strategy that creates balance and fosters a robust value proposition for beneficiaries, providers, and CMS. Emphasized throughout these recommendations is the need to support public-private and federal-state alignment in payment and delivery reform.

### Reporting of TINs and NPIs

We urge CMS to provide greater flexibility and clarity in the annual changes allowed under the current mechanisms to allow logical expansion on an annual basis by ACOs. This should be allowed both within existing large integrated systems operating under a single taxpayer identification number (TIN) and for the addition of new TINs. This will allow ACOs to expand as their experience with the program grows and capabilities improve. Our experience with the implementation of ACOs and other reforms to date, including our ACO pilot sites, is that they generally progress in this way. That is, they start with a limited number of sites and as capabilities and experience grow, expansion to additional provider groups occurs. This approach will also help the program achieve greater success, by permitting the expansion of ACOs that are effective in achieving quality improvements and cost reductions. This approach is especially important in conjunction with our below recommendation of a longer potential contract period.

The initial providers and any additional groups of ACO professionals would have to meet key program requirements, including being of sufficient size to allow benchmark calculation and meeting antitrust requirements. This should apply both to the addition of new TINs representing an additional group of ACO professionals (of sufficient size) and to the logical expansion of the ACO professionals within a single, large integrated system. We recognize that allowing attributable providers to join an ACO during the contract period may pose some antitrust analysis challenges, and we therefore note that appropriate antitrust review would be required prior to expansion beyond specified antitrust review thresholds.

This would also require some modification of the spending benchmarks. Such recalculation should not provide any windfall benefits or penalties to the ACO. For example, this could be accomplished through re-calculation of the spending benchmarks as a weighted average of the original ACO population and the newly added populations of attributed patients. We discuss this issue further in our comments on the benchmark calculation.

***Recommendations***

- Permit ACOs to add additional TINs to join the ACO on an annual basis, provided that they are not part of another ACO.
- Allow large single TIN integrated delivery systems with many employed physicians to begin the program with a subset of their NPIs based on logical subgroups (e.g. all primary care physicians in a single major practice site) of sufficient size and to expand on an annual basis.

## Marketing materials

CMS needs to re-orient its stance towards marketing. CMS should reframe this provision as "educating and engaging beneficiaries," rather than "marketing." Currently, the marketing provisions are far too onerous and do not align with the purpose and goals of ACOs. It is not the ACO's focus to actively advertise to beneficiaries (as it is with Part D plans and Medicare Advantage organizations) and gain beneficiary market share. Rather, it is the ACO's focus to generate revenue from improving care for a relatively stable patient population for whom it is already providing care. Beneficiaries have no change in benefits and can carry on as they otherwise would (i.e., visiting their regular providers). ACOs should not be subject to the administratively burdensome and costly exercise of submitting all "marketing" materials and changes to CMS.

In order to reduce costs and pressures on timelines—on both the ACO and on CMS—CMS should conduct some beneficiary-wide notification and education about ACOs, such as a notable section in the annually updated "Medicare and You" handbook. It could then offer some high-level guidelines for ACO beneficiary communication, borrowing from Part A and B beneficiary communication guidelines.[2] During the contract years, CMS can undergo auditing and passive review on ACO-beneficiary communications. This process will achieve several purposes. First, ACOs and Medicare beneficiaries will understand that "marketing" ACOs is not the purpose of the program. Rather, beneficiary education and engagement with their providers' activities as part of the ACO program is more important. Over the next few years, CMS will be undertaking many other activities that are also changing provider incentives, such as quality reporting, pay-for-performance, readmission penalties, non-payment for unsafe care, many pilot initiatives, and other reforms to the "fee-for-service" Medicare program; beneficiaries should be given an overall sense of how these programs fit together and the role of the ACO program alongside these other reforms. Second, ACOs should not face the onerous task of creating marketing materials without current guidelines, submitting them to CMS before use, and submitting changes to CMS before use. Doing so will open up ACO and CMS resources for other more useful purposes, such as improved infrastructure and quality improvement.

***Recommendations***

- Forgo provisions about CMS approving all marketing materials and changes; instead, CMS can engage in review and passive auditing.
- Establish an effective beneficiary notification process (see below).
- Conduct a Medicare-wide beneficiary engagement regarding ACOs, along with the many other quality and safety improvement initiatives that Medicare is undertaking.

## Notice of ACO participation

Having CMS approve all ACO communications, including notification, will be too time-consuming and costly and may hinder the ACO from its highest possible performance. Instead, CMS may consider providing templates and other sub-regulatory guidance to applicants on key notification messages. Some notification messages must include patient-centered language, assurance that the beneficiary will be able to continue to choose any Medicare provider, descriptions of standard Medicare beneficiary rights and protections under the law, and potentially other issues. It is crucial that CMS's guidance on notification foster patient responsibility and accountability with transparency and access to information.

***Recommendations***

- Distribute sub-regulatory guidance and possibly templates about how notification should proceed to facilitate the development of these materials. If any advance review is required, it should be limited tightly to the initial beneficiary notification and

[2]http://www.cms.gov/Manuals/IOM/itemdetail.asp?filterType=none&filterByDID=99&sortByDID=1&sortOrder=ascending&itemID=CMS019034&intNumPerPage=10

communication process – that is, the letter given or sent to existing primary care patients and those newly joining, and materials available at primary care physician (PCP) practice check in.

- Shift towards a method of modified prospective notification as described more fully in comments to Section 425.6.
- Ensure any guidance regarding notification emphasizes patient-centeredness, patient responsibility, as well as the benefits of an ACO for the consumer, ideally with any requirements message-tested on consumers (in line with our recommendations under Section 425.6). Review should not be required for minor changes to these materials or for other health related communication with beneficiaries.

## Tracks during agreement periods

In addition to the Tracks 1 and 2 outlined in the rule (see payment and quality section for comments on Tracks 1 and 2), we propose a Pre-ACO Track. The Pre-ACO Track can receive the same aggregate data reports that CMS proposes to send to ACOs on a quarterly basis. The data will be based on the population that would be assigned if the group were a Track 1 or 2 ACO. This important receipt of baseline performance information will reduce uncertainty for groups who are interested but not quite ready to become ACOs for participation in the next contracting period. In this section, the NPRM also introduces the notion of the 25% withholding and demonstration of repayment of losses equal to at least 1% of the ACO's per capita expenditure. We believe these two provisions are too burdensome. While CMS needs assurance of an ability of ACOs to pay for losses under the two-sided program as well as repay any early-year bonus payments that are lost based on subsequent performance, both provisions put ACOs in a difficult financial position. There are other ways for CMS to gain confidence in the financial viability of the ACO. For example, ACOs that are participating in one-sided or two-sided models outside of Medicare are likely to have demonstrated some capacity to manage these payments and penalties; or, if the ACO is already participating in Medicaid, state, or private ACO initiatives, or other payment reforms, the same financing mechanism could be applied for the Medicare ACO.

For track 1 applicants, CMS should develop less costly withhold and loss repayment mechanism at the end of performance year 3 if the ACO is eligible and decides to participate in a performance year 4 and 5 (see earlier recommendation). This mechanism should be based on data from performance year 1 and 2, as well as any experiences with private payers. Track 2 applicants should have their withhold and other mechanisms for repaying losses waived. CMS should especially recognize ACOs who are successfully participating in a Medicaid, State, private ACO or other similar payment reforms, as this experience should reduce uncertainty of the financial viability of an ACO.

***Recommendations***

- Create a Pre-ACO Track which allows groups to submit a list of TINs and NPIs and receive quarterly aggregate reports on recent financial performance, quality performance, information on the "assigned" beneficiary population, and utilization data. These groups will not be accountable for costs or quality – and will not be eligible for shared savings. But the baseline performance information will significantly enhance their ability to succeed if they decide to become ACOs later.
- Develop less costly withhold and loss repayment mechanism for Track 1 applicants at the beginning of Year 3, based on Year 1 and Year 2 performance and experience with other payers, if the ACO decides to enter in Year 4 and Year 5.
- Waive or reduce withhold and mechanism for repaying losses for Track 2 applicants, particularly those who have demonstrated participation in a Medicaid, state, or private ACO or other payment reforms. Such a track record reduces CMS's uncertainty on the financial viability of the ACO.

## Shared governance

The shared governance requirements as they stand may prevent many existing ACO-ready organizations from applying. Although the proposed rule specifies that "if the ACO is comprised of a single entity . . . the ACO governing body may be the same as the governing body of that entity, provided it satisfies the other requirements of this section," there are many ways in which the shared governance requirements in the proposed rule are at odds with current governance practices of organizations that are taking important steps to improve the quality and coordination of care.

For example, the rule specifies that at least 75% of the governing body must be held by ACO participants. We agree that the governance structure should ensure that the focus of the ACO is on improving quality of care, beneficiary health, and avoiding unnecessary costs, and we agree that strong clinician and consumer representation on the governing body might help achieve this goal. However, this is not the only way. Furthermore, the provider representation requirement is much higher than what current integrated, financially sustainable, and clinically-sophisticated systems have today. In addition, consumer-led systems will not meet the provider representation requirement. Geisinger Health System, the Mayo Clinic, Cleveland Clinic, HealthPartners of Minnesota, Monarch HealthCare, and many hospitals have boards with much lower provider representation than 75%. Although the rule allows groups to leverage currently existing governance structures for Shared Savings Program, the overly prescriptive 75% rule effectively forces either radical changes to existing board structures or the creation of a new and unproven legal entity to meet the governance requirements.

The governance provision also requires the ACO have at least one Medicare beneficiary served by the ACO without a conflict of interest with the ACO on its governing body. If CMS retains this specific form of a beneficiary participation requirement, we recommend that CMS clarify what "conflict of interest" would mean for the Medicare beneficiary representative. The rule is also unclear on what role the beneficiary will play in the governance body or how much voting control they must have.

Instead, we recommend that CMS should not require ACO governance structures to give beneficiaries voting power. Rather, ACOs should have the flexibility to develop beneficiary representation in more meaningful ways. For example, the Brookings-Dartmouth ACO pilot Tucson Medical Center proposed that a non-voting, ongoing advisory group of beneficiaries would provide much more valuable and appropriate input than a single beneficiary on a governance board.

Currently, the shared governance provisions do not adequately support ACOs in accessing, leveraging, and effectively using multiple streams of capital for investing in high-value care. With the 75% ACO provider representation requirement, many boards will have only limited expertise in raising capital and making targeted, effective investments for continuous quality improvement – a critical task for ACOs. With a more flexible participation requirement, ACOs will have greater flexibility to add stakeholders with expertise in raising capital and expanding infrastructure such as private payers, entrepreneurs, community-based organizations, employer representatives, state/Medicaid representatives, and more. For example, the Mayo Clinic board of trustees includes representatives of large companies, law firms, investment companies, media, research institutions, accounting standards organizations, as well as Mayo leaders and clinicians. Among the current trustees approximately 40% are physicians.[3] The Mayo Clinic governance and management structure by-law requires that the board of trustees have substantial development, investment, and business planning committees/ capabilities. Similarly, the Geisinger Health System foundation board of directors has representatives from foundations, employers groups, and corporations.

[3] http://www.mayoclinic.org/governance/trustees.html

***Recommendations***

- Require meaningful membership of ACO participants in the ACO's governing body from a diverse group of stakeholders, and account for existing governance arrangements that are effective
- Clarify beneficiary representation on the governing body, but do not require a beneficiary to be a voting member. The rule should foster meaningful beneficiary engagement and feedback through other mechanisms that may be more effective, like patient advisory boards.

## Leadership & management structure

While the NPRM noted that the legal entities and governance structures may be based upon pre-existing entities, it is not clear on whether leadership and management structures can also be based on pre-existing structures. For example, if an integrated health system becomes an ACO, do they need a separate executive devoted solely to Shared Savings Program? Or will the current executive subsume those duties? We recommend that CMS clarify that leadership and management can be based upon pre-existing structures, and that the ACO not be required to develop a new, concurrent structure that is separate from what currently exists.

The rule stipulates that the medical director must be full-time for the ACO. We recommend that this stipulation be revised to ensure that organizations with strong medical leadership that can effectively manage the new population be able to do so without major new administrative requirements. If the rule is to leverage current leadership structures, the medical director should not be solely devoted to the Medicare ACO but to the ACO organization regardless of payer, and to related activities that the institution is undertaking outside of the ACO (e.g., helping additional provider groups undertake new quality improvement steps). The exact percentage of time for the medical director should be determined based on the size and scope of the ACO organization.

Allowing ACOs to leverage current leadership will reduce start-up cost burdens for the ACO. For instance, hiring a completely new executive, medical director, and compliance officer for the Shared Savings Program are estimated to cost between $.5M to $1M.[4] While ACOs will cause some organizational disruption by shifting providers to a value-based system, if current leadership resources can be re-allocated to the ACO, and new personnel are hired in the targeted areas where they are needed, the ACO will have a smoother, less burdensome implementation path.

The rule also says that ACO participants must have a meaningful commitment to the ACO. Meaningful commitment may take the forms of financial or human investment in the ongoing operations of the ACO. We suggest that if "meaningful commitment" is financial backing (such as equity holders of the ACO) and goes beyond "time and effort," the ACO should be given some financial consideration (e.g. a lower withholding or increased shared-savings). Everett Clinic, a Medicare Physician Group Practice (PGP) demonstration site, requires that all board members be a corporation shareholder. Physicians, too, can also choose to be shareholders.[5] Governance structures similar to Everett's demonstrate an extraordinary commitment from providers and extra effort to raise capital. CMS may not need to hold such management structures to the same strict withhold standard and such arrangements can be incentivized with greater cash flow.

The rule contains many application and management requirements that will be entirely new to providers, even those who are already implementing ACO-related reforms. CMS should consider technical

[4] Assumptions: executive = $320,000, medical director = $320,000, compliance officer = $140,000. Total = $840,000

[5] Fact sheet, Everett site visit: Interest on the investment and growth in equity position do not accrue to the physicians personal stock holdings to prevent skimming patients

assistance (TA) and sub-regulatory guidance—rather than regulation—to help groups re-configure themselves to be successful ACOs. Before and after Part D went into effect, CMS offered sub-regulatory guidance to plans interested in participating. The sub-regulatory guidance consisted of memoranda, FAQs, and other written/oral communications. Sub-regulatory guidance can provide program flexibility so long as it does not go so far as to create surprises and instability in the program.

Lastly, the rule says that the ACO must provide some application documents (i.e. charters, remedial processes, agreements, etc.) upon request. CMS should specify cases in which these documents would be requested. If CMS is more specific about these supplemental application materials, groups will be better able understand the extent of resource requirements, reducing uncertainty about the cost of participating in the program.

***Recommendations***

- Clarify that leadership and management structures can be based on pre-existing structures; the ACO will not necessarily need to create an entirely new and parallel structure. This will reduce start-up costs and organizational upheaval, allowing the ACO instead to focus on lowering costs and improving beneficiary care.
- Do not require a full-time medical director; instead, specify that the Shared Savings Program needs a medical director with sufficient time devoted to the Medicare ACO.
- Provide sub-regulatory guidance on ACO applications and formation to groups before and perhaps during the start of the program.

## Compliance plan

We agree that the Shared Savings Program compliance program should coordinate and leverage existing compliance efforts, as a solid compliance plan and efforts do not segregate by populations served. We also appreciate that the rule encourages the ACO entity to coordinate its compliance efforts with the existing compliance efforts of its ACO providers and suppliers, in order to avoid duplicative efforts.

There are some aspects of the compliance provision that may be too burdensome for ACOs, as they have been in many other parts of the Medicare program. First, consideration should be given to limiting the compliance training requirement to the compliance officer. This reduces burden and cost to the ACO overall while maintaining the desired impact of having a high-quality, compliant ACO. Second, the rule stipulates that the ACO must "report suspected violations of law to an appropriate law enforcement agency." This requirement is unclear – CMS has not defined a "suspected violation," or the "appropriate law enforcement agency," and it is unclear as to when the duty to report arises or whether the requirement extends to ACO providers and suppliers. Moreover, "suspected violation" is a very low threshold for a mandatory regulatory requirement. Medicare Advantage and Part D have voluntary self-reporting as opposed to mandatory self-reporting. Mandatory self-reporting has proven difficult to implement in programs both in and outside of CMS, and we recommend that the ACO program is not the optimal program for mandatory self-reporting. The mandatory self-reporting may impose too many costs on ACOs, detracting from the goal of lowering spending. Mandatory self-reporting will raise legal fees and resources for compliance personnel and mechanisms.

The proposed rule makes no mention of incentives or protections for self-reporting. For example, the ACO could have reduced penalties, (e.g., avoidance of criminal charges) for self-reported violations.

***Recommendations***

- Make self-reporting voluntary rather than mandatory.
- Encourage self-reporting with incentives such as possible protection from criminal charges and reduced penalties.

## Written request for shared savings payment

Once the ACO is notified that it qualifies for shared savings or losses, it should not have to request the savings. The ACO's application and submission of quality data should suffice in lieu of documenting compliance with program requirements at the time of shared savings/losses notification. The process outlined seems to create additional burdens for the ACO and may slow cash flow.

***Recommendations***

- Remove the requirement to have written request for shared savings payment

## Required reporting on participating ACO professionals

We recommend that CMS permit ACOs to expand and change their provider composition over time, as they gain more experience with ACO implementation and identify additional opportunities for care improvement, as well as circumstances where termination of provider participation in an ACO may be most appropriate. We also note that actual care delivery involves substantial provider turnover on an ongoing basis even within relatively integrated delivery systems. In order to provide the most accurate data support to the ACO and to allow performance measurement and financial benchmark and target setting to be as effective as possible, ACOs should provide regularly updated lists of the NPIs of participating ACO professionals to whom patients are attributed. Because patients have freedom of choice, it may not be reasonable to expect the ACO to provide TINS of all suppliers. We therefore recommend a more limited notification process.

***Recommendations***

- Require the ACO to provide an updated list of ACO professionals to whom patients are attributed on an annual basis. (ACOs undergoing significant mergers or other changes could provide a more timely update.)

## Required processes and patient-centeredness criteria

In order to achieve the goals of lower costs and higher care quality, ACOs may engage in a broad variety of clinical improvement and patient-centered efforts. Given the diversity of opportunities for care improvement and of mechanisms for achieving improvements, CMS should be mindful that requirements should be goal-oriented (such as meeting strong performance measures focused on meaningful outcomes) rather than process-oriented (such as demonstrating a process to achieve those measures of outcomes). Goal-oriented requirements will foster more innovation in how care is delivered, based on the opportunities that exist in particular organizations and communities. We understand that performance measures are far from perfect for evaluating whether ACO goals are being achieved, and that is why we believe the regulation should put more emphasis on supporting improvements in care that actually achieve better results – including a steadily improving capacity to provide better outcome-oriented performance measures to document these care improvements. To get there, CMS should place greater emphasis on ACOs taking steps that will achieve measurably better results, rather than encouraging more structural design or care processes now that may not translate into improvements in quality and cost.

One example of using goal standards, rather than design or process standards, is the PGP demonstration. PGP sites participated because of their strong interest in improving and managing care. Participants implemented a wide range of initiatives aimed at improving quality and efficiency, including chronic disease management, high risk/high cost management, managing care transitions, palliative care, and using evidence-based protocols. In other words, the sites had flexibility in designing care management strategies to reflect their own circumstances—but whatever strategies they undertook, they were held

accountable for lowering costs and improving quality.[6] Ideally, the ACO quality measures and cost-savings imperative will drive patient-centeredness innovation, and CMS should not require onerous documentation on particular kinds of clinical efforts.

Thus, CMS should not require, but rather encourage, the ACO to provide detailed documentation on a full range of plans to promote evidence-based medicine, beneficiary engagement, internally report on quality and cost, and coordinate care. To support this less burdensome alternative to detailed documentation and review, CMS might consider adapting a straightforward template or survey from those already in use to characterize ACO activities (such as HIT, care management, and other capabilities). Such a survey would not only would result in more limited burden for ACO staff (existing surveys can be completed in a matter of hours); they would also be more likely to produce comparable data on the range of activities that ACOs are undertaking, leading to insights that could guide revisions to the Shared Savings Program in the future.

***Recommendations***

- Develop a straightforward template or survey like those currently in use now to describe and potentially evaluate ACOs – enabling CMS to get more meaningful information on what ACOs are undertaking in a less burdensome way.
- Shift from requiring to encouraging the documentation of the ACO's plans to promote evidence-based medicine, beneficiary engagement, internally report on quality and cost, and coordinate care as well as processes and patient-centeredness criteria in the application process.

[6] Evaluation. Kautter, Pope, Trisolini, Grund. "Medicare Physician Group Practice Demonstration Design: Quality and Efficiency Pay for Performance." Health Care Financing Review. 2007; 29(1).

## 425.6 Assignment of Medicare FFS Beneficiaries to ACOs

### Overview

This section balances two critical issues: (1) the technical assignment of patients to an ACO (which is necessary to hold the ACO accountable for quality and costs for the spectrum of patients they treat), and (2) the important matter of engaging and informing patients on their participation in an ACO. In order to strike the appropriate balance between these issues and to empower patients and providers to be accountable for their care, we encourage CMS to consider a modified prospective assignment of beneficiaries as well as additional measures to ensure that the Shared Savings Program accurately captures the heterogeneity of care a patient receives over the course of their assignment to an ACO. As noted previously, we also strongly recommend that the benchmark based on patient assignment be adjusted over time, as the provider composition of the ACO and potentially the patient population treated by the ACO changes. Based upon a number of analyses we have completed on topics related to attribution, we have several recommendations for improving this section of the NPRM and supporting the goal of empowering patients to be more effective decision makers for their own care. For example, our analyses show that our proposed assignment mechanism comes close to a concurrent attribution strategy that reflects the beneficiary population treated.

### Assignment methodology

The assignment of patients to an ACO is at the core of holding the ACO accountable for the cost and quality of care it delivers. CMS has considered several patient assignment methodologies, and each comes with its own set of strengths and weaknesses. We support CMS in its effort to protect patients and ensure they receive a single, high standard of care regardless of the attribution methodology, but we also understand providers' needs for predictability regarding patient assignment.

We believe that the attribution, data support, and notification elements of the ACO program should be designed to achieve the following key aims:

1. Increase certainty for healthcare providers through transparency in attribution;
2. Ensure that as many as possible Medicare beneficiaries seen by the provider organization for primary care services are eligible for inclusion in the model;
3. Inform patients as effectively as possible to support engagement and ensure choice;
4. Support providers' efforts to improve and manage care of their Medicare patients, including both the development of timely target budgets and the identification of high-risk, high-cost patients who would benefit from care management; and,
5. Hold providers accountable for what they have the greatest capacity to influence.

In our conversations with patients, advocacy groups, providers, Beacon Communities, our Brookings-Dartmouth Pilot Sites, and other systems striving for better care, we have found that in order for care to be truly accountable, the relationship and therefore attribution between patient and the healthcare system should be prospective and also based on current performance year data. We acknowledge that there might still be concerns regarding beneficiary attribution and its implications for performance and shared savings. To explore some of these concerns, the Brookings-Dartmouth team has completed several analyses regarding the stability of various beneficiary attribution methodologies.

Key findings and interpretations of these analyses include:

- 30% of beneficiaries attributed to an ACO in the current performance year were not attributed in the prior year. This suggests that basing attribution on data prior to the current performance year will lead to incorrect attribution of a substantial proportion of patients; using older years of data for attribution will lead to an even worse fit.

- 87.6% of patients seen by the ACO primary care physicians in a given performance year will end up being attributed to the ACO. That is, the vast majority of patients utilizing services at an ACO will be attributed to the ACO.
- 94.6% of visits in a current performance year to primary care providers and other care coordination team members (beyond just the primary hospital or core set of physicians) in an ACO are for patients who end up attributed to that ACO. This suggests that the ACO can have high confidence that a focus on improving care for all of its primary care patients will be an effective strategy for achieving both quality and cost targets.
- 83% of patients attributed in the current year have a first visit during the first six months of the year. This means that the vast majority of patients in an ACO who will have accessed services will have done so by the first six months.

These results strongly suggest that recent beneficiary utilization is much more predictive of association with primary care providers than more "prospective" data, and that if an attribution mechanism based on recent visits were adopted, ACO providers could be confident that the Medicare beneficiaries they are treating now will be included in their ACO calculations.

The Pioneer ACO model also describes a mechanism for supplementing claims with beneficiary attestation. In particular, it proposes using beneficiary attestation of a relationship with a primary care provider as a basis for attributing new Medicare beneficiaries. If CMS can work out the administrative issues associated with this mechanism, it could be an effective next step toward augmenting beneficiary's demonstrated choices about primary care with an even more explicit affirmative process for beneficiary attribution, not only for new beneficiaries but for existing ones as well.

CMS has proposed that only primary care physicians, including MD and DO physicians with a "primary specialty designation of internal medicine, general practice, family practice, or geriatric medicine" (Section 425.4) are eligible for patient attribution. The current proposal only holds the ACO accountable for patients served through primary care physicians, thereby limiting its total accountability.

There are several problems with this model. This would result in several undesirable consequences:

- Patients who receive a majority of their care from nurse practitioners (NPs) and physician assistants (PAs) within an ACO may not be attributed to the ACO.
- The effective coordination of care by specialists within the ACO who are currently responsible for overseeing the continuum of care for some patients would not be reflected in attribution.
- The total number of Medicare beneficiaries attributed to an ACO would be reduced inappropriately.
- The totality of care provided by an ACO would not be accurately captured.
- Interdisciplinary primary care models based on care by NPs or PAs would not be encouraged or supported.

With respect to the inclusion of NPs, PAs and other health professionals, we understand that CMS faces some statutory constraints on these issues. However, care coordinated by NPs and PAs is an increasingly important element of effective care delivery, and at least NPs and PAs affiliated with primary-care physicians in the ACO should be included in the attribution mechanism. The inclusion of specialists must reflect the coordination of care that specialists can provide for complex patients and still place an emphasis on primary care. To that end, we support the framework proposed by the Pioneer ACO model in which specialists are included. However, this should not prevent primary care physicians alone from forming an ACO.

CMS also states in the preamble section of the NPRM that Federally Qualified Health Centers (FQHCs) and Rural Health Centers (RHCs) are not eligible for attribution, noting an inability to completely identify the physician and the service provided to a beneficiary. As we note in section 425.7, FQHCs and RHCs will be utilizing HCPCS codes as of January 1, 2011 which allows for ease in attribution of these patients to a primary care provider within the FQHC/RHC. We believe that this will enable attribution either beginning in 2014 (to perform the three year look back in calculation of the benchmark) or as an alternative, consider using the agency's demonstration authority to identify a pathway for FQHCs and RHCs to participate in a shared savings program and concomitantly further investigate the methods to calculate their expenditure baseline and benchmark calculations based on available Medicare data and other FQHC payment data.

***Recommendations***

- Introduce a modified prospective methodology of attribution with current performance year data.
    - Adopt a near-concurrent attribution model in which the ACO is held responsible only for the patients that received the plurality of their care from the ACO professionals within the ACO during a time period close enough to the performance year that it approximates the population seen during the year, and does not provide opportunities for gaming (e.g., an attribution mechanism based on most recent visit alone could encourage scheduling more visits with relatively low-cost patients in the weeks before the attribution period ends). A specific example of such an attribution model is one based on beneficiary claims for the 12-month period from July of the preceding year through June of the performance year.
    - Provide lists of attributed beneficiaries to ACOs every six months, and should do so with as little time lag as possible. The more up-to-date the CMS attribution data, the more the tradeoffs between prospective and retrospective attribution can be diminished by instead relying on concurrent attribution.
    - Explore ways to build on its proposal for attestation by new beneficiaries in the Pioneer model.
- Expand the number of providers eligible to have beneficiaries attributed so that a higher proportion of primary care patients seen are within the ACO and thus have aligned incentives, as follows: (a) allow attribution to eligible medical specialists (e.g. cardiologists) for beneficiaries who receive a majority of their care with specialist over a performance year; (b) allow NPs and PAs who are supervised by primary care physicians to be considered as eligible ACO providers (to the extent that is statutorily feasible); and (c) perhaps on a demonstration basis or in another capacity, explore attribution to FQHCs/RHCs.
- Provide ACOs with timely lists of the Medicare beneficiaries seen (at least one visit) and provisionally attributed to the ACO. The data support should ideally include any information available to CMS that would facilitate care management, such as risk scores.[7] At least semiannual and preferably quarterly updates of attributed patients and how performance targets are being met (based on a projected target from the base year) would allow ACOs to identify gaps, select patients for care management activities, and understand their performance compared to a budget.

[7] Patients are informed by practice that the providers are in an ACO: The aim is to improve our care for all of our Medicare patients; you can designate a PCP; you have full freedom of choice. Data sources for beneficiary notification would be: (a) Medicare list of beneficiaries *seen*, regularly updated to help identify new patients; (b) practice lists of primary care patients previously seen by the ACO professionals; (c) new patient appointments (which would result in letter to patient).

## Beneficiary information and notification

Notifying beneficiaries that their provider is participating in an ACO, and offering them information on their rights as beneficiaries of an ACO is essential for engagement, and may also help address concerns about a backlash against ACOs. Beneficiary notification should: a) explain the benefits of receiving care from a provider in an ACO, b) reassure beneficiaries that receiving care in an ACO will not compromise their ability to select a provider, and c) offer beneficiaries information about their rights in an ACO. To this end, notification and information must be clear, understandable, and informative.

CMS clearly recognizes the importance of informing beneficiaries that they will receive care in an ACO in advance of receiving that care. However, we are concerned that the proposed method of notification is not likely to be effective and may actually increase beneficiary fears. Informing beneficiaries immediately prior to their first appointment with a provider that has joined an ACO may not give beneficiaries sufficient time to think about any ACO-related questions they have and make an informed decision about how they continue to receive care from their providers. And, it may cause beneficiaries to assume that they are being notified because they are in danger of losing their benefits or access to providers. Beneficiaries should be informed in advance that their care will be supported by an ACO. Prospective attribution makes this possible for the vast majority of beneficiaries, since they have been and will likely continue to receive care from the providers in the ACO. For beneficiaries newly seen by an ACO's primary care providers, the high likelihood of their being attributed to the ACO suggests that it is reasonable for them to also receive similar information.

In addition to written notification, CMS has proposed to require ACO providers to post signs in their offices alerting patients of their participation in an ACO. This requirement is costly, of unproven value, and duplicative given the requirement to provide written information, and therefore contributes to the problem of unnecessary administrative and financial burdens on ACOs. It may also send a wrong signal to beneficiaries about ACOs.

CMS has specifically asked for comment on what information should be communicated to beneficiaries about benefit structure under the Shared Savings Program. Based on conversations with the Campaign for Better Care, we believe that message testing and focus groups with consumers could be helpful to identify language that informs beneficiaries of their rights in an ACO, and can provide guidance on how this information should be communicated in a form that is understandable yet informative and does not result in consumer backlash. In the meantime, notification letters used by existing ACOs can provide a useful starting point for communicating issues of patient choice and enhancements to benefit structure. One of our Brookings-Dartmouth pilot sites, Monarch Healthcare, developed a notification letter which was sent to all of its commercial payer ACO participants. This letter was message tested with potential beneficiaries and is attached as an appendix to this document.

CMS has also asked for comment on the appropriate form and contents of a standardized ACO notification. At minimum, a standardized notification should include the name of the applicable provider, notification that this provider has joined a new care arrangement, their rights as beneficiaries of an ACO, and contact numbers at the ACO and at CMS for more information. Notification may also include information on ACOs in general, on the specific ACO in which the beneficiary will receive care, and on the benefits of getting care in an ACO. As above, we believe that existing examples of beneficiary communications about ACOs and related issues as well as further message testing with consumers could be helpful in identifying other essential components of notification and to determine how these components should be presented.

Given these issues, CMS should base notification requirements on evidence and actual experiences in beneficiary communication about ACOs. This can be addressed through subregulatory guidance and shared learning about effective means of beneficiary notification and engagement.

***Recommendations***

- Require advanced notification to all patients who are prospectively attributed to an ACO. The requirements for such notification should be evidence- and experience-based, including for example evidence from existing notification letters and other mechanisms for ACO-like care and beneficiary focus groups. With guidance from CMS, notification should include beneficiaries who have been and are receiving primary care from an ACO's providers.
- Eliminate the requirement that ACO providers post signs indicating their participation in an ACO, in light of the lack of evidence around the appropriate modality and effect of ACO signage on provider or beneficiary behavior. CMS should offer further guidance on provider communications once evidence is more developed.
- Use sub-regulatory guidance to further define notification mechanisms and gather further evidence through message testing and focus groups with beneficiaries and through further analysis of notification methods being used by ACOs today inform that guidance.

## 425.7 Payment and Treatment of Savings

### Overview

Creating the right payment conditions for ACOs is critical to the impact of the shared savings program. Doing so means CMS must find the right balance by setting a high, yet realistic, bar for improving care and a path along which organizations committed to the goals of the ACO program can move. We believe that there are opportunities to revise the program so as to better achieve that balance. These opportunities include: adjustments to the methods for calculating the baseline and annual benchmark; providing a larger share of savings to ACOs, especially during the first years of the program when startup costs are greatest and for ACOs that are prepared to accept two-sided risk; increasing the total sharing opportunity; reducing the capital requirements associated with two-sided risk; revisions to the MSR that will more effectively reward savings when they are likely to result from ACO initiatives; more effective alignment of the Shared Savings Program with other federal initiatives, which will create additional incentives to invest in essential care improvement infrastructure; and, perhaps most importantly, through alignment of the Shared Savings Program with private sector efforts to intensify the signal to invest and increase the rewards from investment in programs that will improve the quality and efficiency of care. We believe all of these changes can be implemented while still protecting the key goal of assuring savings to Medicare – by achieving more effective participation, total savings to Medicare are likely to be larger.

### Establishing a benchmark

The calculation of an expenditure benchmark is a fundamental element in establishing the economic opportunity for an ACO. In general, we believe that the methodology for establishing (and then updating) the benchmark is confounded by a number of factors which are outside of the control of the ACO, or which relate to Medicare expenditures that an ACO could not reasonably be expected to reduce through interventions directed toward improving care. The inclusion of these factors (or, in some cases, the failure to adjust for these factors) creates uncertainty and potential inequities in payment. The Shared Savings Program would be stronger and more effective if these were addressed.

Two issues related to establishing the benchmark are particularly important. First, existing variations in cost growth across geographic areas as well as inaccuracies in current CMS methods for accounting for differences in local input and practice costs (recently reviewed by the Institute of Medicine) may create incentives that reward ACO formation in some markets compared to others. We expect that CMS will continue to try to address issues of payment accuracy more broadly for the Medicare program overall, which should help to address this issue within the Shared Savings Program. We also note that CMS may need to account, at least initially, for certain geographic differences in spending trends that are extrinsic to the ACO.

In addition, there are issues in the MSSP that have the potential to disadvantage teaching hospitals, which we believe should inform methods for establishing the benchmark, and for the computation of per capita costs (considered in the section that follows). These have to do primarily with the inclusion of IME and DSH payments. We are concerned that failure to consider these factors—each of which raises the "price" of care in teaching hospitals, and therefore has the potential to create an environment in which ACOs may be inclined to shift their referrals away from academic centers so as to achieve apparent savings due to avoiding education-related payments alone, not due to shifting to care that is otherwise more efficient. The IME and DSH payments have implications for the calculation of the benchmark. The issues of average cost and case-mix have implications for the calculation of program year expenditures (so are considered in the next section).

***Recommendations***

- Consider a methodology to adjust the baseline for geographic variation in the cost structure in different markets. We acknowledge that this might take more process and scrutiny by the agency.
- Exclude IME and DSH payments from the benchmark.
- Incorporate these issues as appropriate in the benchmark calculation, using methods such as those described below.

## Computing per capita Medicare Part A and Part B expenditures and updating the benchmark

As we have noted above, it is important that ACOs be held accountable for those costs which they can influence through improvements in care, but that there be some insulation from those costs over which they may have limited control. These issues need to be addressed in the benchmark (both the initial benchmark, and as it is updated), but clearly also in annual calculations of per capita costs.

### Computing per capita Medicare Part A and Part B expenditures

We have noted above, that IME and DSH payments should be excluded from the benchmark through the Secretary's authority to adjust the benchmark but must also be excluded from the calculations of per capita expenditures for the ACO. We acknowledge CMS' concerns and thoughtful comments regarding the constraints in the Affordable Care Act that may limit their authority to exclude these expenditures from program year results. However, we do believe that there is flexibility within the statute and the Secretary's authority to use "other payment models"[8] to remove these expenses in its calculation of performance year expenditures.

In conjunction with this step, we recommend that, longer term, CMS work collaboratively to develop a set of metrics that capture the important benefits delivered by hospitals that receive IME and DSH payments, and consider strategies to provide the additional rewards to those hospitals based at least in part on performance on these additional metrics.

***Recommendations***

- Exclude IME and DSH payments from the benchmark calculation, as well as from the calculation of per capita expenditures.
- Develop and include, in the longer term, a set of metrics that assess the performance of hospitals that receive IME and DSH funds, and incentives in the MSSP to reward hospitals based on their performance on those metrics.

### Updating the benchmark

The overriding principles that guide our comments related to updating the benchmark are those that guide our comments in the sections above: hold ACOs accountable for expenditures (or trends) that are potentially subject to control through programmatic intervention, but attempt to insulate them from expenditures (or trends) that are out of their control.

As a result, we encourage CMS to update its benchmarks based on changes in the population which can reasonably be expected to influence cost and that are beyond the control of the ACO providers. There are two such changes that we want to highlight: changes in the population as the result of the inclusion of new providers/new TINs; and changes in population risk.

[8] 124 Stat. 1029 *thru* 124 Stat. 1084, subsection (i)

We have noted, elsewhere, our concern based on the experience of ACO implementation to date and delivery reform implementation more generally that the NPRM provides no mechanism to add physicians/TINs during the contract period, and strongly recommended that that the rule be revised to allow for physicians/TINs to be added or removed over time. The changes in providers/TINs may change the characteristics of the beneficiary population that is associated with them, and therefore require recalculation of the benchmark on an annual basis to avoid improper incentives. We recommend that CMS update the benchmark on an annual basis, by recalculating off of the population base as it changes with the inclusion of new TINs.

A specific example of how the benchmark could be updated in the second year of the ACO program to address these concerns is as follows. The ACO's initial benchmark would be trended forward by the update amount, that is, the expenditure target for calculating shared savings based on the first-year experience. This creates a second-year benchmark for the ACO's continuing population. For the new beneficiaries in the ACO resulting from physician/TIN changes and other factors, the benchmark calculation mechanism would be applied to set a benchmark for new beneficiaries for the second year directly. The second-year benchmark for the ACO would then be calculated as a weighted average of these two benchmarks. The same approach of creating a current-year benchmark that is a weighted average of the prior-year benchmark and the "new beneficiary" benchmark would be repeated for subsequent years.

This approach does not penalize ACOs for adding providers with relatively risky populations or reward them for adding relatively healthy populations in subsequent years. It can also be modified to provide some correction for "extrinsic" geographic variations in spending growth. For example, the second-year benchmark for the ACO's continuing population could be calculated based on an update amount that is adjusted for geographic-area differences in spending growth. (Note that this could be done even if a national average spending growth amount is used as a basis for the shared savings target in any particular year.)

We also note that CMS could calculate a benchmark for the beneficiary population leaving the ACO as a check on whether the ACO's activities are deliberately or incidentally creating more favorable beneficiary selection. In particular, CMS might use evidence of substantially higher expected spending in the beneficiary population leaving the ACO (based on the usual mechanism of predicting expenditures based on the three-year weighted average of beneficiary spending) or substantially lower expected spending in the population joining the ACO as a basis for further investigation or possibly further corrective action involving the ACO.

Change in population risk will affect the ability of an ACO to achieve, and therefore to share in, savings; in particular, increases in population risk will make these more difficult. Our analysis suggests that HCC risk-adjustment could affect expenditure benchmarks by 1% per year. This difference could materially affect the probability that an ACO will reach its MSR and hence the probability that it will be eligible to share in savings.

We recognize that the risk adjustment process can be confounded by improvements in coding and clinical documentation that are likely to follow (as it appears that they have in the Medicare

Advantage program and other payment reforms that involve risk adjustment) when there is an incentive to code more completely and accurately and by the more general problems of over-diagnosis associated with more intensive surveillance in high cost regions[9]. We recognize, as well, that the introduction of incentives that encourage more complete and accurate coding creates the potential that risk adjustments to the benchmark may reflect changes in coding practice, not genuine increases in population risk. Finally, we note that the benchmark recalculation process described above will diminish financial pressures for ACOs to avoid taking on higher-risk beneficiaries. While acknowledging all that, we believe that failure to adjust for changes in actual risk presents a greater problem: that ACOs would have an incentive to avoid taking on new patients or to "dump" (encourage patients to receive care elsewhere) when they develop new clinical problems. We therefore believe that in the short term the benefits of risk adjustment (encouraging ACOs to care for frail or complex patients) outweigh the harms (modest overpayment due to over-adjustment). At the same time, we strongly believe that CMS should explore new approaches to risk adjustment, perhaps based on socioeconomic status or patient reported measures of health and functional status that could be ascertained through surveys of samples or of all beneficiaries within the ACO proceeds. The technical challenges inherent in these approaches could be mitigated as quality-related reporting and risk adjustment in Medicare's baseline fee-for-service payment systems advance, and the adoption of health information technology both within and outside of ACOs proceeds.

***Recommendations***

- Recalculate benchmarks annually, for example when TINs are added to the ACO, to reflect changes in the beneficiary population associated with the ACO, using a recalculation method such as the example we have provided.
- Risk-adjust updates to the benchmark on an annual basis, using consistent and predictable risk adjustment methods that align with other CMS initiatives.
- Explore better approaches to risk adjustment that could be incorporated into routine patient surveys or electronic health records as they advance under meaningful use requirements.

## Determination of savings and shared savings rate for ACOs under the one-sided model

Potential ACOs will balance the certain cost of investment against the potential revenue that they can generate through shared savings if they are successful.

We are concerned that organizations—including organizations that we believe are well positioned to succeed as ACOs—see too little economic opportunity under the proposed shared savings model. As a result, we offer a number of specific recommendations which are directed toward achieving the following primary objectives:

- Provide greater up front rewards to support initial costs;
- Provide greater certainty that it will be possible for ACOs to achieve those rewards;

[9] Song Y, Skinner J, Bynum J, Sutherland J, Wennberg JE, Fisher ES; Regional variations in diagnostic practices. N Engl J Med. 2010 Jul 1;363(1):45-53. Epub 2010 May 12. Welch HG, Sharp SM, Gottlieb DJ, Skinner JS, Wennberg JE. Geographic variation in diagnosis frequency and risk of death among Medicare beneficiaries. JAMA. 2011 Mar 16;305(11):1113-8.

- Address statistical issues – in particular, recognize that longer time frames can improve statistical precision;
- Extend the contracting period so that both CMS and ACOs have greater opportunity for savings and modify expectations so that it is the longer time frame that is important;
- Link sharing rate to progressive quality reporting and performance.

Some of the revisions to the calculation of the benchmark and updates to it, along with the ability to phase up ACO participation, and to the methods for calculating per capita costs (all described above), begin to address these goals. We also propose essentially three tracks in which organizations can engage with CMS on a path to accountable care. As mentioned in Section 425.5 of our comments, we propose a "Pre-ACO" track in which organizations which are not quite ready to engage in a shared savings model as proposed might still be able to receive summary information from CMS on their "baseline" quality and cost performance.

We believe that these will strengthen the program considerably. In addition, we recommend that CMS adjust the structure of the shared savings program in other ways to better address the goals of improvements in care and reductions in Medicare spending.

First, we propose that CMS offer a higher rate of savings sharing (including early in the program, to help ACOs offset the early investments required to organize and launch their shared savings initiatives). We believe that is best done by linking the savings share to progressive reporting of quality information. In particular, we recommend CMS consider a 50%-50% sharing rate in the first year of track one with the maximum of possibility of a 75%-25% sharing rate (75% to the ACO) with a savings of up to 60% achieved as early as Year 3 of our proposed Track 1 ACO with one-sided risk.

We propose that the path to achieving a 75%-25% sharing rate be explicitly tied to our proposed quality measure pathway to best ensure that the goal of quality metrics – improved clinical care - is aligned with the proposed shared savings. The ability to achieve early increased shared savings by year 2 is something that has been seen as a necessary step in many existing ACO-related contracts and we believe that it should be paired with increasing the expectations for high quality care as outline in Table 1.

**Table 1: Proposed Track 1 Shared Savings and Quality Performance Alignment**

| | Year 1 | Year 2 | Year 3 | Year 4 (optional) | Year 5 (optional) |
|---|---|---|---|---|---|
| **Total Potential Shared Savings** (with differential achieved through performance on quality measures) | 50%-50% | Maximum 55%-45% (55 to the ACO and 45 to CMS) | 60%-40% (60 to the ACO and 40 to CMS) | 66.7%-33.3% (66.7 to ACO and 33.3 to CMS) Movement to two-sided risk model | 75%-25% (75 to ACO and 25 to CMS) Movement to two-sided risk model |
| **Maximum Losses** | | | | Applies (rate 5%) | Applies (rate 10%) |
| **Core Measure Set** | Payment for Reporting (all) | Payment for Performance (all) | Payment for Performance (all) | Payment for Performance (all) | Payment for Performance (all) |
| **Interim Clinical Process Measure Set** | | Payment for Reporting (33% of measures) | Payment for Performance (33% of measures)<br>Payment for Reporting (33% of measures) | Payment for Performance (66% of measures)<br>Payment for Reporting (33% of measures) | Payment for Performance (all) |

Second, we recommend that CMS increase the performance payment limit to 10% of the ACO's benchmark. This significantly increases the potential gain for the ACO, with little downside for Medicare savings in effective ACOs. Indeed, as it increases the incentive for organizations to achieve further savings, it has the potential to increase the total savings that are returned to the Medicare program.

Third, we propose that CMS develop a methodology to address what we think is a higher level and degree of uncertainty regarding the MSR than is necessary. We are concerned that an annual assessment of savings rate (MSR) may fail to accurately capture the impact of ACO interventions. For example, an organization with 20,000 members that achieves, in successive years, savings rates of 2.3%, 2.4% and 2.4%, will not once clear it's MSR (of 2.5%). Yet that pattern strongly suggests bona fide savings that cannot be attributed to chance. As a result, we encourage CMS to consider alternative actuarial approaches to setting the MSR that look at program performance over more than one year. For example, CMS may set the MSR relatively high for organizations in the first year, but

reduce it in subsequent years for organizations that are achieving consistent savings in repeated years that are highly unlikely to occur by chance.

We also recommend that CMS consider how to leverage the experience of ACOs in private sector (or Medicaid) contracts in their assessment of the ACO's success at achieving savings. Our experience suggests that ACOs with private sector contracts have already demonstrated a commitment to build the infrastructure that is necessary to realize savings, so that savings achieved for Medicare beneficiaries are more likely to be true savings (rather than statistical noise). Further, these contracts provide additional evidence on whether savings achieved for Medicare beneficiaries represent real reductions in cost trends. Consequently, we recommend that Medicare take experience with other payers into explicit and direct account in setting the MSR. An ACO with 20,000 beneficiaries outside of Medicare has much more evidence on quality and cost available than an ACO formed for Medicare alone, and CMS should use this information. For example, if an ACO with a MSR of 2% in Medicare alone achieves 1.5% savings in Medicare and also 1.5% savings in private plans, it is much more likely that the savings are not due to chance than if the ACO achieved savings of 1.5% in Medicare alone.

We also recommend (in the section below) that ACOs with two-sided risk (such as we suggest in years 4 and 5 of Track 1 and all potential five years of Track 2) face a fixed MSR of 1% if their size and previous pattern of savings provide actuarial support for the lower threshold (as in the Pioneer program).

As we have noted above, we strongly encourage CMS to make the Shared Savings Program attractive to potential private sector collaborators including commercial payers, whose participation in multi-stakeholder models can help ACOs increase the number of participating beneficiaries and the total achievable economic opportunity.

***Recommendations***

- Increase the shared savings rate to 55%/45% in year two, and to 60%/40% in year 3, of Track 1 (with three years of one-sided risk) based on progressive increases in quality reporting and performance requirements.
- Increase the performance payment limit to 10%.
- Develop a methodology for evaluating savings on a multi-year basis, so that ACOs (especially small ACOs) that achieve real and sustained savings are more likely to have the opportunity to receive a share of those savings.
- Align the Shared Savings Program with private sector initiatives so that ACOs can benefit from larger, multi-payer, opportunities including encouraging other payers to model a shared savings structure with the Shared Savings Program.

## Determination of savings or losses, and shared savings or loss rates, for ACOs under the two-sided model

The same general principles and goals for developing a successful one-sided shared savings model must apply to the two-sided model. In addition, to encourage participation in the two-sided model and achieve greater total savings, we recommend that CMS adjust the structure of the shared savings program so that ACOs that accept two-sided risk continue to have the opportunity to realize a

significantly higher rate of savings sharing, a significantly greater maximum savings opportunity, and a lower MSR.

As we have proposed above, we recommend an increase in the maximum sharing rate (to 80%) for ACOs facing two-sided risk, linked to progressive enhancement of quality reporting as outlined in Table 2 below. Please note that our proposed quality reporting strategy provides incentives for both an increased shared savings to the ACO along with increasing expectation of performance improvement and enhancement. Similarly, we recommend that CMS increase the performance payment limit to 15% of the ACO's benchmark.

**Table 2: Track 2 Proposed Shared Savings and Quality Measure Alignment**

| | Year 1 | Year 2 | Year 3 | Year 4 (optional) | Year 5 (optional) |
|---|---|---|---|---|---|
| **Total Potential Shared Savings**<br><br>(Differential achieved through payment on quality measures) | 60%-40%<br><br>60% for ACO, 40% for CMS<br><br>Two-sided risk throughout all five years | 70%-30%<br><br>70% for ACO 30% for CMS | 80%-20%<br><br>80% for ACO 20% for CMS | 80%-20%<br><br>80% for ACO 20% for CMS | 80%-20%<br><br>80% for ACO 20% for CMS |
| **Maximum Losses** | Applies (rate 5%) | Applies (rate 7.5%) | Applies (rate 10%) | Applies (rate 10%) | Applies (rate 10%) |
| **Core Measure Set** | Payment for Reporting (all) | Payment for Performance (all) | Payment for Performance (all) | Payment for Performance (all) | Payment for Performance (all) |
| **Interim Clinical Process Measure Set** | Reporting (50% of measures) | Payment for Performance (50% of measures)<br>Reporting (50% of measures) | Payment for Performance (all) | Payment for Performance (all) | Payment for Performance (all) |
| **Advanced Measure Set** | | | | Reporting | Payment for Performance<br>Reporting |

As we have noted above, the annual assessment of savings rate (MSR) may fail to accurately capture the impact of ACO intervention for ACOs facing two-sided risk as well as for those facing one-sided risk. For example, an organization (facing two-sided risk) that achieves, in successive years, savings rates of 1.5%, 1.7% and 1.9%, will not once clear the two sided MSR of 2%. But this pattern is unlikely to be due to chance. To address this, we encourage CMS to consider alternative approaches to setting the MSR that look at program performance over more than one year. For example, CMS may set the MSR at 2% in the first year, but reduce it in subsequent years for organizations that are achieving consistent savings in repeated years that are highly unlikely to occur by chance, especially when similar savings patterns are observed in private-sector ACO reforms implemented by the same organization. We believe that considerable opportunity exists to leverage ACO contracts where they already exist, through better alignment of the Shared Savings Program with private sector and Medicaid initiatives. We recommend that the Shared Savings Program set the MSR for two-sided risk at 1% (as in the Pioneer program) for ACOs with significant private sector and/or Medicaid experience.

Finally, we note that the recently-proposed ACO Pioneer Model initiative offers a pathway for additional redirection of resources for an ACO away from fee-for-service, when the ACO has taken further steps to establish an infrastructure for supporting providers in the coordination and delivery of care, and when the ACO has the experience and more sophisticated performance measures to demonstrate that they are likely to use such resources effectively. The ACO Pioneer Model proposal includes elements of coordination with the Shared Savings Program. To provide a more effective and certain pathway for health care organizations, however, these elements must be further developed and aligned with revisions to the Shared Savings Program. Providers should be able to see a clear, certain, and coherent pathway toward much more support for their investments to improve care and achieve more than offsetting reductions in costs. They should be moving ahead on these investments, not holding off on investment to see if the next initiative or addition from CMS provides a better alternative.

***Recommendations***

- Increase the shared savings rate to a maximum of 80%/20% available as early as the third year of Track 2, and give ACOs bearing two-sided risk the opportunity to achieve such savings based on performance and reporting on advanced and core quality measures as proposed in Section 425.10. In our example model, we also have incorporated payment on performance in year 5 on the Advanced measure set, which we recommend be incorporated as well under sub-regulatory guidance.
- Increase the performance payment limit to 15%.
- Develop a methodology for evaluating savings on a multi-year basis, so that ACOs that achieve real and sustained savings are more likely to have the opportunity to receive a share of those savings.
- Align the Shared Savings Program with private sector initiatives so that ACOs can benefit from larger, multi-payer, opportunities. Reduce the MSR to 1% for ACOs with private sector or Medicaid contracts.
- Align the Shared Savings Program with the ACO Pioneer Model initiative, so that a full set of ACO programs with increasing quality improvement expectations alongside increasingly substantial payment reforms can become a coherent and predictable pathway for moving toward greater support for achieving improvements in patient care.

## Additional Brookings-Dartmouth comments

The comments and recommendations above speak to the proposed rules related to payment and treatment of savings. We want to add two additional recommendations that speak directly to the opportunity to positively change payment conditions, but are not related to specific elements of the rule.

***Recommendations***

- Develop a process, at CMS or, if appropriate, through the CMMI, to provide front-end financial assistance to ACOs to enable their start-up investment (similar to the CMMI advance payment initiative). This process should recognize and seek to leverage other sources of investment support, including complementary payment reforms in Medicare, up-front payments from private payers and states (e.g., medical home payments implemented in conjunction with ACO reforms), and private investment funding.
- Reduce, or completely eliminate, the withhold for ACOs in both tracks, to reduce uncertainty and free up more funds for initial investment.

## 425.8 ACO Quality and Continuous Improvement Goals

We have no comments to this section.

## 425.9 Measures to Assess the Quality of Care Furnished by an ACO

We have no comments to this section.

# 425.10 Calculating the ACO Quality Performance Score and Determining Shared Savings

## Overview

CMS has proposed 65 performance measures across five domains of care. We agree with CMS's decision to choose:

- Measures that cover many important domains, including care experience and population health;
- Numerous measures that address prevalent and high-cost conditions;
- Many measures that are consensus-based and in use today by a broad range of organizations; and
- Measures that are arrayed along the care continuum, allowing the assessment of care across care settings to focus on patient-centered care.

Our comments address concerns raised by many stakeholders, including health plans, providers, aspiring ACOs, employers, and consumers, that the ACO programs should demonstrate a clear commitment to improved outcomes, rely on increasingly sophisticated, patient-centered outcomes over time, and allow a wider array of aspiring ACOs to participate in transforming patient care at the outset of the program. Significant concerns have been raised around the feasibility and burden of the current NPRM measures from organizations ranging from integrated organizations that are undertaking further steps to coordinate care, as well as from less-integrated associations of providers that are undertaking more basic but still critically important steps to improve care delivery. CMS should strike a balance between requiring accountability for improved outcomes at lower costs and providing a pathway for quality measurement and reporting that is flexible to the needs of the patients within a particular ACO. This flexibility can occur while still assuring that ACOs achieve substantial and increasing improvements in quality of care. We illustrate our recommendations with details for one example of a potential pathway with which CMS can strike the aforementioned balance.

## Proposed measure domains and measures

We recommend that CMS adopt a performance measurement approach that expands requirements for performance measurement over the course of the contract period. This progressive approach has been used in a wide range of ACO implementations outside of Medicare. Broadly, we recommend that CMS separate measures into core, interim clinical process, and advanced measure sets. Measures in all sets must advance the fundamental goal of improving quality while lowering cost and align with measures used in other HHS programs as well as private sector initiatives. We also recommend that CMS show flexibility to allow for quality measures that might already be implemented as part of ongoing multi-payer efforts or patient-centered medical home programs. Such measures should be able to serve as at least an interim substitute for similar Shared Savings Program measures if they are not included in the recommended measure sets.

We define core, interim clinical process, and advanced measure sets as follows:

- ***Core measures*** are those that are easily calculable by CMS through administrative data (Part A, B, and D claims) or existing patient survey mechanisms. Also included in the core set are several measures that are in wide use in the private sector and that require access to select clinical data. Many organizations, including the Brookings-Dartmouth ACO pilot sites and many ACO Learning Network participants, have established access to the required data despite the absence of completely deployed electronic health records (EHRs) (e.g., through use of patient registries, electronic receipt of laboratory results, and intranet portals). We understand that many organizations believe that such measures are too challenging to include in the initial core. If CMS decides not to include them in the core, such outcome-oriented measures should be highest priority for ACO measure progression beyond the core.

- ***Interim clinical process measures*** are those that require clinical data on important, evidence-based processes of care that today are less routinely accessible in a standardized format by many health care organizations. These measures often require specific efforts by ACOs to quickly establish reliable access to the needed clinical data and patient records. Clinical data capture capabilities should be expected to significantly improve over time in light of increased investments in electronic data systems and the Department of Health and Human Services' meaningful use requirements. Further, experience gained in establishing access to clinical data for patients with commercial coverage can guide and inform establishing similar access to such data for Medicare beneficiaries (e.g., establishing arrangements with reference laboratories to receive electronic laboratory results for patients undergoing select tests). However, we emphasize that the current measures in this set are indicators of specific processes of care and, while evidence-based, they may not always reflect the most effective and efficient ways for ACOs to improve care for their patient population. Advanced measures (and perhaps for some types of patients, core measures of patient outcomes) are potentially more direct, better ways of assessing whether an ACO is actually achieving better overall patient-centered care and results for their patients than these individual process measures. Consequently, we believe that these clinical process measures should be included in payment primarily as an interim step as ACOs develop better ACO capabilities to directly support patients in receiving the care they want and achieving better results. In areas where ACOs have a well-developed capability to produce core plus advanced measures, scores on interim clinical process measures should not determine whether ACOs achieve maximum shared savings.
- ***Advanced measures*** are those appropriate for organizations that are prepared to produce compelling performance measures beyond those in the core and that reduce the need for dependence on interim clinical process measures. We expect that these measures should be feasible by the later years of the program (as of 2015) under a two-sided risk model, and in organizations that progress to an ACO Pioneer-type model with payment based in part on population health. This more advanced set of performance measures may take time for CMS and collaborators to develop fully, but that development will occur much more quickly if there is a clear incentive and pathway for organizations that wish to do so. These measures more fully address key issues that matter for patients beyond the outcome and patient experience measures included in the core set, including frailty (e.g., a care planning process that is well understood by the patient and caregivers, effective transition management); quality of life and functional outcomes for common conditions (e.g., AMI, hip replacement, diabetes); level of informed patient choice for common preference-sensitive conditions; and episode-based resource use metrics linked to quality of life, functional, and patient engagement measures for common medical and surgical conditions. CMS should rapidly identify compelling, sound, and feasible metrics that address such critical priorities. Such measures should also be emphasized in and aligned with stages 2 and 3 of the meaningful use incentive program, and other CMS, private, and state initiatives related to quality reporting.

Table 3 (below) illustrates this proposed framework with a potential core set and interim clinical process set of measures for each of the five domains proposed by CMS. Each measure is preceded by either its number in the proposed Shared Savings Program rule (e.g., #12) or "NEW" to indicate a measure that was not originally included in the rule. The method of data capture (survey, claims, clinical, or attestation) is also denoted for each measure. "Survey" refers to measures calculated using data from patient surveys. "Claims" refers to measures that can be calculated by CMS on behalf of ACOs using only administrate data from Parts A, B, and/or D. "Clinical" refers to measures that require at least some clinical data; for many of these measures, to aid ACOs with computing these measures, CMS should provide regular data feeds from based on its claims information, including a list of eligible patients to support the "denominator" definition. Provider organizations could augment the administrative data through their clinical data systems to refine the denominator population and determine if the indicated services were

provided or the desired care results achieved. Lastly, "attestation" refers to non-clinical measures (e.g., meaningful use measures) for which ACOs will attest to results reported directly to CMS.

CMS will not make measure specifications available until a later point. Therefore, we will limit our recommendations on measure specifications to ensure that certain principles are adhered to in defining these specifications:

- Rely on already available specifications for commonly used measures (e.g., when HEDIS claims or survey specifications are available, make data collection through EHRs an optional alternative rather than require it as the only source; CMS can revisit this particular issue as the health IT infrastructure of ACOs and the rest of the health care system improves.
- Assure that CMS measure specification match those being implemented outside of Medicare, so that measures derived from Medicare beneficiaries can be combined with measures derived from other patients to provide a more comprehensive picture of provider quality where possible.
- Allow sample-based measurement approaches for certain measures when population-based measurement approaches (i.e., capturing data from all eligible patients) could be burdensome for ACOs that lack complete electronic access to all required data elements for those measures for some or all their patients.
- Allow sufficient flexibility in measure specifications to allow ACOs to access equivalent data elements from readily available sources (e.g., when multiple data sources, such as registries and EHRs, might be appropriate for collection of clinical data, allow all reasonable, auditable data sources to be used).

**Table 3: Potential Measures for Core and Interim Clinical Process Measures**

| Domain | Core Measures | Interim Clinical Process Measures |
|---|---|---|
| Patient/Care Giver Experience | • (#1) CG-CAHPS - Getting Timely Care, Appointments, and Information [survey]<br>• (#2) CG-CAHPS - How Well Your Doctors Communicate [survey]<br>• (#3) CG-CAHPS - Helpful, Courteous, Respectful Office Staff [survey]<br>• (#4) CG-CAHPS - Patients' Rating of Doctor [survey]<br>• (#5) CG-CAHPS - Health Promotion and Education [survey]<br>• (#6) CG-CAHPS - Shared Decision Making [survey]<br>• (#7) Medicare Advantage CAHPS - Health Status/Functional Status [survey]<br>• (NEW) CG-CAHPS - Care Coordination [survey] | |
| Care Coordination | • (#8) Risk-Standardized, All Condition Readmission [claims]<br>• (#9) 30 Day Post Discharge Physician Visit [claims or clinical]<br>• (#10) Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility [clinical]<br>• (#11) Care Transition Measure [survey]<br>• (#12) Ambulatory Sensitive Conditions Admissions: Diabetes, short-term | |

| Domain | Core Measures | Interim Clinical Process Measures |
|---|---|---|
| | complications [claims]<br>• (#13) Ambulatory Sensitive Conditions Admissions: Uncontrolled Diabetes [claims]<br>• (#14) Ambulatory Sensitive Conditions Admissions: Chronic obstructive pulmonary disease [claims]<br>• (#15) Ambulatory Sensitive Conditions Admissions: Congestive Heart Failure [claims]<br>• (#16) Ambulatory Sensitive Conditions Admissions: Dehydration [claims]<br>• (#17) Ambulatory Sensitive Conditions Admissions: Bacterial pneumonia [claims]<br>• (#18) Ambulatory Sensitive Conditions Admissions: Urinary infections [claims]<br>• (#19) % All Physicians Meeting Stage 1 HITECH Meaningful Use Requirements [attestation]*<br>• (#20) % of PCPs Meeting Stage 1 HITECH Meaningful Use Requirements [attestation]*<br>• (#21) % of PCPs Using Clinical Decision Support [attestation]*<br>• (#22) % of PCPs who are Successful Electronic Prescribers Under the eRx Incentive Program [attestation]*<br>• (#23) Patient Registry Use [attestation]* | |
| Patient Safety | • (#24) Health Care Acquired Conditions Composite [claims]<br>• (#25) Health Care Acquired Conditions: CLABSI Bundle [claims]<br>• (NEW) Annual monitoring for patients on persistent medications [claims] | |
| Preventive Health | • (#28) Mammography Screening [claims]<br>• (#30) Cholesterol Management for Patients with Cardiovascular Conditions [clinical] | • (#29) Colorectal Cancer Screening [clinical]<br>• (#26) Influenza Immunization [clinical or survey]<br>• (#27) Pneumococcal Vaccination [clinical or survey]<br>• (#31) Adult Weight Screening and Followup [clinical]<br>• (#33) Tobacco Use Assessment and Tobacco Cessation Intervention [clinical |

* We recommend that CMS allow organizations of various levels of meaningful use to participate at the outset of the program. Our experience is that organizations that do not have EHRs or other electronic clinical data systems in place for all their providers and patients can still make significant improvements in care, and that the experience and care improvement framework developed through these early steps can make subsequent health IT implementation more efficient and effective. Moreover, the requirements to provide performance results that may be efficiently computed through electronic data on the one hand, and access to shared savings in the early years of the program on the other hand, provide additional support for ACOs to quickly progress on a pathway to significantly greater meaningful use of electronic health record systems over time.

| Domain | Core Measures | Interim Clinical Process Measures |
|---|---|---|
| | | or survey]<br>• (#34) Depression Screening [clinical] |
| At-Risk Populations / Frail Elderly | | |
| *Diabetes* | • (#35) Diabetes Mellitus: Hemoglobin A1c Control (<8%) [clinical]<br>• (#40) Diabetes Mellitus: Hemoglobin A1c Poor Control (>9%) [clinical]<br>• (#37) Diabetes Mellitus: Low Density Lipoprotein (LDL-C) Control in Diabetes Mellitus [clinical]<br>• (#41) Diabetes Mellitus: High Blood Pressure Control in Diabetes Mellitus [clinical]<br>• (#42) Diabetes Mellitus: Urine Screening for Microalbumin or Medical Attention for Nephropathy in Diabetic Patients [clinical]<br>• (#43) Diabetes Mellitus: Dilated Eye Exam in Diabetic Patients [claims] | • (#35) Diabetes Composite (All or Nothing Scoring) [clinical]<br>• (#38) Diabetes Mellitus: Tobacco Non Use [clinical]<br>• (#39) Diabetes Mellitus: Aspirin Use [clinical]<br>• (#44) Diabetes Mellitus: Foot Exam [clinical] |
| *Heart Failure* | • (#45) Heart Failure: Left Ventricular Function (LVF) Assessment [claims or clinical] | • (#46) Heart Failure: Left Ventricular Function (LVF) Testing [clinical]<br>• (#47) Heart Failure: Weight Measurement [clinical]<br>• (#48) Heart Failure: Patient Education [clinical]<br>• (#49) Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) [clinical]<br>• (#50) Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD) [clinical]<br>• (#51) Heart Failure: Warfarin Therapy for Patients with Atrial Fibrillation [clinical] |
| *Hypertension* | • (#68) Hypertension (HTN): Blood Pressure Control [clinical] | • (#59) Hypertension (HTN): Plan of Care [clinical] |
| *COPD* | • (#60) Chronic Obstructive Pulmonary Disease (COPD): Spirometry Evaluation [claims or clinical] | • (#61) Chronic Obstructive Pulmonary Disease (COPD): Smoking Cessation Counseling Received [clinical]<br>• (#62) Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy based on FEV1 [clinical] |
| *Frail Elderly* | • (#64) Osteoporosis Management in Women Who had a Fracture [claims or clinical] | • (#63) Falls: Screening for Fall Risk [clinical]<br>• (#65) Monthly INR for Beneficiaries on Warfarin [claims] |

| Domain | Core Measures | Interim Clinical Process Measures |
|---|---|---|
| *Miscellaneous* | • (NEW) Persistence of beta-blocker treatment after a heart attack [claims]<br>• (NEW) Anti-Depressant Medication Management - Acute Phase [claims]<br>• (NEW) Anti-Depressant Medication Management - Continuation Phase [claims]<br>• (NEW) Disease Modifying Anti-Rheumatic Drug (DMARD) Therapy [claims] | • (NEW) IVD: Use of Aspirin or Another Antithrombotic [clinical]<br>• (NEW) IVD: Complete Lipid Panel and LDL Control [clinical]<br>• (NEW) ESRD: Plan of care for inadequate hemodialysis, adult [clinical]<br>• (NEW) ESRD: Plan of care for inadequate peritoneal dialysis, adult [clinical] |

## Analysis of specific domains

Below, we discuss each of the proposed domains in greater depth and, where relevant, make specific recommendations regarding the measures that CMS has proposed for each of these domains.

### Patient/care giver experience

Measuring patient and care giver experience is an essential component of patient-centered health care. We agree with CMS's plan to rely on surveys that are already in use and that belong to the family of CAHPS surveys. As described in the proposed rule, the Patient/Care Giver Experience domain includes four constructs, or groups of closely-related individual items, from the CAHPS Clinician and Group Survey (CG-CAHPS) core questionnaire. Because these constructs are widely used, requiring ACOs to use CAHPS will facilitate measure standardization and comparability of survey results across performance improvement initiatives. We also applaud CMS for including a construct on shared decision-making from the CG-CAHPS supplemental item set. Shared decision-making has been shown to promote consumer engagement and enable patients to make better decisions about their care.[10]

Patient and care giver perceptions of care coordination are also highly relevant to assessing ACO performance. The National Priorities Partnership (NPP) has identified improving care and achieving quality "by facilitating and carefully considering feedback from all patients regarding coordination of their care" as a central goal.[11] Studies have demonstrated both that patient reports of poor care coordination correlate with worse health outcomes[12] and that patient satisfaction with care coordination can be improved through well designed interventions.[13,14] Further, several care coordination items are likely to be included in the forthcoming CAHPS Patient-Centered Medical Home Survey. These constructs and items should be considered by CMS for inclusion. Claims-based measures of care coordination, while important, are not sufficient on their own to address the effects of care coordination efforts on patients and care givers.

CMS has included a "Health Status/Functional Status" construct from Medicare Advantage CAHPS, designated as NQF #6, in the proposed Patient/Care Giver Experience domain. We support the goal of

[10] O'Connor AM., Bennett CL, Stacey D, Barry M, Col NF, Eden KB, Entwistle VA, Fiset V, Holmes-Rovner M, Khangura S, Llewellyn-Thomas H, Rovner D. Decision aids for people facing health treatment or screening decisions. Cochrane Database of Systematic Reviews. 2009; 3: CD001431.
[11] NQF. Preferred practices and performance measures for measuring and reporting care coordination: a consensus report. Washington (DC): NQF; 2010.
[12] Weinberg DB, Gittell JH, Lusenhop RW, Kautz CM, Wright J. Beyond our walls: impact of patient and provider coordination across the continuum on outcomes for surgical patients. Health Services Research. 2007; 42(1): 7-24.
[13] Farmer JE, Clark MJ, Drewel EH, Swenson TM, Ge B. Consultative care coordination through the medical home for CSHCN: a randomized controlled trial. Maternal and Child Health Journal. 2010 Aug 19 [Epub ahead of print].
[14] Corbett HM, Lim WK, Davis SJ, Elkins AM. Care coordination in the Emergency Department: improving outcomes for older patients. Australian Health Review. 2005; 29(1): 43-50.

incorporating more meaningful health status and functional status measures as this program proceeds. However, Medicare Advantage CAHPS does not clearly define a discrete health status or functional status constructs, and NQF #6 refers to the CAHPS Health Plan Survey (HP-CAHPS) rather than to Medicare Advantage CAHPS. Therefore, it is unclear what measures constitute the proposed "Health Status/Functional Status" construct. Regardless of which measures are chosen, while health status and functional status have been used for risk adjustment, these constructs are not currently used for accountability purposes in any major performance improvement or pay-for-performance initiative of which we are aware. In fact, a 2002 report commissioned by CMS found that health status scores, as measured using the Health Outcomes Survey, have limited value for identifying high- and low-performing physician group practices or small geographic areas.[15] The incorporation of compelling outcomes measures such as health status and functional status measures is an essential part of the advanced measurements we have described. CMS and other Health and Human Services' departments must fast-track measures development and testing efforts that will allow such measures to be used for payment purposes. Moreover, the identification of convincing outcome measures to replace less compelling process measures should be a major priority to reduce measurement burden and focus on the identification of patient-focused results for important areas of care. Such measures are generally of much greater interest to physicians focused on improving care and address "value" more effectively than process measures.

CMS has not specified if it will use a leveraged approach or a centralized approach to implement a patient survey. Using a leveraged approach, ACOs would bear the cost of survey collection, but would be allowed to integrate the required survey items into their existing surveys. A 2005 report commissioned by CMS estimated that the average cost for hospitals to collect 27-item HCAHPS as a separate survey was between $11.00 and $15.25 per complete survey, while the average cost to incorporate HCAHPS into an existing survey was only $3.26 per complete survey.[16] Therefore, allowing ACOs to incorporate the required CAHPS constructs into existing surveys would likely significantly reduce costs to ACOs. Using a centralized approach, on the other hand, CMS would field a standardized survey on behalf of all ACOs. This would reduce the burden on ACOs to implement a survey altogether. Regardless of whether CMS uses a leveraged or a centralized approach, CMS should use a survey methodology that ensures that those most likely to experience the unique benefits of ACOs, such as those with multiple chronic conditions and visits across multiple care settings, are well represented in patient survey samples.

To ensure that the results of patient and care giver experience surveys are useful to ACO providers and can directly inform improvements in care, ACOs and providers should receive feedback from care experience surveys regularly, preferably more than once a year. Experience with the Brookings-Dartmouth ACO pilot sites and their payer partners has shown that survey results are best shared with ACOs on a quarterly basis at minimum in order to provide actionable information that allows providers to improve care more rapidly.

***Recommendations***

- Add a care coordination construct to the patient/care giver experience domain. This construct could include one or more of the following constructs and measures:
    - Follow Up Test Results (CG-CAHPS core #22)
    - Other Doctors and Providers at Your Doctor's Office (CG-CAHPS supplement OD1-OD9)
    - Provider Knowledge of Specialist Care (CG-CAHPS supplement PK1-PK2)

[15] Trisolini MG, McCall NT, Pope GC, Klosterman M. Evaluating the two-year follow-up health status of Medicare fee-for-service beneficiaries using the Health Outcomes Survey [Internet]. RTI International. 2002 Nov 25 [cited 2011 May 6]. Available from: http://hosonline.org/surveys/hos/download/HOS_FFS_2YR_Health_Status.pdf

[16] Jordan H, White A, Joseph C, Carr D. Costs and benefits of HCAHPS: final report [Internet]. Abt Associates Inc. 2005 Oct 5 [cited 2011 May 6]. Available from: https://www.cms.gov/HospitalQualityInits/downloads/HCAHPSCostsBenefits200512.pdf

        - Your Care from Specialists in the Last 12 Months (CG-CAHPS supplement SC1-SC8)
        - Coordination of Care from Other Health Providers (HP-CAHPS supplement OHP1-OHP5)
    - Provide sub-regulatory guidance on the definition, specific use, and risk-adjustment approaches for any health and functional status construct. Monitor performance for this construct within the Shared Savings Program before determining how performance should be linked to shared savings.
    - Use a leveraged survey approach (as in the HCAHPS survey program) and permit ACOs to incorporate the required patient/care giver experience constructs into their existing surveys to reduce burden.
    - Provide guidelines or detailed survey protocol regarding the fielding of the required patient/care giver experience survey that includes information on the frequency with which the survey is conducted, sampling, level of results reporting, and mode of distribution. Allow for fielding of surveys that allows ACOs to receive more frequent feedback on the care that they provide (e.g., monthly/quarterly sampling). Lastly, allow oversampling to allow ACOs to internally report survey results at the practice level or the individual physician level as means to give ACO participants actionable, personalized feedback on patient-reported metrics.
    - Over-sample patients with chronic conditions in order to ensure that patients with the most contact with ACOs are sufficiently represented in ACO patient experience surveys.
    - Do not restrict ACO patient/care giver experience surveys to Medicare beneficiaries, similar to HCAHPS.
    - Collect surveys via mail and telephone, as opposed to mail only or telephone only, to ensure the representativeness of the sample to the broader population.

### Care coordination: transitions, information systems

We agree with CMS's decision to include measures of care coordination and incorporate elements of the meaningful use incentive program into the Shared Savings Program. Some of the measures in this domain may be difficult for ACOs to consistently capture at the outset of the program. Further, some of the proposed measures, such as those relating to ambulatory-sensitive conditions, require a very large sample size to produce valid results. Given that some ACOs will not approach the necessary population size for statistical validity, these measures may not be reliable enough to use in the Shared Savings Program. For example, due to the relatively low incidence of admissions for diabetes (short-term complications) and uncontrolled diabetes, organizations with less than 20,000 Medicare enrollees might not accumulate more than 10 cases per year on average.

***Recommendations***

- Evaluate the incidence of admissions for ambulatory-sensitive conditions in each ACO. If these measures are likely to be unstable due to insufficient enrollment size, this instability should be considered by CMS before tying performance results to shared saving.

### Patient safety

Patient safety is a critically important area of care and should be measured across care settings. The measures proposed for the Patient Safety domain pertain only to measurement of safety in inpatient care settings; no ambulatory patient safety measures have been included. Medication safety is one particularly important aspect of patient safety in an ambulatory setting. Among those aged 65 and older, 87% of all hospitalizations from unintentional drug overdose were due to drugs that commonly require outpatient

monitoring.[17] In addition, there was an estimated 177,504 emergency room visits for adverse drug events among patients 65 years of age or older in 2004 and 2005.[18] Therefore, the addition of patient safety measures with low data collection burden and that pertain to ambulatory care will be beneficial. The "Annual Monitoring of Patients on Persistent Medications" measure, for example, is widely used and can be computed through Parts A, B, and D Medicare claims data.

***Recommendation***

- Add the "Annual Monitoring for Patients on Persistent Medications" measure to the core measure set.

### Preventive health

Several measures in this domain require data that are not readily available or are not captured consistently even in EHRs. For example, physicians may not routinely capture influenza immunization, as patients can easily receive this vaccination outside of the physician office, unless they keep a "problem list" in patients' medical record. As a result, CMS should consider if current data collection specifications (via patient survey) for three of the proposed measures (influenza immunization, pneumococcal vaccination, and tobacco use and assessment) can be relied on, at least until electronic clinical data capture systems are more sensitive to this information or until more effective measurement alternatives are developed. Using survey-based data collection approaches would also allow these measures to be included in the core set.

***Recommendation***

- Place the following measures, all of which require clinical data that cannot be easily captured at present, in the interim clinical process measure set:
    - Colorectal Cancer Screening
    - Influenza Immunization (or included as survey measure in core set)
    - Pneumococcal Vaccination (or included as survey measure in core set)
    - Adult Weight Screening and Follow-up
    - Tobacco Use Assessment and Tobacco Cessation Intervention (or included as survey measure in core set)
    - Depression Screening

### At-risk populations: diabetes, heart failure, coronary artery disease, hypertension, COPD, frail elderly

The final domain includes the greatest number of measures and spans a number of at-risk populations, including the frail elderly and patients with diabetes, coronary artery disease, hypertension, and chronic obstructive pulmonary disease (COPD). We commend CMS for their attention to these populations. We anticipate that many potential ACOs are not currently capturing some required data elements in a standardized way for a subset of measures in this domain, despite being able to implement important improvements in care for patients with these diseases. In particular, we foresee challenges extracting standardized, comparable information on aspirin use and patient education, which would impact the following measures:

- Diabetes Mellitus: Aspirin Use; and
- Heart Failure: Patient Education.

[17] Budnitz DS, Pollock DA, Weidenbach KN, Mendelsohn AB, Schroeder TJ, Annest JL. National surveillance of emergency department visits for outpatient adverse drug events. JAMA 2006 Oct 18;296(15):1858-66.
[18] Budnitz DS, Shehab N, Kegler SR, Richards CL. Medication use leading to emergency department visits for adverse drug events in older adults. Ann Intern Med 2007 Dec 4;147(11):755-65.

Further, a number of performance measures for which CMS plans to provide denominator data using the Group Practice Reporting Option (GPRO) tool require clinical data to validly identify the eligible population. Hence, clinical data may be necessary to be able to exclude some inappropriately identified patients from the denominator. These measures include:

- Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD);
- Heart Failure: Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Left Ventricular Systolic Dysfunction (LVSD);
- 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);
- Chronic Obstructive Pulmonary Disease (COPD): Bronchodilator Therapy based on FEV1; and
- Falls: Screening for Fall Risk.

Challenges a potential ACO might face in adapting its IT infrastructure to capture and extract the needed data elements electronically are discussed in detail later in these comments (Section 425.17).

***Recommendations***

- Review measure specification carefully to ensure that required data elements for measures that ACOs are expected to report immediately are routinely captured today through electronic data systems. Over time, alignment with specifications required for meeting meaningful use requirements are essential.
- Delete a process measure of "blood pressure" measurement (#32), if a measure focusing on blood pressure level (#68) is included.
- Clarify strategy for producing an appropriate denominator sample for those measures for which clinical data would be necessary to produce a clean denominator by oversampling the denominator for patients with the condition of interest, requiring ACOs to confirm the appropriate denominator patients, and gathering numerator information accordingly.

## Incorporating measurement into the shared savings program

We recommend that CMS incorporate the core/interim clinical process/advanced measure set approach into Tracks 1 and 2 in different ways to reflect differing levels of risk and expected performance measurement capacity. This approach provides flexibility in ensuring that the Shared Savings Program is attractive to many motivated provider organizations in beginning to implement sustainable efforts to transform care. Scoring of individual measures and domains should be adjusted accordingly to accommodate this approach. Below, we discuss our recommendations for the link of performance measurement and payment in Tracks 1 and 2 in greater detail.

In Track 1, only the core set of measures would be required for accurate and complete reporting in year 1 of the Shared Savings Program. In each successive year, performance on the core measures would be tied to payment. In addition, with each successive year of the program, interim clinical process measures would be added as shown in Table 4 below. In year 2, ACOs would be required to report on a certain number of the clinical process measures (e.g., one-third of the set). In year 3, ACOs would report these measures for payment based on performance and would collect additional clinical process measures for reporting only. This process would continue such that in year 5, ACOs would collect all core and interim clinical process measures for payment. Where ACOs have developed and implemented advanced measures in the same major clinical areas as the process measures, they should be able to substitute these measures for payment purposes. CMS should consider letting organizations choose the sequence for which of the measures from beyond the core set would be collected and tied to payment; this would enable the organizations to focus first on areas where they believe they have the greatest opportunities for

care improvements. For further reference of the relationship between quality measurement and payment please see Section 425.7.

**Table 4: Proposed Progression of Performance Measurement in Track 1**

| | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|
| **Core Measure Set** | Reporting (all) | Payment for Performance (all) | Payment for Performance (all) | Payment for Performance (all) | Payment for Performance (all) |
| **Interim Clinical Process Measure Set** | | Reporting (33% of measures) | Payment for Performance (33% of measures)<br>Reporting (33% of measures) | Payment for Performance (66% of measures)<br>Reporting (33% of measures) | Payment for Performance (all) |

As discussed above, Track 2 is designed for organizations with sufficient health IT capacity to produce advanced performance measures. Accordingly, in Track 2, ACOs would be required to accurately and completely report half of the clinical interim measures in year 1 in addition to the core set, as shown in Table 5 below. In year 2, those measures would be collected for performance scoring and the remaining clinical interim measures would be required for reporting. In year 3, performance on all core and interim clinical measure results would be tied to payment. In years 4 (2015) and 5 (2016), CMS would introduce advanced measures into the program.

**Table 5: Proposed Progression of Performance Measurement in Track 2**

| | Year 1 | Year 2 | Year 3 | Year 4 | Year 5 |
|---|---|---|---|---|---|
| **Core Measure Set** | Payment for Reporting (all) | Payment for Performance (all) | Payment for Performance (all) | Payment for Performance (all) | Payment for Performance (all) |
| **Interim Clinical Process Measure Set** | Reporting (50% of measures) | Payment for Performance (50% of measures)<br>Reporting (50% of measures) | Payment for Performance (all) | Payment for Performance (all) | Payment for Performance (all) |
| **Advanced Measure Set** | | | | Reporting (TBD, but movement beyond clinical process is expected) | Reporting (TBD) |

## Methodology for calculating a performance score for each measure within a domain using option 1 (performance score approach) and methodology for calculating a performance score for each domain

In considering the proposed approach to quality scoring, Brookings-Dartmouth reviewed other programs and approaches to quality scoring and distribution of incentives or shared savings. In Table 6 below, we have listed the programs we reviewed, the quality scoring model used (i.e., whether the program used a performance attainment-only approach or one that took into account either attainment or improvement), and the measure scoring approach (i.e., whether the program scored measures on a threshold or continuum between a threshold [lower bound] and benchmark [upper bound])

### Table 6: Quality Scoring

| | Quality Scoring Model | | Measure Scoring | |
|---|---|---|---|---|
| **Program** | **Attainment Only** | **Attainment OR Improvement** | **Threshold** | **Continuum** |
| MHCQ Demonstrations | X | | X | |
| Physician Group Practice (PGP) Demonstration | | X | X | |
| BCBS MA Alternative Quality Contract | X | | | X |
| CMS Value-Based Purchasing | | X | | X |
| IHA | | X | | X |

We support CMS's proposed approach to score individual measures on a continuum between a threshold (lower bound) and benchmark (upper bound). However, we also recommend scoring on a sliding scale based on either attainment OR improvement targets. In this model, both an attainment scale and an improvement scale are determined for the ACO, and the year's performance score is reviewed against each scale. An attainment scale would resemble the approach used in the proposed rule: no points are awarded for performance below the 30$^{th}$ percentile and a maximum of two points are awarded for performance above the 90$^{th}$ percentile. An improvement scale could be modeled after the approach described in CMS' Hospital Value-Based Purchasing: no points are awarded for performance below the previous year's performance, and a maximum of two points awarded for performance at the attainment benchmark, or the 90$^{th}$ percentile. The ACO would be awarded the higher of the two scores.

In addition, we reviewed currently available national averages of performance measure results to better understand how the proposed scoring approach might impact potential ACOs. For certain measures, the spread between the 90th and 10th percentile can be very narrow. For instance, based on NCQA State of Health Care Quality Medicare HMO measure reported data, the national average for Cholesterol Management for Patients with Cardiovascular Conditions is 84%, while the 90th percentile and 10th percentile are 92% and 77%, respectively. Reliably scoring such measures on a "performance curve" is a challenge.

Further, we reviewed the literature for approaches related to benchmarking and reference populations. In particular, we found that MedPAC advises reporting quality measurement results at the level of the Medicare Advantage payment area; these geographic units consist of metropolitan statistical areas (provided they do not cross state boundaries) and National Center for Health Statistics health service

areas for nonmetropolitan areas. MedPAC also suggests calculating fee-for-service quality results for purposes of comparing MA and FFS using the same geographic units.[19] In addition, benchmarks should not be calculated based on the performance by ACOs only, but be based on regional benchmarks taking fee-for-service and other payment arrangements in the public and private sectors into account. In that way, ACOs would be incented to outperform the "traditional" Medicare program.

Finally, we assessed the presence or absence of risk-adjustment strategies for the proposed measures. As outlined in the Table 7 below, several of the 65 proposed measures that the regulation suggests are risk-adjusted for different factors:

**Table 7: Adjustment Factors**

| Measure | Adjustment Factors | Notes |
|---|---|---|
| All-condition readmission (#8) | Demographics and comorbidities | |
| Ambulatory sensitive condition admissions (#12-18) | Age and sex | Studies have adjusted by age, sex, income, and health status; however, AHRQ specifies age-sex adjustment |
| Patient safety indicators (part of #24) | Age and sex | Studies have adjusted by gender, age, poverty, and health status; however, AHRQ specifies age-sex adjustment. |

Baseline patient risk should be taken into consideration when measuring quality and tying quality to shared savings payments or losses. Many measures are not risk-adjusted, including survey-based measures, attestation-based measures, and process measures. Given that many of the proposed measures are process-based or have specific denominators, there is little reason to risk-adjust. Further, given that actual spending and benchmark spending are risk-adjusted, the savings to which the quality score is applied is already risk-adjusted by demographics and health status. As measures become more sophisticated, consistent and effective risk adjustment methods may become more important.

***Recommendations***

- Develop a methodology that will address how measures for which individual ACOs have small eligible populations (e.g., N< 30) can be reliably and fairly scored.
- Maintain the proposed approach to score individual measures on a continuum between a threshold (lower bound) and benchmark (upper bound).
- Score based on improvement OR attainment targets. In this model, both an attainment scale and an improvement scale are determined for the ACO, and the year's performance score is reviewed against each scale; the ACO is awarded the higher of the two ratings.
- To the extent possible, calculate benchmarks on a regional level (e.g., at the geographic unit level that MedPAC has recommended for Medicare Advantage payments). Benchmarks should not be based on the performance of ACO providers alone.
- Develop approaches to reliably and fairly score measures with a narrow distribution (taking into account random error). For example, some initiatives have implemented

[19] MedPAC. March 2010 Report to the Congress--Medicare Payment Policy: Chapter 6. Available from: www.medpac.gov/chapters/Mar10_Ch06.pdf

"threshold" scoring for such measures alongside different scoring methods for other measures in their shared savings or incentive programs.
- Continue to risk-adjust outcomes-based measures that have been previously risk-adjusted using the most robust adjustment possible (i.e., based on diagnoses, not just age and sex).
- Risk-adjust outcomes measures that have not been previously risk adjusted in subsequent contract periods.
- Do not risk-adjust process measures and patient experience measures unless evidence indicates such adjustment is important.

## Shared savings eligibility

CMS has proposed that the quality measures for the Shared Savings Program will be divided into five domains for the purpose of scoring. Individual scores for the measures within each domain will be added to determine domain scores, and each domain will be weighted equally in determining an ACO's overall quality performance score.

Sorting proposed measures into a core and interim clinical process measure set as we have proposed creates a more equal distribution of measures across domains for the core set. Under such a scenario, equal weighting of domains based on assigned measures will ensure that providers can be equally motivated to work on all measures and domains simultaneously. With uneven measure distribution across domains, measures in sets with relatively more measures may be relatively less valued for improvement as the contribution of each measure towards accessing shared savings is relatively less.

To accommodate core and interim clinical process measures, as proposed above, we recommend making modifications to the proposed scoring methodology.

***Recommendations***

- Weigh each domain in the core set equally in determining an ACO's overall score on the set of core measures.
- Score interim clinical process measures individually rather than by domain.

## 425.11 Incorporation of Other Reporting Requirements Related to the PQRS and EHR Technology under Section 1848 of the Act

### Physician quality reporting system

CMS plans to align PQRS requirements with the Shared Savings Program such that no extra reporting will be required of ACO participants to earn PQRS incentives. Eligible professionals that are ACO participants will constitute a group practice for PQRS and will be able to submit PQRS data through the ACO. To qualify for the PQRS incentive, eligible professionals must submit all 65 measures proposed for the Shared Savings Program; failure to meet the Shared Savings Program standard will preclude eligible professionals from receiving a PQRS incentive. We applaud CMS for considering the aligning of requirements across multiple programs but as we mention in our comments under Section 425.10, we are proposing a core set of quality measures and an advanced set of quality measures. To stay consistent with the intention of CMS to align PQRS requirements with the Shared Savings Program, we recommend substituting the proposed 65 measures with our suggested Core Measure Set.

***Recommendation***

- Substitute the Shared Savings Program proposed set of 65 measures with the Brookings-Dartmouth Core Set of Measures for purpose of PQRS incentive (as proposed in our comments to Section 425.10)

### EHR technology

We agree with CMS on the need to promote the deployment and meaningful use of health IT and to align measures across programs. Organizations currently face a number of barriers and facilitators to health IT adoption that should be examined. A timeline for full EHR adoption includes the following steps:

- Decision to purchase an EHR system;
- Selection of a product and/or vendor;
- Preparation and planning for pre-implementation;
- Implementation; and
- Post-implementation training.

Currently, EHR adoption rate are still low, especially for fully functional systems that ACOs will need to efficiently support the quality measurement required by the regulation. Fully functional systems can store information on patients, patient problems, clinical notes, prescription orders, test results, medical history and follow-up, test orders, drug interactions, electronic information, and reminders. In contrast, a basic system can only perform a subset of these functions—it can store patient information, patient problems, clinical notes, prescription orders, and test results. A national survey conducted by the Office of the National Coordinator in 2008 found that 4% of physicians have an extensive, fully functional EHR system and 13% have a basic system.[20] Another survey conducted by the Centers for Disease Control in 2008 and 2009 found that 4% of physicians have a fully functional system and 17% have a basic system.[21] Despite a low current EHR adoption rate, 80% of hospitals and 40% of physicians say they intend to participate in the Meaningful Use incentive program. In a 2010 survey of 643,000 physicians

[20] DesRoches, Catherine, Eric Campbell, Sowmya Rao, Karen Donelan, Timothy Ferris, Ashish Jha, Rainu Kaushal, Douglas Levy, Sara Rosenbaum, Alexandra Shields, and David Blumenthal. "Electronic Health Records in Ambulatory Care—A National Survey of Physicians." The New England Journal of Medicine. 2008: 359(1).

[21] Hsiao, Chun-Ju, Paul Beatty, Esther HIng, David Woodwell, Elizabeth Rechtsteiner, and Jane E. Sisk. "Electronic Medical Record/Electronic Health Record Use by Office-based Physicians: United States, 2008 and Preliminary 2009." National Center for Health Statistics, Centers for Disease Control. 2009.

conducted after the passage of the American Recovery and Reinvestment it was found that EHR adoption increased significantly ranging from 29% to 73%, depending on practice size, ownership, and affiliations. Adoption rates grew most strongly in practices owned by hospitals or health systems; growth in small practices was the least strong. [22]

Various stakeholders have pointed out barriers to EHR and other health IT adoption. The foremost barrier is capital costs. The estimated average costs for initial implementation range from $33,000[23] to $47,000[24] per physician, and maintenance was estimated to be $1,500 per physician per month.[25] Frequently, capital equipment expenditures are funded directly from physician income, making physician groups wary of implementing EHRs. In addition, actual costs often overrun expected costs and/or vendor estimates.

Brookings-Dartmouth pilot sites estimate that successfully reporting all of the proposed Shared Savings Program measures would cost between $2-4 million (more than the $1.7 million average for PGP sites). Moving from paper to EHR costs roughly $60-100K per provider. The lack of a ramp-up period for systems improvements may prevent some organizations from participating in the Shared Savings Program. Return on investment is another concern of providers that can hinder EHR adoption. Health IT and EHR benefits are only fully realized if workflow is re-designed. Therefore, benefits may be difficult to realize and providers may be uncertain that the benefits of EHRs will outweigh the costs.

Other barriers to widespread EHR adoption include dissatisfaction with available systems/vendors and concerns around implementation (e.g., the purchased system would soon become obsolete, ease of use and reliability of systems, provider capacity to implement, loss of productivity of up to 15% in early months of implementation, need to redesign workflow around health IT).

Despite the barriers to health IT adoption, there are several important facilitators as well. Frequently cited facilitators of health IT adoption include federal financial incentives (e.g., meaningful use) and protection from personal liability for record tampering by external parties. An ONC survey found that PCPs and practitioners in large group settings are more likely to use EHRs than other types of providers. Groups with more than 50 physicians were three times as likely to have basic system and four times as likely to have fully functional system as groups of three or fewer.

Balancing barriers and facilitators, the Brookings/Dartmouth pilot sites estimate that it could take two to five years to finish building the health IT infrastructure necessary to report all of the proposed Shared Savings Program measures using EHRs. Additional staff, improved information technology services, and changes in the current allocation of staff across the organization will be necessary to meet these challenges. Many organizations have begun this transformative process, but will require additional time to deploy health IT comprehensively and consistently throughout the delivery system. For example, the University of Illinois Medical Center took six years to plan and implement EHRs. It took three years for Cincinnati Children's hospital to add new functions to their current IT infrastructure. Harvard Vanguard, previously a large multi-specialty group, took four to five years to move from making the decision to have an EHR to a fully deployed, functional EHR.[26]

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[22] "Physician Office Usage of Electronic Healthcare Records Software," SK&A, October 2010. http://www.skainfo.com/press_releases.php?article=99.

[23] Gans, David, John Kralewski, Terry Hammons and Bryan Dowd. "Medical Groups' Adoption Of Electronic Health Records And Information Systems." Health Affairs. 2005: 24(5).

[24] Fleming, Neil, Steven Culler, Russell McCorkle, Edmund Becker, and David Ballard. "The Financial and Nonfinancial Costs of Implementing Electronic Health Records in Primary Care Practices." Health Affairs, 2011:30(3).

[25] Ibid.

[26] Healthcare Information and Management Systems Society. "Making IT Happen: Strategies for Implementing the EMR-EHR." 2006. Accessed at http://www.himss.org/content/files/davies/Davies_WP_Implementation.pdf.

In order to support aspiring ACOs committed to improving quality and lowering costs, flexible rules around meaningful use should be offered. Our suggested requirements for measurement and our proposed linkage to payment will offer a pathway for ACOs in ramp-up time for EHR/Health IT adoption and meaningful use.

This proposed pathway will commit organizations to specific measureable performance attainment or improvements. ACOs' efforts may be significantly aided by full deployment and meaningful use of health IT, but could also be achieved by organizations who are still building their systems. Thus, in the early years of the program, it is feasible for CMS to achieve its goals of improving quality at lower costs without requiring that 50% of ACO providers demonstrate meaningful use of health IT. ACOs will become meaningful users over the course of the program, in part further aided by the needed investments from accrued savings in the early years of the program.

***Recommendations***

- Handle EHR adoption and meaningful use requirements flexibly in the early years of the program. Such a requirement recognizes that improved quality at lower costs can be achieved by organizations without requiring that 50% of providers are demonstrated meaningful users of health IT.
- Extend Stark law safe harbors to allow for the donation of hardware and extend the exception for the donation of e-prescribing and EHR systems – set to expire at the end of 2013 – through at least the three-year contract period of the Shared Savings Program.

## 425.12 Monitoring

### Overview

Monitoring is important for protecting beneficiaries and making sure that ACOs meet the core goal of simultaneously lowering costs and improving quality for all beneficiaries. Our recommendations reflect the belief that monitoring and related sanctions should result from ACO failures to meet this goal, and should not result from failing to adhere to structural or technical requirements. Furthermore, monitoring is more meaningful when the ACO can be held accountable for its total population as well as by programs. This allows ACOs to be evaluated on its overall strengths and weaknesses at a programmatic level.

### Monitoring of ACOs: general rule

The rule cites that it may use beneficiary satisfaction surveys to monitor avoidance of at-risk beneficiaries. It is unclear what surveys have been validated for this purpose. Further, methodology for measuring levels of satisfaction may not necessarily accurately reflect quality, and it may be difficult for providers and groups with systematically different reporting mechanisms to be held accountable for this.

***Recommendations***

- Ensure that some groups do not systematically report different levels of satisfaction, unrelated to quality. If this is the case, then adjust survey results accordingly.
- Validate beneficiary satisfaction surveys for monitoring.

### Monitoring ACO avoidance of at-risk beneficiaries

We agree with CMS that avoidance of at-risk beneficiaries in order to reduce the likelihood of increasing costs to the ACO is a grave violation of the principles behind accountable care. ACOs that appear to be avoiding at-risk beneficiaries to reduce costs should be required as part of its CAP to re-assess its clinical processes, leadership, compliance plans, etc. If an ACO continues to avoid at-risk beneficiaries during or after its corrective action plan (CAP), CMS should terminate the ACO.

Close monitoring of avoidance of at-risk beneficiaries must be coupled with timely data-sharing between ACOs and CMS. Providers cannot be expected to properly budget and care for at-risk populations without timely, complete data. CMS has proposed to share aggregate reports on a quarterly basis, but should consider a more frequent sharing timeframe. Our comments on data sharing go further on this point.

In addition, monitoring of avoidance of at-risk beneficiaries should also be coupled with a spending benchmark that is risk-adjusted annually. This will relieve some of the monitoring pressure for CMS and will create a disincentive to avoid high-cost beneficiaries.

***Recommendation***

- Couple monitoring of avoidance of at-risk beneficiaries with modified prospective/current attribution, timely data-sharing, and updating benchmark risk adjustment.

### Monitoring ACO compliance with quality performance standards

Monitoring quality performance standards must focus on clinical improvement and measuring results rather than measurement capabilities. When monitoring quality performance standards, CMS should differentiate between reporting that is incomplete or inaccurate because of difficulties in measurement calculation and measures that fail to meet a clinically significant standard.

The rule says that an ACO will be given a warning if it fails to meet minimum attainment within a domain. The quality measurement provision says that all measures within a domain must have a score above the minimum attainment level in order for the domain to be eligible for shared savings. The monitoring provisions need to clarify whether a single measure within a domain failing to meet minimum attainment level is in fact the criteria to trigger a warning.

When a measure or domain fails to meet the minimum attainment level, CMS should request a written explanation from the ACO as to why it failed to meet the minimum attainment level. If CMS determines that failure was due to poor quality care, the ACO's quality performance should be closely re-evaluated the following year. If the ACO continues to fail to meet the standards in the following year, the agreement may be terminated. However, if CMS determines that the failure was due to technical difficulties in calculating and submitting the measure – and the failure was not a reflection of care quality – CMS should not require such a stringent level of monitoring and re-evaluation.

In addition, CMS may consider designating some measures as bellwether measures. Such measures would be widely used and relatively simple to calculate. If an ACO fails to meet attainment on these bellwether measures, CMS may assume that the failure is due to poor quality care, and start the CAP process.

***Recommendations***

- Differentiate between failure to comply with quality performance standards because of lack of data infrastructure and poor quality care. ACOs that fail because of poor quality care should be subject to closer monitoring than ACOs that fail because of faulty data processes.
- Designate some measures as bellwether measures. Such measures would be widely used and relatively simple to calculate. If an ACO fails to meet attainment on these bellwether measures, CMS may assume that the failure is due to poor quality care, and start the CAP process.

## 425.13 Actions Prior to Termination

We agree that ACOs should be given the opportunity to take corrective actions prior to termination. The notion of improvement is central to the Shared Savings Program, and ACOs should have the flexibility to attempt to correct non-compliance. Allowing ACOs to take corrective actions prior to termination will be especially important in year 1 of the Shared Savings Program, as it may take ACOs time to acclimate to program requirements, such as reporting using the GPRO tool. We also agree that corrective action processes do not apply to determinations made by government agencies or determinations that an ACO has violated the Sherman antitrust act, Clayton Act, or the Federal Trade Commission Act.

However, the proposed rule does not clearly define either all of the actions that could be undertaken prior to termination or the sequence in which these actions might occur. Although the NPRM states that CMS may give a warning notice, request a CAP, or place an ACO on a special monitoring plan prior to termination, the proposed rule does not clearly define either "warning notice" or "special monitoring plan." Further, the NPRM does not explicitly define the scope of violations for which a CAP would be required. Because an ACO cannot request a reconsideration review for certain determinations, per §425.15, more clarity regarding the CAP process is essential.

Further, other than when an ACO fails to meet quality standards or when an ACO's assigned population falls below 5,000, it is unclear when CMS will give a warning notice rather than a CAP. CMS provides no details about how a special monitoring plan would work or when it will be implemented. Similarly, the sequence of actions prior to termination is vague. For example, it is unclear whether an ACO that is placed on a special monitoring plan but continues to underperform would have the opportunity to then implement a CAP or whether the ACO could be terminated without further action.

***Recommendations***

- Clearly define "warning notice" and "special monitoring plan." Also, clearly define the sequence of actions prior to termination and list all of the violations that could result in each action.
- Limit the list of possible actions prior to termination as much as possible to promote parsimony and ease of understanding (unless CMS intends that the CAP, warning notice, and special monitoring plan processes will all serve distinct and necessary purposes). For example, a distinct special monitoring plan seems unnecessary given the option for ACOs to implement a CAP.
- Explicitly define the scope of violations for which ACOs will be required to submit and carry out a CAP.

## 425.14 Termination, Suspension, and Repayment of Shared Savings

The NPRM lists sixteen distinct violations for which CMS would have the discretion to terminate an agreement with an ACO. While we understand CMS's desire to ensure that ACOs conform to Shared Savings Program requirements after entry into the program, creating such an expansive list of violations that can result in termination introduces substantial uncertainty for potential ACOs and may discourage potential ACOs from participating in the Shared Savings Program.

Further, we are concerned that the NPRM may go beyond CMS's authority to terminate ACOs. Section 3022(d) of the Affordable Care Act enumerates only two grounds for termination from the Shared Savings Program: (1) avoidance of at-risk patients, in order to reduce the likelihood of increasing costs, and (2) failure to meet quality performance standards. While we agree that these specific violations should be grounds for termination, we believe that CMS may lack the statutory authority to terminate ACOs from the Shared Savings Program for many of the remaining violations listed in the NPRM.

In addition to these overarching concerns, we believe that CMS should provide further guidance on specific details of the proposed termination process. As proposed, ACOs terminating their participation in the Shared Savings Program are required to give CMS 60-day notice and to notify all ACO participants and providers, who in turn must notify beneficiaries "in a timely manner." However, CMS has given no guidance on how ACOs should notify participants and providers or how providers should notify beneficiaries. CMS has further proposed that, for minor violations that pose no immediate risk to beneficiaries, ACOs will be able to submit a CAP before termination. We agree that CMS should allow ACOs to fix problems prior to termination. However, CMS has not provided sufficient guidance on the CAP process. Since an ACO is not eligible for shared savings for the performance period under a CAP, lag time between ACO completion of a CAP and CMS final approval should be minimal and absolutely clear. For example, it would be unfair to an ACO if CMS did not sign off on a CAP until three months after the ACO had rectified the original problem. CMS might instead consider imposing fines ACOs for any violations while continuing to allow receipt of shared savings; with this option, ACOs would be better able to take appropriate corrective actions.

***Recommendations***

- Revise termination guidelines such that only avoidance of at-risk patients in order to reduce the likelihood of increasing costs and failure to meet quality performance standards are grounds for termination.
- Clarify how beneficiary notification requirements for ACOs that are terminating participation in the Shared Savings Program will be implemented.
- Clarify how long the CAP process will last and create standardized guidelines on how the process will be structured.

## 425.15 Reconsideration Review Process

Transparency will be essential to ensure that the Shared Savings Program is embraced by providers, beneficiaries, private payers, and the broader public. We agree that ACOs should be allowed to request reconsideration of certain CMS determinations, including all termination determinations except for those related to failure to meet quality performance standards.

However, we are concerned that the reconsideration review process lacks transparency. As proposed, both the initial reconsideration decision and the final reconsideration decision, if requested by the ACO, will be conducted by CMS officials. We are concerned that this system may introduce bias into the reconsideration review process and that reconsideration review decisions will not be appropriately transparent to the general public. Finally, it is unclear if ACOs continue to earn shared savings during reconsideration review for termination.

***Recommendations***

- Include non-CMS personnel in the adjudication process to prevent bias and make decision justifications publicly available.
- Clarify how shared savings will work in cases of reconsideration of review.

## 425.16 Audits and Record Retention

Auditing ACOs will be essential to ensure that ACOs follow Shared Savings Program regulations and that data produced by ACOs are accurate. We agree that ACOs should be required to retain all books, contracts, records, and documents that pertain to the ACO itself. However, the NPRM appears to suggest that ACOs will also have to keep duplicates of their individual providers' records. Because ACOs will be able to pull claims records from their providers, this requirement seems duplicative and could generate an unnecessary and costly burden upon ACOs.

Further, we agree that audit and record retention requirements for the Shared Savings Program should align with requirements for other Medicare programs as much as possible to ensure consistency across programs. We therefore support CMS's proposal to mirror Medicare Advantage with regard to requiring ACOs and their participants to maintain records for ten years from the final date of the agreement period or from the final date of an audit. However, we are concerned that CMS's proposal to extend record retention to six years from the date of final resolution in the event of termination, dispute, or allegation of fraud by the ACO organization or its members is inconsistent with requirements for other Medicare programs. The six-year record retention requirement typically applies only to disputes with government agencies and not to those between providers.

***Recommendations***

- Remove requirement that ACOs keep duplicate copies of individual providers' records.
- Apply the six-year record retention extension only to disputes between ACOs and government agencies.

## 425.17 Requirements for Quality Measures Data Submission by ACOs

### GPRO tool

We believe that CMS has taken the right approach to data submission by allowing ACOs to leverage their existing IT tools and processes to support data collection. That said, we have a number of concerns about an ACOs' ability to report on all of the measures requiring use of the GRPO data collection tool beginning in year 1 of the Shared Savings Program. Given the centrality of the GPRO tool to performance measurement and reporting in the Shared Savings Program, we are concerned that uncertainty surrounding the deployment of the GPRO tool may dissuade provider ACO participation and that unforeseen issues related to the deployment and use of the GPRO tool may hamper performance measurement and improvement efforts.

The GPRO tool is relatively new, having been deployed in 2010 for PQRS. Since 2010, only 36 large group practices and integrated delivery systems have submitted data using the GPRO tool. As a result, there have been limited opportunities to examine and make improvements to the GPRO tool. In addition, CMS plans to expand the use of the GPRO tool from 26 measures in PQRS to 47 measures in the Shared Savings Program. While CMS has proposed that the existing GPRO tool be expanded, refined, and upgraded over time, CMS does not provide sufficient information about either the process for updating the GPRO tool (e.g., the amount of time it will take to update this tool, when the tool will be available to ACOs) or the process by which users should install the GPRO tool and train staff to use it.

Furthermore, our Brookings-Dartmouth pilot sites have all reported having little to no experience with GPRO and felt that they would need technical guidance and rapid feedback on the tool itself. Feedback should therefore be at least quarterly (rather than twice a year).

***Recommendations***

- Conduct an assessment of current users' experience with the GPRO tool and identify areas for improvement before fully launching the tool for the Shared Savings Program.
- Exhibit flexibility for the use of GPRO in the first year and at a minimum, provide a contingency plan for measure submission (e.g., paper-based reporting tool) if there are unexpected delays or disruptions in the deployment of upgrades and revisions to the GPRO tool. Such contingency plans are often used in software deployment, and this practice will ensure that ACO participants will still be able to submit measure results on time for shared savings consideration. The contingency plan must be communicated in advance of any Shared Savings Program implementation and ideally should be communicated in frequent intervals to all ACOs during the five years of the program.
- Provide more clarification on the process and timeline both for updating the tool and for informing potential ACO applicants of the projected cost of using and upgrading the tool.
- Provide data in a format that allows ACOs to use the GPRO tool to calculate measure results at least quarterly, enabling ACO to have timely and actionable measure results.

### Data audits

Data audits are essential to ensure the validity of performance measure results reported by ACOs using the GPRO tool. We agree with CMS's approach for proposing a data audit process for the Shared Savings Program.

Two different types of performance measure data audits are common:

- Assessment of ability to produce valid measure results, used by the National Committee for Quality Assurance (NCQA) for HEDIS measures and the Integrated Healthcare Association (IHA) Pay for Performance Program; and

- Verification that reported measure results match data in the medical record, used by CMS in the PGP Demonstration Project and by some pilot sites in the Better Quality Information to Improve Care for Medicare Beneficiaries (BQI) Project

We support CMS's proposal to use the latter method to audit ACO performance measure results. Data audits must be comprehensive enough to ensure the validity of reported measure results, but the audit process should not be overly burdensome and hinder or detract from other ACO efforts. Focusing on data verification will ensure that measure results can be audited if necessary without requiring ACOs to undergo an additional assessment of their performance measurement process.

However, the proposed rule provides little guidance on how a data audit will be triggered and whether audits will occur on a per-domain or per-measure basis. It is unclear if CMS intends that the ACO will not receive credit for any measure in a domain with a mismatch rate greater than 10%, or if mismatches will be assessed on a per-measure basis. Further, in the PGP Demonstration, CMS repeated the entire sampling process up to three times (up to 90 medical records in total) before determining that a PGP site would not receive credit for a given domain. It is unclear if CMS is planning to use this method in the Shared Savings Program or whether only a single 30-beneficiary sample will be drawn.

***Recommendations***

- Clarify when an ACO might be required to complete a data audit. CMS should audit any ACO whose performance results change drastically from one year to the next.
- Audit at least one measure from each domain for every participating ACO in year 1. This will ensure that the GPRO tool is being used correctly and that baseline results are valid.
- Provide more guidance on how samples will be drawn when an audit is conducted. We recommend auditing on a per-measure basis because measures in each of the domains proposed for the Shared Savings Program address different conditions and have different denominators (unlike in the PGP demonstrations).

## 425.18 The 3-year Agreement with CMS

We recommend that ACOs have the option to extend contract periods beyond the minimum three years required in the Statute. Improving care delivery and efficiency is a long-term investment for providers, CMS, and patients. CMS needs to give ACOs options to align the contract timeframe and the ACO investment timeframe. If these two timeframes mismatch, the program will fail to support providers in a fundamental way. With only the option of a three-year contract, potential applicants may be unable to generate savings and may be hesitant to make the long-term investments needed to truly improve care. Giving ACOs the option to extend the time period will help the Shared Savings Program provide comprehensive support for continuous quality improvement and build the capacity to take on risk in later years. Similar programs to create a "value track" for care recognize that it takes time for providers to transform care. The Alternative Quality Contract (AQC) from Blue Cross Blue Shield of Massachusetts is for five years, the PGP Demonstration was for five years, and the Pioneer ACO program can last up to five years. [27][28][29]

***Recommendations***

- Give ACOs the option of extending their agreements for a fourth or fifth year after the three-year contract period ends (see comments to "425.7 Payment and Treatment of Savings" for more details).
    - For one-sided participants, they have one-sided risk in the first three years but will need to bear risk in the fourth and fifth years.

[27] http://www.cms.gov/DemoProjectsEvalRpts/downloads/PGP_Fact_Sheet.pdf
[28] http://www.bluecrossma.com/visitor/pdf/alternative-quality-contract.pdf
[29] http://innovations.cms.gov/wp-content/uploads/2011/05/Pioneer-ACO-RFA.pdf

## 425.19 Data Sharing

### Overview

Comments in this section reflect our recommendation that CMS shift towards a modified prospective attribution (see section 425.6). No matter the attribution model, timeliness of data sharing, content, and format are key areas for CMS's focus. With retrospective attribution, CMS's current data opt-out provision may be very challenging to implement.

### Sharing aggregate data

Aggregate data will be crucial for developing a budget, improving delivery, and managing utilization and supplier partners. Improved accountability relies on having metrics for which the ACO can be held accountable. Past experience from the Brookings-Dartmouth private ACO pilots, state ACO-like initiatives (e.g., the AQC) and other programs demonstrate that failure to provide data to providers for managing performance may be the single greatest barrier to successful implementation.

Although CMS proposes to give quarterly reports on all assigned beneficiaries to ACOs and monthly identifiable claims upon request, it is not clear what the data lag will be. Financials, utilization, and quality will only be useful to providers if it is timely. For previous demonstration or incentive programs, there was usually six-month or greater lag in CMS's data. Moreover, providers in these demonstrations have commented on the lack of accessibility of the data in the format delivered from CMS. Many ACOs, particularly ACOs with limited analytical resources (whether internal or external to the governance structure) will struggle to clean and distribute data that is provided as part of a larger "data dump." Both the time lag and format of data may hinder an ACO's ability to develop a budget and an overall quality plan.

***Recommendations***

- Work with providers and other private sector analytical vendors to get feedback on what kinds of aggregate reports and formats would be most helpful for lowering costs and improving quality.
- Ensure that data lags for aggregate reporting do not exceed three months.
- Include aggregate utilization data outside of the ACO and its suppliers.

### Data use agreement

CMS should clarify the process for entering into a data use agreement (DUA) with the ACO. The proposed rule implies that an ACO will enter into a DUA when first requesting beneficiary-identifiable data. Entering into a DUA at this point may hold up an ACO's ability to analyze claims to produce tailored care plans and budgets. We suggest that CMS work with ACOs during the application review process to start DUAs. Most—if not all—functional ACOs will request claims-level data and will need to enter the DUA. Starting the process with an ACOs application to the Shared Savings Program will save both CMS and the applicant ACO time and resources.

***Recommendations***

- Develop templates and processes for making the DUA process as expedited as possible.
- Start the DUA process during or immediately after the application review.

## Sharing beneficiary identifiable data

CMS must make sure that beneficiary-identifiable data-sharing is 1) timely and 2) useful for ACO providers. Providing ACOs – and the health professionals driving the actual improvements in care delivery – with near real-time data on their beneficiaries would enable them to take more effective steps to achieve care improvements. Timely patient-level information is crucial for helping ACOs produce high quality care, coordinate care across providers formally within the ACO and with the outside providers seen by the ACOs patients, and sustain their ACO business. In the PGP demonstration, sites struggled with delayed claims data from CMS—without timely data, sites struggled to evaluate and revise their delivery interventions. CMS is currently providing such timely "data feeds" on a monthly basis in demonstrations now, including the Medicare Health Care Quality Demonstration. Private payer ACOs, such as CIGNA, ACQ and the Brookings-Dartmouth pilot sites are also working to provide timely data feeds to their provider partners. It is also important that the ACO receive claims for patients seen by the ACO professionals within the ACO (who may be attributed in the coming year) as well as those already attributed.

For some ACOs with strong data analysis capabilities, provision of complete claims-level data for all potentially and already attributed patients will markedly enhance their ability to improve and manage care across the continuum. In addition, the current DUA process may require modification to ensure that the data can be used to best advantage for care improvement and coordination and to align the DUA requirements to the extent possible with existing HIPAA rules and the protections those rules provide to claims-based personal health information.

For ACOs with less data management capacity, providing ACOs with useful, user-friendly data that has already been processed into standardized reports will be crucial to helping them improve care and lower costs. For these ACOs, "data dumps" of raw claims may simply be ignored or they may not have the resources to bear the cost burden of having additional analysis done. While we recognize that CMS does not have the capacity to produce tailored, sophisticated reports for all ACOs, CMS can work with providers to come up with a high-leverage claims sharing strategy and formats.

***Recommendations***

- Ensure that data lags for beneficiary-level data do not exceed three months at most.
- Consider developing a modified DUA process for ACOs that allows the data to be used for care improvement and is aligned with current HIPAA rules and protections.
- Work with providers to get feedback on what kinds of high-leverage formats and sharing processes will be most helpful for sharing claims.
- Clarify that ACOs will receive all claims —including those from providers outside of the ACO.

## Beneficiary opportunity to opt-out of claims data sharing.

This recommendation pertains to the retrospective attribution model as outlined in the NPRM. We recognize the need to protect beneficiary rights, specifically as it pertains to confidentially of patient health information. At the same time, we believe the onus of requiring ACOs to provide in-person information on the use of beneficiary level data – as well as the opportunity to opt-out of data sharing – could impede the success of the Shared Savings Program. Such a restriction would prevent, for example, a physician receiving data on a patient s/he has served for years because that patient did not schedule an

appointment until six months following ACO formation. The provider would, therefore, have no data on the costs accrued by that patient in the aggregate health system due to this delay in reporting.

As an alternative, we suggest CMS allow ACOs to notify patients *prior to their office visit* through a CMS-regulated letter that would be branded by the individual ACO. Doing so would accomplish two goals: first, it allows ACOs to begin the process of receiving patient level data in a more timely fashion to manage costs; and, second, it would provide patients a more timely notification of their potential implicit participation in the Shared Savings Program. Under such a scenario, a reasonable timeframe could be set for implicit opt-in (e.g., two to three weeks after sending patient notification letters) at which point ACOs could begin requesting patient-level data from CMS.

CMS could further stipulate that the provider still provide in-person counseling on the implications of patient-level data sharing during the subsequent office visit.

***Recommendations***

- Allow ACOs to send out opt-out notifications using pre-approved CMS language so to increase likelihood of communication between physicians and their patients on this important issue.
- Provide the ACO with template language about opting out of the data sharing that the ACO should then be able to brand and adjust as needed for their beneficiaries.

## Beneficiary claims data sharing for modified prospective attribution

Should CMS adopt our recommendation of a modified prospective model of attribution, with patients able to opt out of the ACO in the beginning of the contract period while keeping their provider, the issue of data sharing should be easier given the prospective patient notification that is proposed in Section 425.6. Regardless, we recommend maintaining the regulation's existing data opt-out process but encourage providing language to facilitate this discussion between providers and patients.

***Recommendations***

- Provide three-month claims data with a minimal lag for the patients prospectively attributed starting from the beginning of the contract period.
- Maintain regulation's existing data opt-out process for patients attributing during a given year.

## 425.20 New Program Standards

To reduce uncertainty, we generally recommend that CMS refrain from establishing new program standards, particularly around shared savings, during the 3 year agreement period (or 5 year program as we recommend under Section 425.7 “Payment and Treatment of Savings”). Areas of the regulation that will require updates, such as quality measures, should be done with ample lead time and communication to participants. We especially recommend that CMS refrain from establishing new standards that will have an impact on ACO care delivery or distribution of shared savings.

***Recommendations***

- Limit the volume and frequency of regulatory updates especially around shared-savings to decrease uncertainty.

## 425.21 Managing Significant Changes

We have no comments on this section.

## 425.22 Future Participation of Previous Shared Savings Program Participants

In general, we agree with CMS' efforts to ensure that there is transparency throughout the process of participating in a shared savings program. We encourage CMS to be mindful of balancing the need for transparency with the expectations of reporting and determine how best to request disclosures from ACO suppliers and participants. Regarding the Disclosure for Participation, the NPRM requests that the ACOs participants or its providers/suppliers must report whether it has an affiliation with another Shared Savings Program ACO. We understand the need for this reporting mechanism for the sake of accountability but, given that an ACO supplier might work with several ACOs, we encourage CMS to offer a standard reporting template that is consistent and brief.

***Recommendations***

- Offer a standard template that is distinct with regard to reporting from ACO suppliers and participants who might be affiliated with multiple ACOs (in contrast to ACO providers to which patients are attributed)

## 425.23 Public Reporting and Transparency

We agree with the requirement that ACOs publicly report detailed performance information. Appropriate and meaningful public reporting serves two purposes vital to the mission of the Shared Savings Program: 1) ensuring greater accountability and fiduciary responsibility among ACOs for care delivered; and, equally important, 2) providing consumers with the data they need to make better decisions regarding the value of health care they receive. We believe the principles of public reporting in the final Shared Savings Program rule should be designed to incorporate both of these goals.

We agree that public reporting – particularly on organizational finances – clearly advances the goal of furthering accountability among participants in the Shared Savings Program. However, we also believe that the proposed requirement that specifically asks ACOs publicly report how shared savings are distributed may be too stringent, reaching beyond what is necessary to ensure public accountability. While we believe there may be opportunity to disclose such information to CMS for evaluation and informational purposes, releasing this data could drive significant financial and competitive risk to organizations and drive away participation from the program. Moreover, we think requiring such reporting exceeds precedent of other programs. The Hospital Inpatient Value-Based Purchasing Program, for example, will not require hospitals to publicly report the amount of value-based incentives received.

Further, on the goal of consumer engagement, we believe that much of the currently required information (e.g., shared savings or losses, distribution and use of shared savings, ACO structural details) do little to contribute to the goal of helping consumers make better decisions regarding the value of care they receive. Based on experience in Hospital Compare, and subsequent public-private ventures spawned out of the Community Health Data Initiative, we believe that focus must be placed not only an *quantity* of data released to public, but also on its *accessibility* and *reliability*. The accessibility of Hospital Compare, for example, comes from the focus in information it provides (e.g., address, detailed performance measure results, and Medicare volume and median payment for specific conditions). Similarly, IHA publicly reports address and performance using star ratings for participating health plans, groups, and hospitals, as well as number of providers by specialty for medical groups. On its website, IHA provides a transparency report that lists total performance payments and average per-member per-month payments for commercial HMO and POS products for each major plan, but no information is provided on how these payments were used by plans. Reporting of total all-payer per-capita costs may also help consumers choose where to receive care.

***Recommendations***

- Require ACOs to disclose distribution of shared savings only to CMS
- Develop a portal and work with private sector (potentially building off efforts already underway at CMS through the consumer health data initiative) to make accessible information of clear use to consumers (e.g., detailed performance measure results, as proposed in our comments to §425.8, and basic organizational information such as name and location, contact information, and number of participating providers and suppliers).
- Expand requirement for ACOs to publicly report total all-payer per-capita cost over time.

## 425.24 Overlap with Other CMS Shared Savings Initiatives

The exclusion of providers and suppliers who participate in other shared savings programs under Medicare is understandable from both a programmatic and financial perspective; however, we would encourage CMS to consider a mechanism to encourage other shared savings participants to align quality measures as well as consider a similar data sharing mechanism between the other programs (if they do not already occur) between CMS and the practice pilot programs under Section 1866E, 1115A or any other initiative.

The opportunity to build upon the important investments made by CMS in prior shared savings efforts should not be lost in an effort to avoid duplication of payment. Given the emphasis on quality and patient-centered care, we encourage CMS to include the other shared savings programs in any learning collaborative and technical assistance programs, as well as provide data feedback to the organizations in a similar manner that would be afforded to any prospective ACOs.

***Recommendations***

- Include data sharing with other shared savings initiatives and to encourage alignment and harmonization of quality measures that are reported in other programs
- Include other shared savings initiatives in learning collaborative and technical assistance programs.
- Consider inclusion of other shared savings initiatives in any evaluation program where methodologically appropriate or as a subset analyses.

## APPENDIX: Sample Beneficiary Notification Letter

May, 2011

Dear Member:

We're very pleased to tell you some exciting news about your health care. You've been selected to participate in an optional new pilot program from Anthem Blue Cross in partnership with your personal doctor, who is affiliated with Monarch HealthCare.

This program, called an Accountable Care Organization (ACO), was developed through collaboration between Monarch HealthCare and Anthem Blue Cross. Under this program, you'll receive all the same benefits you currently enjoy from your Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company PPO plan ("Anthem Blue Cross PPO plan"). But now, as you visit your Monarch HealthCare-affiliated doctor, you and your covered dependents will enjoy additional support and services *at no additional cost*.

These services are an enhancement to your current Anthem Blue Cross PPO plan. They're designed to help you:

- Better manage and improve your health
- Coordinate your care
- Control your health care costs

**Here's how the ACO works, and what it means to you.**

Traditionally, as a member of a PPO plan, you can choose to receive care from many doctors who are part of a broad network. This is a good system, but there is room for improvement. The most significant change we can make right now is to do a better job of coordinating your care among all of your health care providers.

If you decide to participate in the ACO, you and your dependents may continue to see any physician you wish. You're still a part of the Anthem Blue Cross PPO plan, just as you were before. However, by seeing a physician affiliated with Monarch HealthCare, you will benefit from the additional services being offered to you and your dependents through the ACO.

**The ACO is a new approach to your existing Anthem Blue Cross PPO plan.** With the ACO, you'll experience a whole new level of coordination of care.

- Your personal doctor will now have detailed clinical information about important **services you need**. Monarch HealthCare will help your doctor coordinate those services for you. This will help you maintain good health, and provide you with better clinical results and a better patient experience if you're living with a chronic condition.
- If you're experiencing a health care problem, your doctor may introduce you to a **Monarch Care Navigator**, who is a caring and knowledgeable professional who will work closely with your doctor's practice to assist you when you have complex questions about your treatment plan. Your Care Navigator will help you understand the often confusing array of health care options.
- If you need **supportive resources and programs**, your doctor will direct your Care Navigator to help you connect with them.
- If you're hospitalized, we're available to assist you in arranging any needed **therapy and follow-up visits** after you leave the hospital. Should you need to make an appointment or contact a physician, help is only a phone call away. Our goal is to keep you focused on your health and recovery.

It's easy to take advantage of all that this new ACO program has to offer. Simply choose to receive your care at the office of your Monarch HealthCare-affiliated doctor. Bring the enclosed new member ID card(s) with you the next time you visit your Monarch-affiliated doctor,* so that the office knows that you're entitled to the ACO enhancements, and destroy your old card(s). If you choose not to participate in the ACO, simply continue to use your existing cards.

Monarch HealthCare has considerable experience in supporting patients' needs with personalized assistance when you need help accessing health care services. This exciting new ACO is an excellent fit with that Monarch tradition. We're eager to bring our expertise to this innovative approach to care.

Remember, as an Anthem Blue Cross PPO member, you have the choice to seek your medical care with a doctor outside of Monarch HealthCare. You'll still be covered as you are now. You simply won't be able to enjoy the advantages the ACO has to offer.

In the coming weeks, we'll provide you with additional details about this new program. We will be working hard to satisfy all regulatory** requirements to make the launch a success. On behalf of your doctor, you may also get a call, letter or email from your doctor's office staff or Monarch HealthCare. We look forward to working with you to improve not only your health, but also your health care experience.

In Good Health,

Nancy Boerner, MD
Chief Medical Officer
Monarch HealthCare

Michael J. Belman, MD, MPH
Medical Director
Anthem Blue Cross

P.S. If you have questions...

- Start with the enclosed Frequently Asked Questions, or visit www.anthem.com/ca/aco/monarch.
- If you still have questions, please call Monarch HealthCare at 888-346-2810.
- If you wish to speak to an Anthem representative, please call the number on the back of your Anthem Blue Cross health plan ID card.

*Although you can only receive the additional ACO services with your Monarch HealthCare-affiliated doctor, your new card will work for all your Anthem Blue Cross PPO benefits, just the way your old card(s) did before.

**Pending Department of Managed Health Care approval.

## Anthem Blue Cross and Monarch HealthCare ACO Pilot Program Member FAQs

**When does the ACO program begin?**

The program is active now. Starting with your next visit to your Monarch HealthCare affiliated doctor, you and your covered dependents will enjoy additional support and services *at no additional cost*.

**What do I need to do to take advantage of the ACO?**

Just two things:

1. We've enclosed a new member ID card(s). Present your new ID card(s) when you or your covered dependents are receiving services. The "ACO" designation on your card(s) will alert your doctor's staff that you're eligible for the ACO services when you visit your Monarch HealthCare-affiliated doctor.
2. Choose to receive your medical care from physicians and hospitals affiliated with Monarch HealthCare, as you may have in the past.

**How was I selected to be part of the ACO?**

Selection criteria for the ACO program were developed by Anthem Blue Cross and Monarch HealthCare. Members selected for participation are Anthem Blue Cross PPO members who have received a majority of their care from a doctor affiliated with Monarch HealthCare.

**Can my family take part in the ACO, too?**

Yes. The covered dependents on your plan can also enjoy the enhanced care experience of the ACO.

**Will my health plan benefits, costs, deductibles or copays change?**

No. Your benefit plan remains unchanged. All that's different is the way that you'll receive health care services from your physicians affiliated with Monarch HealthCare.

**How is my Anthem Blue Cross eligibility impacted?**

There is no impact to eligibility. You're still a part of the Anthem Blue Cross or Anthem Blue Cross Life and Health Insurance Company PPO plan ("Anthem Blue Cross PPO plan"), just as you were before. The only difference is that now you have access to enhanced services when you choose to visit a Monarch HealthCare-affiliated doctor.

**Do referrals/authorization requirements change with the ACO?**

No. Since the pilot program is using the Anthem Blue Cross PPO network, there are no changes to referrals/authorizations.

You and your dependents can continue to see any physician you wish. If you or your covered dependent(s) are referred to a specialist by a physician in the ACO and you choose to go to a different specialist, that's your choice. There will be no impact to your benefits as long as you continue to abide by the stipulations set forth in your current Anthem Blue Cross PPO plan.

**How are claims impacted?**

Claims are not impacted at all. Since the pilot program is using the Anthem Blue Cross PPO network, there are no changes to claims mailing addresses and claims processing.

**If this is an "enhanced" program, how come it doesn't cost any more? What's the catch?**

The idea behind an ACO is that it works to make your health care experience more efficient in two different ways.

1. The first and most important is that it gives your doctor the ability to partner with you to help manage and treat serious, chronic or recurring conditions. The goal is to provide care that's coordinated so that your doctor can focus more on preventive care and programs that help you stay healthy.

   Consider, for example, a diabetes or asthma patient who had two hospitalizations last year. If that patient participates in a preventive-care program identified by your health care team under the ACO and as a result, has no hospitalizations this year, that saves a lot of money – not just on direct medical expenses, but also for the patient. There are fewer copays, fewer out-of-pocket costs and no loss of income due to being in the hospital. (And, of course, there are benefits of being healthier that can't be measured in dollars, like reduced strain on family members and just being able to enjoy your life.)

2. The second is that by coordinating your care with a single medical practice, your medical practice team will better know your needs and be able to better assist with communication among the doctors, specialists and hospitals that take care of you. Your health care team will have clinical information which will improve your health care team's ability to coordinate your care and will help reduce duplicate or unnecessary testing and inconvenience to you.

Together these two changes in managing health care will allow Anthem Blue Cross and Monarch HealthCare to use your health care dollars more efficiently. And that will enable us, as a team, to provide a better patient experience without incurring additional costs for you.

**A friend is also an Anthem Blue Cross PPO member. Can he or she get the ACO?**

No. Eventually, we hope to expand the ACO program and offer it to all of our Anthem Blue Cross PPO members. For this pilot, however, only preselected members, and their covered dependents are eligible.

**If there are other enhancements down the road, can I take advantage of them as well?**

The program details we've described in the enclosed letter are just the beginning. As we develop additional enhancements, we'll automatically add them to the program. You won't have to do anything to get these and other enhancements as they are rolled out, and there will be no additional cost to you.

**Why did I receive a replacement health plan identification card?**

The new health plan ID card has an "ACO" designation to identify members who can participate in the ACO program. When your Monarch HealthCare-affiliated doctor and staff see this designation, they can take the proper steps to provide you and your covered dependents with the enhanced benefits the ACO offers. Again, your benefits have not changed. Nor are you restricted to seeing doctors within the ACO program or Anthem Blue Cross PPO network.

**What do I do if I need a replacement card or need to order additional ID cards with the "ACO" designation?**

If you need to order a replacement card or additional cards please contact Anthem Blue Cross. Please make sure to inform the Anthem Blue Cross representative that you are part of the ACO program to ensure they send you the ID card (s) with the ACO designation.

**Will the ACO-identified card work with all PPO services, even ones outside of the ACO program?**

Absolutely. You or your dependents can use the same card to seek services as before. The only difference is that you will only enjoy the enhanced ACO care coordination with the doctors affiliated with Monarch HealthCare.

**Will I be required to see a certain primary care physician, or to use a specific hospital, facility or specialist?**

No. You and your dependents may continue to see any physician you wish. However, by seeing a physician affiliated with Monarch HealthCare, you will benefit from the additional services being offered to you and your dependents through the ACO.

**What if I don't want the ACO?**

As an Anthem Blue Cross PPO member, you have the choice to seek your medical care with a provider outside of Monarch HealthCare. You'll still be covered as you are now. You simply won't be able to enjoy the advantages the ACO has to offer. The good news is that there are over one thousand outstanding physicians affiliated with Monarch in Orange County if you wish to enjoy those advantages.

**Do these programs have a track record of success?**

ACOs are new to Anthem Blue Cross and Monarch HealthCare, as they are for much of the health care industry. However, they've been tested for some time. Pilot programs undertaken elsewhere have already achieved higher quality care, higher patient satisfaction and significant cost efficiencies. We feel confident that you'll like the ACO. We're excited about implementing it, and about helping you experience the next level of excellence in patient care.

**Where can I get more information?**

Start with www.anthem.com/ca/aco/monarch. We'll continually update this site as we develop and grow the program, so it's a good resource for you.