



AMERICAN ACADEMY *of* ACTUARIES

June 6, 2011

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attn: CMS-1345-P
PO Box 8013
Baltimore, MD 21244-8013

Re: Comments on proposed rule for the Medicare Shared Savings Program: Accountable Care Organizations

To Whom It May Concern:

On behalf of the American Academy of Actuaries'¹ Health Care Quality Work Group,² I appreciate the opportunity to provide comments to the Centers for Medicare & Medicaid Services (CMS) on the proposed rule on accountable care organizations (ACOs).³ The proposed rule specifically addresses the Medicare Shared Savings Program created by the Affordable Care Act (ACA).

The Academy has consistently called for Medicare reform, including slowing the growth of health care spending, to ensure the program's financial sustainability. We believe payment and delivery system reforms, including the development of ACOs, can be an important part of that reform. We also recognize that it is important to strike an appropriate balance between incentivizing provider participation through fewer restrictions and/or increased payments to ACOs and reducing Medicare cost growth. With that said, our comments in this letter are specific to the proposed rule and focus on ways to increase the potential for ACO success in the shared savings program.

The process of creating ACOs will be complex, and we commend CMS for developing a proposed rule that provides a strong framework for moving forward with implementation. We agree with the apparent movement toward stronger integration, new payment options, primary care providers (PCPs), and many other elements of the program. We do, however, have some concerns with the proposed rule.

¹ The American Academy of Actuaries is a 17,000-member professional association whose mission is to serve the public and the U.S. actuarial profession. The Academy assists public policymakers on all levels by providing leadership, objective expertise, and actuarial advice on risk and financial security issues. The Academy also sets qualification, practice, and professionalism standards for actuaries in the United States.

² The primary drafters of these comments are: Michael Thompson, FSA, MAAA; Susan Pantely, FSA, MAAA; Geoff Sandler, FSA, MAAA; Robert Tate, FSA, MAAA; Sara Teppema, FSA, MAAA, FCA; and Greger Vigen, FSA.

³ CMS proposed rule to implement Section 3022 of the Affordable Care Act—the Medicare Shared Savings Program: <http://www.gpo.gov/fdsys/pkg/FR-2011-04-07/pdf/2011-7880.pdf>.

Before addressing our more detailed technical comments, we want to offer a few general comments on the rule:

- The proposed rule covers an extensive range of issues associated with the creation of ACOs. We are concerned, however, that the requirements in the rule may be difficult to comply with in the time allowed, particularly for new organizations.
- The proposed rule places the burden of initial investment and the risks associated with forming an ACO on the provider community. While the rationale behind the imposition of these risks on providers is understandable, the cumulative effect could discourage many potential ACO organizers from participating in the shared savings program.
- To ensure the success of the shared savings program, and ACOs in general, it may be useful for CMS to consider easing some of the restrictions in the short term. Successful participation by early adopters could lead to other organizations opting to participate, which would assist in the long-term success of the program.

Our detailed comments will address four components of the proposed rule—patient assignment, benchmark development, shared savings, and data.

Patient Assignment

Medicare fee-for-service (FFS) beneficiaries will continue to have a choice in the providers from whom they receive their services under the shared savings program. A proposed rule, beneficiaries would be assigned to an ACO using a methodology based on beneficiary incurred claim information. The following are detailed comments on several key issues related to the proposed patient-assignment methodology:

- *Use of a retrospective approach*—A retrospective assignment method raises concerns about the ability of ACOs to manage population health in a way that generates savings. Actuaries have experience measuring and evaluating the types of care-improvement activities that ACOs will need to use to manage the health of their assigned populations, such as chronic care outreach programs and proactive care planning. These programs can be effective in improving health and reducing medical costs—but they require a significant investment of time and money. This investment cost actually can exceed the medical cost savings unless the care managers have sufficient information, in advance, to target interventions effectively to those patients who could benefit the most.

Reports based on a theoretical population may not provide the ACO with sufficient information to make appropriate changes. To effectively coordinate care and implement care management program, providers need to know which patients for whom they are coordinating care. As a result, retrospective assignment could discourage participation in the shared savings program. We suggest allowing ACOs to use a prospective assignment method.

- *Definition of primary care services*—Assignment is based on services provided by PCPs (e.g., internal medicine, geriatric medicine, family practice, or general practice) only. Many Medicare beneficiaries have conditions that are best managed by specialists, so they often receive the majority of their care from a specialist. Given the significant role of specialists for this population, an assignment method that includes certain specialists might be warranted.

In addition, shortages of PCPs exist in certain regions of the country. In these regions, specialists deliver the majority of primary care services. It would be difficult—if not

impossible—for ACOs to form in such regions. While encouraging more PCPs in these regions would be appropriate, allowing specialists who wish to participate in an ACO as PCPs also may help facilitate the creation of ACOs in these regions.

- *Creation of a plurality threshold*—The plurality test does not set a minimum threshold of services for a member to be assigned to an ACO. If an ACO is responsible for a small portion of a beneficiary’s services, the ACO would have limited opportunity to influence care or care coordination. A threshold could be established on the proportion of services performed by an ACO, for a given beneficiary, to prevent providers from being evaluated on beneficiaries for whom they provide limited services.
- *Implementation of individualized care plans and integration of community resources*—The rule proposes that ACOs must have in place a program aimed at identifying high-risk patients in targeted populations. An individualized care plan specific to a beneficiary’s needs, including identification of community resources, must be developed. It would be more difficult to develop and coordinate individualized care plans for beneficiaries using a retrospective assignment method.
- *Technical aspects*—Section 425.6(b) of the regulations provides the technical details of the assignment methodology in five steps. We have the following comments on the technical description:

Step (3)⁴ calculates a single number—the total allowed charge for primary care services—for each beneficiary. The rule should clarify whether the intention for the plurality test is to calculate total allowed charges for each non-ACO provider or in aggregate for all non-ACO providers.

Step (5)⁵ includes a plurality test but only references Step (4), which does not include non-ACO providers. Based on the rule, it appears that non-ACO providers are intended to be considered in the plurality test. Step (5), therefore, also should reference the total allowed charges for non-ACO providers in the plurality test.

Benchmark Development

The proposed rule establishes a shared savings program for participating ACOs. To determine whether an ACO saves money for the Medicare program, the claims for the beneficiaries assigned to that ACO are compared to a benchmark established for the ACO. We offer the following comments related to the development of the benchmark:

- *Determination of the benchmark population*—The benchmark population consists of beneficiaries who received the plurality of their treatment from PCPs participating in the ACO over the prior three years. This population may not necessarily be the same population that would be ACO members during the prospective performance measurement period. This

⁴ Step (3) of the assignment methodology states: “Determine the total allowed charges for primary care services that each of the beneficiaries identified in paragraph (b)(2) received from any provider or supplier during the performance year.”

⁵ Step (5) of the attribution methodology states: “Assign a beneficiary to an ACO if the beneficiary has received a plurality of his or her primary care services, as determined by the sum of allowed charges for those services under paragraph (b)(4) of this section, from primary care physicians identified under paragraph (b)(1) of this section, who are an ACO participant.”

could result in a potential mismatch between the population used to establish the benchmark and the population measured against that benchmark for determination of shared savings. It is important to test the stability of the ACO population over time to ascertain whether population changes between the benchmark period and the performance period are material.

- *Measurement of claims costs*—Once the benchmark population is established, the Medicare FFS Part A and Part B claims for this population during the prior three-year period are determined. For those medical providers who were already efficient providers during the three-year benchmark period, their benchmark period claims will reflect those efficiencies. Their potential future savings opportunities relative to their own benchmark, therefore, will be smaller than for less-efficient providers. This may be a disincentive for more efficient providers to participate in the program.⁶ The financial incentives, therefore, are strongest for the less-efficient providers that begin to deliver more cost-effective care. A benchmark based on regional FFS costs (e.g., as was used in the PGP demonstration project), or a shared-savings formula based on the degree of improvement instead of the dollar amount of improvement, might provide more balanced savings opportunities for all providers.
- *Adjustment of benchmark data for health status*—Once an individual initially is assigned a score in the benchmark period, this score would be used for the remainder of the three-year benchmark period and for projection into the performance period. This approach does not recognize changes in the health status of the benchmark population over time. Particularly in a Medicare population, the effects of aging of the population can be pronounced and can more than offset an ACO's effectiveness in managing the portion of its population with medical conditions. Consequently, deterioration in health status should be considered through either full reassessment or a simpler adjustment, such as an aggregate demographic adjustment.
- *Projection of benchmark for performance period*—Using a flat dollar amount for adjusting the national average growth rate will reduce regional variations in health care costs by compressing the benchmark in higher-cost regions. Efficient providers still will have lower benchmarks and lower potential savings opportunities due to the way the initial benchmarks are determined. This is true in both high-cost and low-cost areas. The use of a national average to project the benchmark to future years would mitigate some of the disparity between high- and low-cost providers to a limited degree.

Shared Savings

The three-year commitment, combined with limited potential savings and significant downside risk, may reduce the financial incentive for some plans to participate in the program. While a multiyear agreement is critical to develop a sustained ACO arrangement under the program, there are multiple concerns with the approach as currently outlined. The limited upside potential likely will be inadequate to attract many potential provider organizations, since there is downside risk and a substantial investment to develop the ACO infrastructure.

- *Recognition of initial investment*—CMS estimates start-up costs for an ACO of \$1.8 million, but there is no recognition of this investment in the savings formula. One approach would be to allow an imbalanced sharing of savings with the ACO in the early years to accelerate the

⁶ We note that there has been some recognition of this disincentive. Shortly after the release of the proposed ACO rule, HHS announced a new "Pioneer" ACO model that would allow certain already efficient organizations to receive a greater share of savings in exchange for taking on more risk.

potential recoupment of that investment, mitigate cash flow concerns, and improve the likely return on that investment. Another approach may be for CMS to provide funding assistance for the initial investment.

- *Requirement of 2 percent threshold of savings*—ACOs cannot achieve any share of the savings unless the savings exceeds the 2 percent threshold established by the proposed rule. This requirement is intended to avoid shared savings payments if results are achieved due to normal statistical variation. Depending on the size and the maturity of the ACO, this could decrease substantially the expectation of actual savings. An alternative approach is to allow unpaid savings to be recognized and shared based on cumulative savings, which would be subject to less variability.⁷
- *Requirement to meet quality metrics*—The requirement to meet 65 quality metrics for an ACO to be eligible for some or all of the shared savings could be a significant challenge to an ACO expecting to realize shared savings. This expectation will be factored into the financial evaluation of the potential return to the organization participating in a shared savings program. It would be crucial to maintain a more balanced approach in which incentives are aligned on both financial and quality metrics.
- *Impact of patient mix inside and outside of an ACO*—A provider organization that transforms its processes to utilize resources more efficiently, may realize less revenue overall on its patient mix. To the extent that shared savings are paid only on a small subset of its overall patient population, the provider incentives to maximize revenue would be skewed to the current model (i.e., FFS). An alternative would be to consider the need for a transition period financial model that enables provider organizations to preserve overall margins as delivery systems are transitioned to a more efficient and effective model. Temporary supplemental bonuses based on reductions in select overall utilization metrics (e.g., emergency room utilization) might be one approach that could support this transition period.
- *Accounting methodology for runout claims*—With respect to the runout period for determining shared savings, given the 25 percent withhold proposed, a three-month runout with a residual factor could be utilized for interim accounting. Final amounts could be trueed up at a later date. This would deliver results to the ACO earlier while still protecting both sides from missed estimates.⁸ The interim accounting could be done on a conservative basis, enabling most of the shared savings to be released. The final accounting would be done using six months of data.⁹ This could provide reasonable cash flow while still basing any distribution on the latest possible estimate of actual results.
- *Determination of shared savings potential after three-year period*—It is unclear how sustainable the upside potential is in a shared savings model after the three-year period. If the targets are “rebased” according to the results from the first three-year period, and those first three-year results contained savings, then further savings to ACOs will be reduced. A longer-term view should be considered to reflect a transition to a more balanced reimbursement model for high-performing ACOs.

⁷ For example, if an ACO achieved 1 percent savings in Year 1 and 1.5 percent savings in Year 2, it would be eligible to participate based on the cumulative unshared savings of 2.5 percent.

⁸ For example, at the end of the three-year period, both interim and final accounting would be possible.

⁹ An even longer runout period could be used to true-up final accounting if the ACO financial arrangement is in its last year.

Data

The proposed rule highlights data that would be provided to an ACO. Given an ACO's responsibility for cost, a complete and detailed view of the underlying claims data is needed on a timely basis. We suggest several expansions or clarifications of the data framework in the proposed rule:

- *Inclusion of both aggregate reports and detailed data*—Analysis of health quality and efficiency requires both aggregate reports and related detailed claims data for each beneficiary. Aggregate reports help to identify patterns, flag potential problems, and set priorities. Meaningful action for a particular patient, however, requires detail for that patient.

The aggregate report set should enable an ACO to deliver results and facilitate an understanding of the population and the efficiency of the program. Many report sets are available from data vendors and insurance carriers and can be viewed to broaden the reporting package and provide economies of scale for smaller ACOs.

The final rule should specify the timing of aggregate reports, to enable the ACO to plan and manage its program.

We recommend that a panel of experts in health analytics and claims data—from data vendors, insurance carriers, and other experts—make recommendations on the reports that should be provided.

- *Expansion of data elements to include beneficiary-identifiable claims data*—Since an ACO is accountable for program cost, it should be provided details on the claims experience of its assigned patients. The list of data elements presented in the proposed rule does not include the dollars paid or allowed for each service, which may be an oversight. Cost data for Part A, Part B, and Part D claims must be available to the ACO to properly manage its assigned patients.

The expert panel recommended above could provide input on a complete list of data fields that should be provided to the ACO. This list should include (but is not limited to) the following fields for each assigned patient:

- Disabled status and dual eligibility (Medicare and Medicaid) status
- Member zip code
- Location of service
- Procedure code (revenue code for outpatient facility claims)
- Multiple diagnosis codes
- Discharge status
- Facility/provider identification
- Submitted dollar amount, allowed dollar amount, and paid dollar amount
- Place of service
- Whether the physician is participating in Medicare
- Summary totals to reconcile the detailed data with expected data
- Coverage information (e.g., whether a member was in the program the entire year or in a Medicare Advantage program)
- Prescription dosage
- Pharmacy identification

- Pharmacy zip code
- Start and end data of pharmacy coverage
- *Definition of the timing of release of beneficiary identifiable claims*—The proposed rule states that data are released monthly if a beneficiary has service from a PCP in the ACO during the performance year. It would be helpful to clarify the timing and content of the data to be released. The following examples attempt to clarify our questions with respect to the data period and timing of the release of beneficiary identifiable claims.

For each beneficiary below, when will the data be released? What period of data will be in the first release?

- Patient 1 first sees a PCP in February. The visit is submitted to Medicare and recorded in April. We recommend that the data period either start in January of the prior year (calendar-year basis) or include 12 months of incurred claims data starting in March of the prior year and ending in February of the current year.
- Patient 2 first sees a PCP in July. The visit is submitted to Medicare and recorded in September. Similar to Patient 1, we recommend that the period for data either start in January of the prior year (calendar-year basis) or include 12 months of incurred claims data starting in August of the prior year and ending in July of the current year.

For both patients, will data continue to be released throughout the remainder of the year, even if each patient has no additional visits to a PCP? This would create a data file that would grow during the year as each month more patients are included in the file. Although growing monthly files is not preferred, it would be a way to obtain the needed data.

- *Inclusion of pharmacy detail in the data set*—We want to reinforce the importance of pharmacy data. This information is crucial to obtain results on both quality and cost.
- *Inclusion of three years of historical claims data for assigned members*—ACOs will be held accountable for financial benchmarks that are based on experience from the three prior years. The beneficiary identifiable claims data underlying these benchmarks should be provided to the ACO, including paid-claims dollar amounts from all three years. This data should be available to the ACOs as soon as members have been assigned so that the ACO can verify the accuracy of the benchmarks and gain a deeper understanding of the health conditions of potential members.
- *Review of the use of data vendors*—The handling of claims data requires substantial experience, which providers typically do not possess. Requiring the data to be handled entirely within the ACO is likely to create errors and be expensive. Some ACOs, especially smaller or start-up programs, may want to consider outside vendors with expertise in this field to provide economies of scale and enable a focus of resources on quality and efficiency. The proposed rule should clarify whether such data vendor relationships are acceptable. Throughout the proposed rule, business associates appear to be acceptable, but one section prohibits data sharing with “anyone outside of the ACO.”¹⁰

¹⁰ Section II.C.6 of the ACO proposed rule (p. 19557)

- *Review of the need for a data explanation in the application process*—The proposed rule requires an ACO to “explain how it intends to use these data” during this application process.¹¹ Because most ACOs will be start-up organizations, it will be difficult for them to anticipate and describe the wide range of analytic needs that will arise during the course of the three-year program. This requirement appears to be stronger for ACOs than other programs, such as Medicare Advantage. Comparable requirements during the early years of the program may be more appropriate.

While many of our concerns are highlighted in this letter, we haven’t addressed every aspect of the proposed rule in detail. We would welcome the opportunity to discuss any of the items identified in this letter, as well as the proposed rule in general, with you at your convenience. If you have any questions or would like to discuss these items further, please contact Heather Jerbi, the Academy’s senior health policy analyst (202.785.7869; Jerbi@actuary.org).

Sincerely,

Michael J. Thompson, FSA, MAAA
Chairperson, Health Care Quality Work Group
American Academy of Actuaries

¹¹ Section II.C.6 of the ACO proposed rule (p. 19557)