



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: Medicare Shared Savings Program: Accountable Care Organizations  
76 Fed. Reg. 19527 (April 7, 2011); CMS-1345-P

Dear Dr. Berwick:

AARP is pleased to provide comments on the Proposed Rule to implement Section 3022 of the Affordable Care Act (ACA) concerning the Medicare Shared Savings Program (MSSP) and Accountable Care Organizations (ACOs). As part of the health care reform legislation that was enacted last year, AARP advocated for innovative approaches to health service delivery that will improve the quality and affordability of care for people in Medicare. AARP strongly believes that these types of delivery system reforms are critical to ensure the program continues to meet beneficiaries' health care needs and is sustainable now and in the future. The MSSP has the potential to make significant progress toward these ends in the traditional Medicare program.

New delivery models are needed system-wide to contain spiraling health care costs and improve quality. ACOs represent one such model that holds great promise. However, if ACOs are to succeed in Medicare, unprecedented transformation will have to occur in the traditional program where fee-for-service payments provide incentives for volume, not quality, and lead to fragmentation, not coordination. We hope that by changing how care is provided in Medicare fee-for-service, people in Medicare will benefit from: access to providers who are committed to improving coordination across all settings; person-focused care through better patient/physician partnerships enhanced by shared-decision making and support for self-management; and, greater attention to quality, safety, cost, and efficiency. This will take a major culture change, professional and clinical leadership, and a new business model for virtually the entire provider community, all of which require time, focus, and commitment.

We commend the Centers for Medicare and Medicaid (CMS) for striving to encourage physician and hospital participation in the MSSP, while establishing high performance standards for ACOs. AARP feels strongly that a combination of requirements and incentives must compel hospitals and providers to move away from “business as usual,” while permitting enough flexibility to allow diverse models to develop in the MSSP. AARP believes it is important that this emerging delivery model succeeds in Medicare so that beneficiaries experience the benefits of coordinated, patient-centric service delivery. We share CMS’ vision of the three aims of better care, affordable care, and healthy populations and communities and want to see this vision fully realized in Medicare.

*New Pioneer Accountable Care Organization Model.* We note that several important questions that went unanswered in the proposed rule were addressed in the materials released by the Center for Medicare and Medicaid Innovations (CMMI) on May 17, 2011, describing three additional initiatives regarding Medicare ACOs. AARP is pleased that CMMI will test a wider range of ACO approaches that might otherwise be impermissible under the MSSP. However, any approach must ensure that patients are effectively engaged and are assured of receiving necessary services.

These regulations need to permit a clear and feasible transition for those in the provider community who are prepared and able to accept responsibility for change and accountability for the cost and quality of care they provide. We understand that the timeframe for organizations to meet ACO requirements will vary depending on how far along any particular entity is in adapting to the new environment. The proposed regulations generally strike the proper balance between setting new expectations while permitting needed flexibility.

In our comments, we first make a general statement about the overall direction of the regulations and then address specific sections of the proposed rule. As a consumer organization, our comments are focused on those parts of the proposed rule that will have the greatest impact on Medicare beneficiaries and do not address other topics, such as the payment models and risk adjustment, although we recognize these are important to the success of ACOs.

### **General statement**

The proposed rule requires a prospective ACO to document its plans for meeting the requirements. CMS has identified the wide range of activities that should be pursued by successful ACOs and requires the ACO to describe how it intends to accomplish those activities. CMS notes that it weighed whether the rules should be prescriptive or allow prospective ACOs latitude to encourage innovation; the agency opted for the latter. While we believe there needs to be flexibility to develop new ways of providing care, we think that CMS needs to offer more guidance in areas where there is evidence of best practices or expert consensus around certain capabilities and functions (for example, in the areas of care coordination and shared decision making). More specific requirements could help guide ACOs and also reassure the public and beneficiaries that ACOs have been

organized in ways that will support high quality care, especially for ACOs that are small and newly formed.

*Deem approved standards of accrediting bodies:* We understand that the National Committee for Quality Assurance (NCQA) is developing a module for the MSSP to accompany its ACO standards. NCQA standards are a combination of structure, process, and performance results. We suggest that CMS consider deeming NCQA's ACO standards, and those of other qualified organizations (which would be consistent with CMS' past practice of deeming accreditors' standards in the Medicare Advantage program) when they meet or exceed those established by CMS. This could simplify CMS' administrative burden and would also promote synergy between Medicare and the private sector, thereby reducing the effort ACOs will have to make to operate in both sectors.

### **Provision-specific comments**

#### **§ 425.4 -- Definition of "at-risk" beneficiaries**

*Broaden the definition of "at-risk beneficiaries":* The proposed rule defines an "at-risk beneficiary" as someone who (1) has a high risk score on the CMS-HCC risk adjustment model; (2) is considered high cost due to having two or more hospitalizations each year; (3) is dually eligible for Medicare and Medicaid; (4) has a high utilization pattern; or (5) has had a recent diagnosis that is expected to result in increased cost. We agree that these five categories merit the "at-risk" designation. In addition, given that health care disparities often are evident based on racial and ethnic differences in sites of care, we recommend the addition of another category (or series of categories) to the definition of "at-risk" that accounts for the influence on care resulting from an individual's residence in a medically underserved area or having low-socio-economic status.

*Ensure the collection of data on race and ethnicity:* One important way to monitor disparities is to require data collection on race, ethnicity, and primary language. We note that the proposed regulation includes as one criterion of patient-centered care the evaluation of population health needs and consideration of diversity. AARP believes it is essential for the ACO to collect patient information to better understand the composition of its population, provide culturally and linguistically appropriate services, and detect health care disparities. To the extent feasible, ACO performance reports should be stratified by race and ethnicity to facilitate detection of disparities of care and made publicly available.

#### **§425.5 – Eligibility and Governance Requirements**

##### **§425.5(b) -- Eligible providers and suppliers**

*Exclusion of Federally Qualified Health Center and Rural Health Clinics:* The ACA specified four groups permitted to form an ACO: (1) group practice arrangements; (2) networks of individual practices; (3) partnerships or joint venture arrangements between hospitals and physicians; and (4) hospitals employing physicians. Other

providers and suppliers -- such as Federal Qualified Health Centers (FQHCs), rural health centers (RHCs), and Medicare-enrolled providers and suppliers not meeting the definition of ACO professional -- cannot form an ACO on their own, but they can participate in an ACO (and share in any relevant savings or losses). In the preamble to the Proposed Rule, CMS notes that “defining eligibility narrowly ...has the potential to impede development of ACOs that include other provider and supplier types, especially those that provide services in rural and other underserved areas”. 76 Fed. Reg. at 19537.

In light of this concern, it is regrettable that CMS’ narrow interpretation of the statutory provision concerning entities eligible to be ACOs effectively precludes FQHCs, RHCs, nurse-led medical/health homes, and medical specialists who provide primary care services, from being designated as ACOs. As noted in a recent research brief on this topic,<sup>1</sup> beneficiaries who are medically underserved typically live in communities where there are not sufficient numbers of primary care physicians to serve them; thus the FQHCs’ health teams and nurse-led medical homes provide access to primary care for these population groups. We are concerned that the proposed rule will effectively remove ACOs as an option for medically underserved patients—a group that could greatly benefit from the improvements in care ACOs promise to bring. This proposed regulation provides little or no incentive for ACOs to include FQHCs due to the prohibition of the assignment of Medicare beneficiaries who receive their care from FQHCs to ACOs for shared savings purposes. AARP urges CMS to make every effort to ensure that beneficiaries in all types of communities have access to ACOs, and that care patterns do not make chronically-ill beneficiaries, or those living in rural or medically underserved areas, ineligible, de facto, for care from ACOs. Further, we specifically encourage CMS to expand the groups permitted to form an ACO through the MSSP and the Pioneer model to include FQHCs, nurse-led medical homes, and rural health centers.

We note that the new Pioneer ACOs’ solicitation is open to a second “alignment” step wherein a group of eligible specialist physicians (such as nephrologists, oncologists, rheumatologists, cardiologists, etc.) who billed for the plurality of evaluation and management charges could participate in shared savings. We are pleased with this additional category because we do not want beneficiaries with chronic diseases who receive the bulk of their care from specialists excluded from ACOs. However, these groups of specialists should be held to the same quality and efficiency standards as others.

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<sup>1</sup> Rosenbaum, S., Shin, P., “Medicare’s Accountable Care Organization Regulations: How will Medicare Beneficiaries who Reside in Medically Underserved Communities Fare?” RCHN Community Health Foundation, Policy Research Collaborative, Policy Research Brief #23, April, 20, 2011.

#### **§425.5(d)(2) -- Coordination of Antitrust Agency**

We commend the CMS, Federal Trade Commission (FTC) and the Department of Justice (DOJ) for their commitment to ensure ACOs operate in pro-competitive markets. In our May 31, 2011, letter commenting on their joint statement concerning ACO oversight, AARP expressed its concerns about the potential for market dominance, cost-shifting to the private sector, and the impact on premiums. We strongly urge the agencies to collaborate on data collection and analysis to detect patterns of anti-competitive practices that could threaten the viability of the MSSP. In this connection, we urge CMS to implement requirements for ACOs to report publicly on the cost and price of care.

#### **§425.5(d)(4) -- Marketing materials**

CMS proposes that all ACO marketing materials and activities must be approved by CMS before they can be used. If the ACO makes any changes to any approved materials, they must be approved by CMS. An ACO that fails to adhere to these requirements will be placed under a corrective action plan or terminated, at CMS' discretion.

AARP agrees that it is a good practice for CMS to review any materials intended for beneficiary audiences, especially during the early phase of the MSSP. In addition, it is an important safeguard against inappropriate marketing practices for CMS to review materials in advance and monitor ACO practices on an ongoing basis. We urge CMS to develop model documents that can serve as templates to help expedite the review process.

#### **§425.5(d)(5) -- Notice of ACO participation**

*Advance notice to beneficiaries:* The proposed rule requires ACOs to notify beneficiaries that their physicians/suppliers are participating in an ACO. Although the ACA is silent on beneficiary notification, we commend CMS for recognizing the value of informing patients about the MSSP in advance. AARP strongly favors prospective notice to beneficiaries because it permits ACO participants to engage patients in conversations describing their rights, responsibilities and also how they (the ACO professional) will be providing care. Further, it is essential for beneficiaries to be informed about the possible consequences of receiving care in an ACO and that participating providers may have unique incentives that could affect service delivery under the ACO arrangement. Finally, advance notice will allow beneficiaries to evaluate their options to determine the best ACO for their circumstances.

*Timely and effective communication:* We believe this notice should be written in "plain English" and address low health literacy levels, with versions that are culturally and linguistically appropriate.

CMS' intent to develop a communications plan, including educational materials and other forms of outreach to help beneficiaries learn about the MSSP, will be critical to its success. Standardizing the advance notice about a provider's participation in the program and the potential for CMS to share beneficiary identifiable data with ACOs when a beneficiary receives services from a participating physician would reduce the burden on ACOs and the potential confusion among beneficiaries. As noted earlier, materials that supplement those standardized by CMS should be reviewed to ensure accuracy and clarity.

Although the proposed rule does not specify how far in advance the beneficiary should be notified of her provider's participation in an ACO, we think it is highly desirable for her to find out well before arriving for an office visit, at which point she might see a notice posted but have little practical recourse. AARP urges CMS to require ACO participants to notify their patients of their involvement in an ACO as soon as possible (ideally, at the beginning of each year) so that patients are given enough time to decide if they want to continue to receive care from the participants.

Finally, CMS also proposes that ACOs be required to provide timely notice to beneficiaries if they will no longer be participating in the MSSP, including the effective date of the termination of their agreement with CMS. Beneficiaries should be given this notice as soon as possible, but in no fewer than 60 days in advance of the termination, in order to give them an opportunity to consider their options.

#### **§425.5(d)(8)(ii) -- Composition of the governing body**

*Control of the ACO by ACO participants:* CMS proposes to require that ACO participants must constitute 75 percent of the governing body. AARP supports the concept of ensuring that physicians and other clinicians (as opposed to a dominant entity, such as a hospital) have an effective means of influencing the policies of the ACO.

*Beneficiary participation in governance:* The proposed rule requires the ACO governing body to include a Medicare beneficiary or representative who has no conflicts of interest. AARP strongly agrees that the consumer voice needs to be part of the ACO policy decision-making process, and we support the requirement to have at least one beneficiary (or a beneficiary representative) on the governing body. Moreover, we strongly urge CMS to consider requiring additional consumer representation so that the consumer representative is not viewed as simply "token" participation. AARP believes patient engagement is an essential element for ACO success and consideration of the consumer/patient perspective in policy making will be essential if ACOs are to genuinely introduce a paradigm shift in care delivery. It will be important for the ACO leadership to accept the beneficiary representative as an equal member of the governance group, and therefore steps should be taken to ensure that technical assistance or other support is provided to this individual, as needed, to enable him to make an effective contribution. We think it would be beneficial to have non-clinical perspectives reflected on the governing body and we support inclusion of purchasers, and other payers, in addition to consumers.

**§425.5(d)(13) -- Sufficient number or primary care providers and beneficiaries**

Under the proposed rule, an ACO would be determined to have a sufficient number of primary care ACO professionals if the number of beneficiaries historically assigned over the three-year benchmarking period exceeds the 5,000 threshold each year. This is the same approach that CMS will use to assign beneficiaries to an ACO.

AARP believes that ACOs must be built on a strong primary care foundation with a sufficient number of providers to meet the needs of the population it serves. We hope that this foundation will reflect a strong commitment on the part of the ACO to medical homes because we have confidence that the strong collaboration among multi-disciplinary team members is the most effective way to ensure care coordination and patient-centered care for patients.

**§425(d)(15) – Required process and patient-centeredness criteria**

The proposed regulations determine if an ACO is patient-centered based on whether the ACO adheres to nine principles: (1) implementation of the Clinician and Group Consumer Assessment of Health Providers and Systems (CAHPS) and an appropriate functional status survey module); (2) patient involvement in ACO governance; (3) evaluation of the health needs of the ACO's assigned population, including consideration of diversity in its patient population, and a plan to address the needs of the population; (4) systems to identify high-risk individuals and processes to develop individualized care plans for targeted patient populations, including integration of community resources to address individual needs; (5) systems for care coordination, including a process in place (or clear path to develop such a process) to electronically exchange summary of care information when patients transition to another provider or setting of care, both within and outside the ACO; (6) processes for communicating clinical knowledge/evidence-based medicine to beneficiaries in a way that is understandable to them; (7) processes for beneficiary engagement and shared decision-making; (8) written standards for beneficiary access and communication and a process for beneficiaries to access their medical record; and, (9) internal processes for measuring clinical or service performance by physicians across the practices, and use of these results to improve care and service over time.

AARP applauds CMS for its thoughtful and comprehensive approach to the patient-centeredness requirements. We support the nine principles for patient-centered care because they are essential features of a reformed delivery system, and we agree that an ACO meeting the criteria should be considered to have met the requirement to be patient-centric. Entities that can perform these functions can be expected to provide individualized care by addressing the values, preferences, and circumstances of patients and their family caregivers. We urge that the requirement for the ACO to document how it will meet the patient-centered criteria be more than a paper exercise, and that CMS evaluate the documentation carefully and also monitor how the plans are implemented. As noted earlier, we think this is an area where CMS could provide greater guidance and share best practices and processes that more mature organizations have determined are effective.

*Beneficiary Experience of Care Survey:* Consumers find information from other consumers salient and useful. The requirement that ACOs conduct surveys of patients about their experience of care with their physicians is of great importance to ensure that ACOs practice patient-centered medicine. We applaud CMS' decision to require a standardized survey instrument for the MSSP. Independent survey organizations should administer the core Clinician/Group (C/G) CAHPS survey and protocol. Special protocols will be necessary for extremely vulnerable patients, such as homeless beneficiaries to accommodate their unique circumstances. We recommend that CMS work with the Agency for Healthcare Research and Quality (AHRQ) to develop additional questions focused more specifically on care coordination, shared decision-making, prevention, and meaningful use of IT.

Surveys should be designed to produce reliable results at the individual physician level and (aggregated) at the ACO level. Measurement and reporting at the ACO level only is not adequate because research has shown that much of the variation on patient experience measures occurs at the individual physician level. Knowing how an ACO scores on average is not sufficient to guide incentive programs that can motivate individual physicians. Also, for a program to be truly patient-centered, it must give consumers this information, which they understand and want more than other quality measures.

ACOs should be required to show that they are using the survey results from both levels in processes to improve quality, enhance patient engagement and inform consumer decisions. All results should be reported to the public to reinforce the provider's motivation for quality improvement and guide patient choice. C/G CAHPS is already used in the private sector and the proposed rule provides an important opportunity for CMS to align the MSSP with employer initiatives where the survey results can be used by health plans and others to guide contracting, creation of high performing tiers or networks, benefit design, and pay-for-performance programs.

*Partnerships with community resources:* ACOs must establish partnerships with community stakeholders to advance the three-part aim. We believe this is a particularly important requirement because community resources often provide patients and caregivers the support to enable elders and others to remain independent in their communities for as long as possible.

#### **§425.6 -- Assignment of Medicare fee-for-service beneficiaries to ACOs**

*Assignment restricted to primary care physicians:* CMS proposes to assign Medicare beneficiaries to an ACO at the end of each performance period, as determined by the primary care physician who provided the beneficiary with a plurality of primary care services. To operationalize this methodology, CMS defines primary care physicians as doctors of medicine and osteopathy in internal medicine, family practice, general practice and geriatric medicine. Notably missing from this list, are advance practice nurses and physician assistants, who provide primary care, particularly in underserved areas. With current demands for primary care growing while the supply of primary care physicians is

dwindling, we believe it is short-sighted to preclude non-physician clinicians from being designated as primary care providers.

*Assignment of patients to ACOs:* We are concerned that assignment of patients to ACOs by means of patient attribution at the end of the contract period will undermine the ACOs' ability to set explicit performance targets, which requires knowing the patients in advance. It would improve patient care if ACOs could identify the population for which it is responsible and then develop targeted approaches to meet the needs of the people it will be serving. AARP strongly believes that the ACO should organize its care processes for all its patients, not just the subset upon whom it will be evaluated. It is our hope that changing the incentives will allow providers to focus on improving quality of care – not increasing quantity of procedures and tests – which is valued under today's fee-for-service. AARP believes ACOs need to know their assigned population of patients upfront to best manage their patient populations. Moreover, we believe this is consistent with and reinforces CMS' plans to prospectively make historic claims data available to ACOs. We hope that ACOs will use the data to improve care and not simply focus care coordination services only on the subset of their patients who are in the ACO. However, we recognize that some providers may still be tempted to game the system to maximize profit, and we believe CMS must guard against this by carefully monitoring ACO behavior. CMS must ensure that the ACO does not provide "extra" services for non-ACO patients in an effort to make up for a perceived loss of revenue from the ACO population. The monitoring activities CMS will be undertaking underscore the need to ensure it receives adequate resources to conduct necessary and sufficient oversight.

#### **§425.9 -- Measures to assess the quality of care furnished by an ACO**

CMS proposes that ACOs must report 65 quality measures and, for the last two years of the 3-year agreement, meet specified performance requirements. ACO performances will be compared to benchmarks and the ACO will have to meet the threshold on all measures, generally set at 30 percent or the 30<sup>th</sup> percentile for the traditional Medicare program or Medicare Advantage rate, to qualify for shared savings. An ACO would be disqualified from sharing in savings in each year in which it fails to meet the benchmark threshold.

AARP believes that the general framework of the proposed quality assessment approach is strong and includes the basic elements for a comprehensive reporting program. We believe there is great value in shedding light on the activities and performance results (e.g., on cost/quality of care) of providers because of strong evidence that providers, in particular, respond to public reports and feedback. Notwithstanding this overall favorable impression, we do have concerns about whether it is realistic for all ACOs to report on all specified measures. As proposed, all aspects of the multi-faceted program must work together to produce reliable results, including accurately matching patient claims to the "correct" ACO; transmitting data in a timely way; ensuring that data derived from multiple sources yield valid comparisons; and creating benchmarks for measures that have not been widely used. Much hinges on meeting these challenges.

*Importance of high value, high leverage metrics to assess performance on quality and cost:* ACOs should be accountable for providing evidence-based care that improves health outcomes, and we need metrics that will provide information about whether this is happening. We strongly support public reporting so that results are available to inform beneficiary choice and to incent ACOs to improve quality. It is important that the metrics used to assess ACO performance focus on areas that are important to measure (e.g., high cost, high prevalence, high variation) in order to achieve the primary purpose of the MSSP – to align payment with high quality, cost-effective care. The measures should also be meaningful to consumers. While some measures of structure and process may be appropriate for newly formed ACOs, as quickly as possible, assessment should be cross-cutting and based on outcome measures that include patient-reported outcomes on functional status and experience with care, care coordination, and shared decision making. Measures to assess cost, efficiency, and resource use are also necessary to provide a complete picture of ACO performance and to give CMS a better understanding of how ACOs achieve savings. To the extent feasible, CMS should align performance assessment with other federal and private sector programs. This will reduce the reporting effort for ACOs, and allow ACOs to target improvement initiatives across all payers and thereby achieve the greatest possible impact from quality improvement and public reporting.

Of the 65 measures, CMS has proposed for first year reporting, we especially favor the inclusion of Clinician/Group CAHPS (see section on patient engagement for full discussion); Risk-standardized, All Condition Readmission; the Care Transition Measure; the percentage of Physicians Meeting Stage HITECH Meaningful Use Requirement; and the requirement to measure functional status. We fully expect the measure set to improve as better measures are developed specifically for ACOs and more practices acquire the capacity to collect and report data electronically.

*Sources of data and data collection:* For the first year, CMS is proposing that ACOs report measures that rely on three different data sources: claims derived from CMS systems and calculated by CMS for the ACO's assigned patient population; the GPRO tool that ACO's would use to report specified measures; and surveys.

AARP believes it is very important for CMS and consumers to have information to compare ACOs. It would be counterproductive to allocate savings based on invalid comparisons. However, given the three different data sources (and likely different data collection methodologies, such as chart abstraction and electronic records), we lack confidence that these will yield comparable results. We urge CMS to make addressing this issue a top priority to identify best approaches to achieving comparable reports from ACOs.

*Implications of small numbers/sample size requirements:* As noted, data collection is considerably hampered by the low use of electronic records among potential ACOs' participants and providers. While the data collection effort for ACOs will be reduced by the claims-based measures that CMS is proposing for the first reporting cycle, these measures lack the clinical information necessary to fully portray ACO performance. CMS intends to overcome this limitation through the use of the GPRO tool to obtain beneficiary laboratory results and other information. However, the GPRO tool needs to be built out, refined, and upgraded to support clinical data collection and measurement feedback to ACOs. AARP is concerned that many of the proposed measures rely on a data collection approach that is not yet fully purposed for its intended use. We urge CMS to accomplish this in time for Year One in January 2012.

In addition, in light of the minimum ACO size requirement of 5000 beneficiaries, it may not be feasible for many ACOs to have an adequate sample for all the measures. As a consequence, many ACOs may not be able to report all 65 measures, leaving an incomplete picture of their performance, and also leaving them ineligible for shared savings. This problem could deter ACO participation and deny CMS and beneficiaries needed information about ACO performance. We urge CMS to examine the 65 measures to determine the likelihood that certain types of ACOs may not be able to meet proposed sample size requirements due to small prevalence/incidence and to consider options to address this issue.

*Meaningful use:* Use of health information technology (HIT) will be essential for most ACOs to comply with requirements and meet expectations to coordinate and improve care. It is a fundamental tool to push decision support to participating providers, foster clinical integration, and information exchange. HIT is also the most efficient, inexpensive, least burdensome way to obtain data on ACO performance. Therefore, we applaud CMS' intent to align the MSSP with the EHR incentive program, for this will facilitate data collection and reduce the compliance effort for those ACOs participating in both programs and also assure patients secure access to their personal health information electronically.

#### **§ 425.18 -- Three-year agreement**

CMS proposes to adopt an annual ACO application period during which a cohort of ACO applicants would be evaluated, and further proposes that the performance years be based on the calendar year. This presumably means that the first cohort of ACOs would be approved for a start date of January 1, 2012. AARP believes that offering an additional start date of July 1, 2012 (with a 3.5 year agreement period, with the first performance year defined as 18 months), would serve two purposes. First, it would give entities contemplating application more time to get organized and, second, it would also spread the review burden for CMS over a longer period of time.

## **§425.19 – Data sharing with ACOs**

*§ 425.19(d) – Sharing beneficiary identifiable data:* An important ACO capability will be to identify, produce, and manage data to evaluate and address the health needs of its patient population as a whole as well as the individuals that comprise its “population”. We expect that ACO participants already will have information about the utilization of beneficiaries they served before joining an ACO; and, moving forward, complete information on the services it provides or coordinates on behalf of its fee-for-service beneficiaries. However, the ACO may not have information on services, supplies, medications, etc., that beneficiaries choose to receive outside of the ACO, nor will it have information for those who are new patients to ACO participants.

To help ACOs accomplish the goals of the Shared Savings Program, CMS proposes to share three types of data with them: (1) aggregate data reports with de-identified claims history of the services rendered for an ACO’s historically assigned or potentially assigned beneficiaries, and, when available, other data on financial performance and quality performance scores; (2) upon the ACO’s request, four data elements -- beneficiary name, date of birth, sex, and Health Insurance Claim Number -- about each beneficiary who would have been assigned to the ACO based on historic data or who was assigned during a given performance period; and, (3) at the ACO’s option, beneficiary identifiable claims data (only the minimum data necessary to accomplish specified purposes) on a monthly basis, in the form of a standardized data set for beneficiaries currently served by the ACO participants and ACO providers/suppliers.

AARP believes there is value to the ACO in having specific data on its entire population in advance, but we believe it is important to assure beneficiaries that their personal health data will be handled confidentially and their privacy protected. As noted in the preamble, there is considerable likelihood that a high percentage of historically assigned patients will already be receiving care from the ACO participants, and presumably those patients will have established, trusting relationships with their clinicians. We urge CMS to carefully monitor this part of the data sharing plan.

We are also concerned that sharing identifiable patient data at the start of the program could give the ACO an opportunity to avoid historically high-cost, high risk patients. CMS’ proposed approach at §425.12 (Monitoring) to ensure that ACOs do not avoid “at-risk” beneficiaries (through a series of steps designed to sanction the ACO in the event untoward behavior is suspected) is a post hoc approach and, in our view, not likely to eliminate opportunities for favorable selection on the part of the ACO. We agree that CMS should analyze claims, examine other beneficiary documentation to identify trends and patterns suggestive of avoidance of at-risk beneficiaries, and investigate and sanction ACOs for unacceptable conduct. However, we believe that the combination of methods outlined will not adequately deter ACO’s from shunning high risk/high cost patients. Therefore, we support the strictest penalty, immediate contract termination, when there is evidence the ACO has deliberately avoided caring for at-risk beneficiaries.

*§ 425(g) Beneficiary opportunity to opt-out of claims data sharing:* As part of the broader notice requirements, ACOs will have to provide beneficiaries with notice and a “meaningful opportunity” to opt-out of having their claims information shared with the ACO for purposes of the ACO’s care coordination and quality improvement work. ACOs would only be allowed to request beneficiary identifiable claims data for beneficiaries who have visited a primary care participating provider during the performance year and have not opted out of claims data sharing.

AARP agrees with CMS’ view that beneficiaries should be notified of -- and have meaningful control over -- who has access to their personal health information for purposes of the MSSP. Assuring individuals secure electronic access to their health information will encourage them to use and share their information. We support the opt-out approach, because opting-in could be a burden for some beneficiaries who would not exercise this option and therefore lose out on the value of their clinicians sharing relevant claims information from other providers. We think the opt-out provision is consistent with efforts to enhance patient engagement by creating trusting relationships between patients and providers. The conversations between clinicians and patients about the value of clinicians sharing information present an opportunity to enhance communications as well as understanding of the care delivery process.

## **Conclusion**

AARP believes implementation of the provisions of section 3022 of the ACA present an unprecedented opportunity to strengthen and improve the traditional Medicare program by reforming the delivery of care to improve quality and ensure greater efficiency and resource use. We appreciate CMS’ leadership and efforts to make Medicare become more accountable, transparent, and patient-centric and commend its challenge to the clinical community to achieve this triple aim in health care. Clearly, leadership and bold action will be needed in the private sector and other public programs to support the Medicare ACO program. We urge CMS to work with other payers and programs to ensure common goals and requirements for ACOs whenever appropriate.

ACOs will need timely feedback, clear and certain guidance, and in many cases, technical support and assistance. Beneficiaries will need the assurance of effective oversight of ACOs and enforcement of the requirements. We believe that all sectors will need to work to align incentives and clearly articulate realistic, yet challenging expectations that emphasize accountability, effective performance, patient-centeredness, and collaboration.

Dr. Berwick  
June 6, 2011  
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Thank you for the opportunity to comment on this important matter. If you have any questions, please contact Nora Super on our Government Affairs staff at 202-434-3770.

Sincerely,

A handwritten signature in black ink, appearing to read "David Certner", with a long horizontal flourish extending to the right.

David Certner  
Legislative Counsel and Legislative Policy Director  
Government Affairs