October 26, 2017

Mr. John Pilotte
Director of Performance-Based Payment Policy
Center for Medicare
Centers for Medicare & Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Building
200 Independence Avenue, S.W.
Washington, DC 20201

Re: Opportunity for ACOs to provide suggested enhancements to program reports and claims and claim line feed (CCLF) files.

Dear Mr. Pilotte,

The National Association of ACOs (NAACOS) appreciates the opportunity to submit suggested report and CCLF file enhancements. NAACOS is the largest association of ACOs, representing more than 3.2 million beneficiary lives through over 260 Medicare Shared Savings Program (MSSP) ACOs, Next Generation, ESCO and Commercial ACOs. NAACOS is an ACO member-led and member-owned, non-profit organization that works on behalf of ACOs across the nation to improve the quality of Medicare delivery, population health and outcomes, and health care cost efficiency.

During October 2017, NAACOS conducted outreach of ACOs, as well as collected feedback through discussions, research, and telephone interviews. The following recommendations represent this collective process. As you will see, the detailed feedback reflects the desire to see ACOs achieve the long-term sustainability necessary to enhance care coordination for Medicare beneficiaries, reduce healthcare costs, and improve quality in the Medicare program.

Proposed Changes to the CCLFs:

1) Add the TIN the claim was paid to for all Claim files (specifically the Part A Header in addition to the CCN/OSCAR Number). Currently this is included in the Part B file and is very helpful. Under the currently delivered data, ACOs use NPI to try and map to TINs for Part A claims and NPIs can work at more than one TIN. [MODIFICATION]
2) For credit adjustments to prior claims, please add the claim ID to which it pertains [ADDITION]
3) Implement "PUSH" mechanism for delivery of CCLFs under the Data Use Agreement. Alternatively Provide secure, scriptable access to CCLF files, e.g. by secure file copying via SFTP or other secure transfer protocols. [ADDITION]
4) Add the allowed amounts in addition to the paid amounts to Part A and Part B files. [MODIFICATION]
5) Add count of records and length of file layout. Can sum of total Paid Amounts be added for claim files? This would provide ability to confirm that no data was lost during the download process. [MODIFICATION]

6) Where available, include CPT Modifiers [ADDITION]
7) Add Claims Paid Date for all Part A, Part B, and Part D claims. [ADDITION]
8) For both Part A and Part B:
    a) Add separate columns for CPC+ demonstration care management fee (CMF) and comprehensive primary care payments (CPCP).
    b) Add a column for the Oncology Care Model (OCM) participants and care management fee payments
    c) Add the amount of the beneficiary coordinated care award. This is needed to study which beneficiaries received up to $50/year incentive and whether it was effective in improving patient compliance.
9) Part A
    a. ED costs breakout - in addition to amount that was paid by Medicare, include the amount that was billed by the institution [ADDITION]
    b. Populate the "Point of Origin" codes consistently [ADDITION]
    c. Enhance the natural key or add a unique identifier for the life cycle of an individual claim. When one of the fields (PRVDR_OSCAR_NUM; CLM_FROM_DT; CLM_THRU_DT; BENE_EQTBL_BIC_HICN_NUM.) of the natural key changes, it is no longer useful in linking related claims together.
    d. Add a field for the DSH/IME/UCC payments. This is needed for removing costs that do not impact the ACO.
    e. Add the Ambulatory Payment Classification (APC) group for outpatient claim types. This is more consistent with how outpatient claims are paid by Medicare.
    f. Consistently populate the line-level payment field. This is needed for determining the plurality of charges for CAH/FQHC/RHC and ETA hospital attribution using institutional revenue codes.
    g. Add discharge date to appropriate claims. This would allow for understanding of when the beneficiary completed their hospitalization / SNF visit, etc. to ensure proper care is/has been provided.
10) Part B
    a. Please add ordering doctor for clinical lab; ordering doctor for home health [MODIFICATION]
    b. Convey all 12 diagnoses from claims. Only 8 diagnoses are currently provided out of 12 diagnoses on the claim. All 12 diagnoses are needed to compute CMS-HCC risk scores and assign poly-chronic patients to appropriate risk strata. [MODIFICATION]
    c. Add a field for the DSH/IME/UCC payments. This is needed for removing costs that do not impact the ACO.
    d. Provide a major "Service Type" classification to Include the name, address, and ZIP code of the service location (item 32 on Form 1500):
        i. Provided for each PCPs and non-PCPs:
            1. primary care services –office
            2. procedures-office
            3. procedures – facility
            4. Drugs – office
            5. Therapies- office
            6. Other- office
            7. primary care services-facility
11) Part D
    a. Add the allowed and paid amounts to the Part D CCLF file (the file includes only beneficiary's payment amount now). ACOs use this file in risk score algorithms and Medicare paid amount is needed for these algorithms. [MODIFICATION]

b. Add grouping information to the Part D file (ex: therapeutic class). This would help ACOs group similar drugs together. [MODIFICATION]
c. Add mail order versus walk-in pharmacy delivery, and Compound Code [ADDITION]
d. Identify beneficiaries excluded from Part D reporting [ADDITION]
e. Add missing key information such as NDC to reversed claims [ADDITION]

12) Please add Medicare enrollment start date for each beneficiary in the CCLF8 file. This would help ACOs distinguish if a beneficiary didn't have historical claims data because they were not enrolled in Medicare or if they just didn't incur any claims. [MODIFICATION]
13) Please add three years of historical data for an initial claims data load for an individual beneficiary. [MODIFICATION]
14) Add paid claims for service dates that occurred prior to a beneficiary no longer being eligible. When a beneficiary is no longer assigned to the ACO, a provider participant is deleted or a beneficiary opts out of data sharing, paid claims are currently suspended. Complete prior period data is required to fully complete claims for the prior years. [MODIFICATION]
15) Demographic File CCLF8
    a. Assist ACOs to improve patient matching by including in CCLF8 the beneficiary's full middle name instead of just the middle initial. [MODIFICATION]
    b. Add telephone number where available [ADDITION]
    c. Death dates – improve completeness of these dates. [MODIFICATION]
    d. Add the Medicare supplemental policy, or Medigap policy, enrollment status. This can be used to identify beneficiaries who would benefit from out-of-pocket protection that a Medigap plan offers fee-for-service beneficiaries. [ADDITION]
    e. Add an institutional flag. This field is needed for computing the CMS-HCC risk score.
    f. Add a field indicating beneficiary voluntary alignment. This is needed to determine the impact of voluntary alignment and how well the ACO is performing at encouraging voluntary alignment among its beneficiaries. [ADDITION]
    g. Add a field indicating beneficiary request for voluntary alignment which is **not** implemented due to CMS determined eligibility issues, and explanation codes for those exclusions. [ADDITION]
16) If circumstance arise that new fields are added to CCLF, please consider appending to the end of the data file instead of inserting within the file structure. This will allow those ACOs that have the defined data import parameters (field names and field lengths) the ability to make a minor change before importing data into their data warehouse. [MODIFICATION]
17) Provide machine-readable schemas for all CCLF files, for example, by providing CCLF files in a comma- or tab-delimited file formatted with appropriate header rows, or by providing schema definitions for the fixed-width files in a format usable by computers (e.g. json, xml, ini). The BPCI data is in CSV format with headers. The latter is a lot easier to read because we can match up the columns of data with the header and read it all in at once. With fixed format files without headers we have to consult the data spec and manually separate and name the columns. With BPCI data each field (column) is separated from the others with a comma and there's a field name at the top of the column so we immediately know if the format of a file has changed, and the identifier of the new field. [MODIFICATION]
18) When a new column of data is going to be replaced within the CCLF, please retain that old field in its current place and structure (contents as null). The new column could be appended to the end of the file which will allow those ACOs that have the defined data import parameters (field names and field lengths) the ability to make a minor change before importing data into their data warehouse. [MODIFICATION]
19) Consider providing access to a rolling 12-month aggregated data set for easier recovery by the ACOs should either a) CMS distribute incorrect data which corrupts the ACOs data warehouse or b) ACOs experience an internal corruption of their data warehouse. Access to aggregated data files

for the performance year will allow the ACOs the ability to load a complete year's dataset in one pass if needed. [ADDITION]

20) CCLF 2: Please help ensure that there are no claims in CCLF which cannot be found in CCLF 1. CUR_CLM_UNIQ_ID have been noted in CCLF2 and not found in CCLF. CCLF1 is the umbrella file of CCLF2, CCLF3 and CCLF4? [MODIFICATION]
21) CCLF 9
    a) Add all historical HICNs for a member, the first time that a member presents in the files. [MODIFICATION]
    b) Add a crosswalk of all HICNS to the new MBI [ADDITION]
    c) Add a flag for HICN changed status [ADDITION]
22) Bundles. Please enhance CCLF files to reflect any Bundle Episodes incurred by beneficiaries associated with the ACO. Consider providing enough detail to show the specific FFS claims that are aggregated into the Bundle and what the financial impact of that Bundling is. Deliver an "end of bundle" flag to designate the end of the episode [ADDITION]
23) Provide the demographic-only risk adjustment model coefficients for each performance year from 2016 to the 2012 performance year. Provide the prospective model coefficients for 2017 and 2018 performance years. Prospective risk adjustment model coefficients are always available for Medicare Advantage the year prior to the calendar year. This is needed to reconcile lower risk scores under the demographic only model. [ADDITION]

Proposed Changes to the Program Reports:

1) ASSGN Reports
    a. In the Quarterly ASSGN file consider validating that NPIs be listed in descending order of allowed charges. This will improve ACOs assignment attribution to the NPI level. [MODIFICATION]
    b. Include non-normalized HCC score for each beneficiary. Thank you for adding HCC scores that are renormalized by enrollment category. The renormalized scores are helpful for comparing to the financial reports received, but not when comparing beneficiary risk level among all beneficiaries together. [MODIFICATION]
        i. Include Demographic RAF for each beneficiary [ADDITION]
        ii. Add improved designation indicator for HCC Risk Regression Model is used for each beneficiary. [ADDITION]
    c. Include beneficiary address and phone number information. This level of detail is being provided to NGACOs. This will help ACOs in patient matching. [MODIFICATION]
    d. Include date of Medicare eligibility change to enhance accuracy of Assignment work at ACO level [ADDITION]
    e. List all counties without limiting list of counties to 1% level [MODIFICATION]
    f. Consider offering these files in machine readable - pipe or comma delimited format [MODIFICATION]
    g. Table 1-1 [MODIFICATION]
        i. Continue to include fields newly included in 2016 Annual QAASGN (Continuously Assigned/Newly Assigned, Demographic Risk Scores)
        ii. Add field for new MBI Beneficiary ID
        iii. Adjust HCCs so that ACOs can calculate/reproduce the averages provided in the financial settlements. (If CMS believes this can be done, then please issue a document to explain how to do this.)
        iv. Provide document on how demographic scores are calculated.
        v. Add field for total cost per participant with category breakdown similar to report provided in table 3 of QRUR. If not in quarterly, then once per year, with annual settlement. (We acknowledge concern with data opt-outs and substance abuse

redaction, but since CMS already does this for QRUR, then should be able to do for ACOs. Standardized amount provided in QRUR will be better than nothing.

h. Annual Prospective Assignment Lists (P.A***.ACO.HASSGN.Dyymmdd.Thhmmss) could also include patient demographic and contact information and for Track 1+, Track 3 Please add beneficiary to provider 1:1 mapping and adjust monthly eligibility flags in table 1 to actual eligibility start and end dates. [ADDITION]
i. Add EXPU report in the release of the preliminary assignment list, currently the release is limited to HASSGN and AASR reports. [ADDITION]

2) Expenditure / Utilization Reports
   a. Detailed specifications of services included in each of the categories [ADDITION]
   b. Expenditure & Utilization for the current Calendar Year to date, monthly spend as well as rolling 12 months [ADDITION]
   c. Break down Hospital Outpatient into more sub categories [MODIFICATION]
   d. Part B
      i. Subtotal Physician services into provided by [MODIFICATION]
         1. PCP
         2. non-PCP (including APPs; NP/PAs)
         3. facilities
      ii. Group Part B drugs into major types: Immunizations, Chemo Thx, and Other split by Facility Infusion vs Facility Drug Costs [MODIFICATION]
      iii. Allowed and Paid Amount for Part B drug expense [MODIFICATION]
   e. Adding Per Episode Costs to all Utilization/Expenditure reports to correspond to information presented in the QRUR Reports [ADDITION]
   f. Expenditure / Utilization Reports are used for settling financial performance bonuses with Providers, and therefore having details and summaries at the Category level would be useful (Aged/Non-Dual; Dual; Disabled & ESRD). [MODIFICATION]
   g. Adjust completion factors for variable "claims through" dates. If this is not possible, then perhaps CMS could provide a range of completion factors based on the number of days change in lag so that ACOs can calculate. [MODIFICATION]
   h. Establish a completion factor for utilization statistics or clarify footnotes comparing these amounts to annual amounts with different claims run-out periods. [MODIFICATION]
3) When new line items are added to the reports (I.e. Substance Abuse, Outpatient, Dialysis Facility in the Utilization/Expenditure Report), we request that CMS provide the historical data or the prior reporting periods. This will allow the ACO's to develop trend analysis on this data [MODIFICATION]
4) Regional impact. Please communicate Performance Year regional healthcare spending trends directly to each ACO. [ADDITION]

Proposed Changes to the Next Generation ACO Program Reports:

1) NGACO Provider TIN/NPI/HICN file, V*.TINNPIHIC.LIST.Dyyyymmdd.csv – please include one Attributed provider NPI per member in this list? Additionally, indicate specialist vs. primary care provider in the report. [MODIFICATION]
2) NGACO Alignment List Report, P.V*.NGALIGN.RP.Dyymmdd.Thhmmsst. Please add beneficiary to provider 1:1 mapping and adjust monthly eligibility flags in table 1 to actual eligibility start and end dates. [ADDITION]
3) Monthly Expenditure Report (Report 6-1). Please add an itemization of all paid amounts that contribute to our ACO's total cost but do not appear in claims data. It is understood that CMS already itemizes costs associated with Opt-Outs and Substance Abuse claims, but ACOs would also benefit from a line item for costs associated with other claims-suppressed beneficiaries (e.g., those suppressed who were associated with a terminated provider and had no other engagement with a provider in our ACO for 12 months). [ADDITION]

4) Please add whether specific line items are partially or fully represented in the CCLF claims paid amounts. For example, there are line items in the MER for "Sequestration", "Operating DSH" and "Uncompensated Care Payments". We'd like to know if the dollar amounts associated with those line items are coming through in the claim paid amounts. [ADDITION]

Proposed Changes to the Public Data Files:

1) Medicare Shared Savings Program Participants File: (https://data.cms.gov/Special-Programs-Initiatives-Medicare-Shared-Savin/2017-Medicare-Shared-Savings-Program-Participants/futz-eezk/data)

   Add the provider TIN to the participating legal business name (PAR_LBN). This field is required for determining which TINs belong to the same ACO for patient attribution. This file should be updated annually to incorporate ACO provider participant list changes. Historical files back to 2012 should be added as well as 2018 files when provider participant lists are finalized. [ADDITION]

2) OACT Trend: https://www.cms.gov/Medicare/Health-Plans/MedicareAdvtgSpecRateStats/Downloads/Narrative-2018-Payment-Notice.pdf

   Add separate trend projections for ESRD, Disabled, Aged Non-Dual and Aged Dual beneficiaries in addition to separately stated ESRD and non-ESRD US per capital cost (USPCC) trend. This is needed for determining annual trend impact to the ACO for national assignable FFS trend. [ADDITION]

3) Shared Savings Program (SSP) Benchmark Rebasing PUFs: https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/SSPACO/SSP_Benchmark_Rebasing.html

   Update for 2016 as soon as possible, and moving forward these updates should be made regularly and much earlier for each performance year. Medicare Advantage releases the 2017 county-level cost benchmarks and risk scores prior to January 2018. ACOs should similarly have 2017 county-level cost benchmarks and risk scores prior to January 2018. [MODIFICATION]

   Provide recalculated 2014 and 2015 SSP benchmark rebasing PUFs incorporating the 2016 change in dual-eligible enrollment type definition i.e. the addition of Dual status codes 04 and 08. This is needed to compare trends on a comparable basis for 2015 to 2016 and 2014 to 2015 regional trend amounts. [MODIFICATION]

4) Public Use Files:
   Release updated historical PUFs and NPRM datasets with unified HCC and truncation threshold calculations as currently employed by the program. At this point, when we receive the PY16 PUF, it will not be comparable to prior years due to the change from all FFS to assignable beneficiaries. [ADDITION]

   For all public and programmatic data sets, release the specific expenditure truncation thresholds used for expenditure calculations, not merely that they are truncated at the 99th percent (this calculation is not replicable outside of CMS databases). [MODIFICATION]

Overall Reporting

ACOs understand and respect the restrictions around substance abuse and opt-out data. ACOs would be interested in collaborating to define data that is more granular, but still protects the beneficiary's privacy and complies with the relevant regulations [ADDITION]

A key aspect of ACO performance depends on data needed to effectively coordinate beneficiary care. Much of that data is available in the Medicare HIPAA Eligibility Transaction System (HETS). We strongly urge CMS to implement a system to push notifications to the ACOs of all 271 eligibility transactions returned by CMS in response to 270 transactions submitted by Medicare providers and suppliers for beneficiaries assigned to each ACO. This information is instrumental for ACOs to be involved in beneficiary care across settings. [ADDITION]

ACOs are at a critical turning point and effective reports and CCLF files are key for program success. We appreciate changes which were implemented from last year's recommendations. We respectfully request CMS to consider the feedback from the ACO community detailed in this letter. NAACOS would also like to request a meeting to discuss the recommended enhancements in-person. NAACOS believes that a discussion on this topic would enhance both ACOs and CMS in better understanding limitations and opportunities.

We appreciate your continued partnership to ACOs and opportunities to collaborate on refining these important shared savings programs.

Sincerely,

Clif Gaus
President and CEO