NAACOS DATA TASK FORCE

A REQUEST FOR IMPROVEMENT

IN THE DATA PARTNERSHIP

BETWEEN

CMS AND ACOS

JANUARY 2014

Background

ACOs are highly complex organizations committing to an equally complex job of redesigning healthcare delivery to achieve lower costs and improved quality for Medicare beneficiaries. The Medicare Accountable Care Organization (ACO) seeks to ensure that patients, especially the chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors.

The success of the ACO program is largely dependent on the timely transfer of patient information and coordination of care. Further, the ACO requires accurate and timely data from CMS identifying their aligned beneficiaries and claims for their services. These data are valuable for evaluating subpopulations (i.e., patients with highly prevalent conditions or multiple chronic conditions), cost and utilization of services to identify areas of opportunity, and most importantly determining whether or not the ACO is achieving their financial goals.

CMS has made great strides to provide accurate and timely data to their ACOs, but there have been glitches and gaps in the provision of the data and areas have been identified where additional data would be valuable and where improvements in the reports would benefit the ACO and its beneficiaries.

The National Association of ACOs (NAACOS) is a member owned and governed non-profit organization helping ACOs to be individually successful through shared learning as well as through collaboration with CMS to make the overall MSSP program successful. This White Paper is intended to identify enhancements to CMS data and reports that would strengthen the MSSP program and increase the ACOs' probability of success

Four Important Data Topic Areas

CMS provides various data and reports to MSSP ACOs on a periodic basis. We have identified the following four sections for discussion:

- Beneficiary Assignment Reports

- Expenditure and Utilization Report

- Claims and Claim Line Feed (CCLF)

- Data Reconciliation and Other Reporting Issues

CMS provides data files and reports in these areas monthly or quarterly from a myriad of Medicare source files, owned by many different policy, operations and actuarial components. The reports are assembled and distributed under the leadership of the Performance-Based Payment Policy Group in CMS, however, because their production affects operational personnel and budgets throughout CMS, the final decisions about content and priority resides with the Administrator of CMS. In each section to follow, we will describe our understanding and view of the data files and reports, a statement of the challenges ACOs face in interpreting reports and data, and recommendations for changes.

We have restricted our comments to administrative data issues between ACOs and CMS, reserving public policy issues on subjects such as alignment and benchmarking rules for a future communication.

BENEFICIARY ASSIGNMENT REPORTS

Each quarter ACOs receive a pair of beneficiary assignment reports in an excel format. File one is named *[ACO number] QASSGN [Date] [Time]*. We will refer to this file as the "Assignment Report." File two is named *[ACO number] QASR [Date] [Time]*. We will refer to this file as the "Member Summary Report." Each Excel file has multiple tabs. We will refer to each report by its table number.

The tables included in the Assignment Report are as follows:

> **Table 1-1** List of all assigned beneficiaries

> **Table 1-2** List of assigned beneficiaries with a count of primary care services and the TIN used for assignment

> **Table 1-3** List of assigned beneficiaries with a count of primary care services and the CMS Certification Number (CCN) used for assignment

The tables included in the Member Summary Report are as follows:

> **Table 2-1** Summary of the beneficiary assignment count and exclusions

> **Table 2-2** Beneficiary count distributed by the portion of primary care services

> **Table 2-3** Beneficiary count distributed by the number of primary care services

> **Table 2-4** Count of beneficiary by death status, eligibility type, hospice status, gender and age

> **Table 2-5** Count of beneficiary by county

> **Table 2-6** Beneficiaries by HCC with frequency rates

THE ASSIGNMENT REPORT (TABLES 1-1, 1-2 & 1-3)

These tables are the source used by ACOs to capture the preliminary assignment of beneficiaries. The current format and information contained in the table is useful but would be more helpful with some additional information, which we have outlined below.

The data available in these tables is used by ACOs to identify each beneficiary in other data sources, such as a practice's EMR. This identification provides for many critical and essential care coordination, cost reduction and quality improvement activities. Properly distinguishing "James" from "Jim" is an essential task, not always resolved by use of the HICN, Name, and DOB. The alignments which fail through this comparison are the most intractable ones requiring a disproportionate manual interaction. Any additional data elements which will allow a more automated process to match patients will be an improvement.

It is critical to associate each beneficiary with a primary care physician (PCP) and this is one of the key fundamentals associated with the concept of accountable care. This PCP/beneficiary alignment also supports critical population health management activities. The existing tables provide the ACO Participant TIN, but that is not sufficient for the PCP/beneficiary alignment.

Table 2 lists the assigned beneficiaries and the ACO participating TINs from which the beneficiaries have received qualifying primary care services. This table also provides the number of total qualifying primary care services provided to the beneficiary for each TIN.

If the ACO has a participating FQHC, Table 3 will list the beneficiaries assigned to the FQHC, with specific FQHCs identified by CCN (CMS Certification Number), and the number of primary care services delivered to the beneficiary by each FQHC listed.

RECOMMENDATIONS: ASSIGNMENT REPORT

Table 1-1 can be made more useful by retaining, for at least one report cycle, the beneficiaries dropped, with the drop date and the reason the beneficiary is no longer eligible for preliminary assignment.

Including the address for each beneficiary in Table 1-1 would substantially improve the process of identifying a specific beneficiary in EMR and practice management systems.

The Three Part Aim is best achieved if each beneficiary has a fully engaged relationship with a PCP. To assist in assuring a beneficiary to PCP relationship exists, we recommend expanding Table 1-1 to include the identification of the NPI, in addition to the TIN, upon whom the beneficiary assignment was made. Further, this report already exists for the Pioneer ACO attribution and should be readily available to MSSP ACOs.

CMS has previously provided detailed examples of the assignment process with regards to assignment to a TIN. For ACOs that have a large proportion of assigned beneficiaries coming from FQHCs, additional guidance along with detailed examples would be helpful. We would like to see how assignment works when only FQHCs have provided primary care services, as well as cases where both FQHCs and participating TINs have provided services.

Tables 1-2 and 1-3 provide the same information as Table 1-1, with the only difference being the TIN or CCN used for assignment. This approach allows for duplication and processing errors. We recommend the data be incorporated into Table 1-1 by adding to Table 1-1 the count of primary care services and the TIN/CCN, as appropriate. This serves to reduce the preparation time needed by CMS and reduces the potential for errors.

Additionally, we recommend revising Table 1-1 to include the following fields. Items in **BOLD** indicate a new field to this report:

FIELD NAME

- HICN
- First name
- Last name
- **Street address**
- **City**
- **State**
- **County**
- **ZIP code**
- Gender
- Birth date
- Deceased beneficiary death date
- **Count of qualifying primary care services by NPI, TIN and CCN**
- **ACO Participant NPI or CCN used for assignment**
- **Assignment step flag**
- Beneficiary change status (0 = not previously assigned, 1 = previously assigned, **2 = no longer assigned**.)
- **Beneficiary Change Status Reason**
- **Medicare entitlement date**

- **Notation of a change in HICN**
- **Individual HCC markers by beneficiary**
- **Declined data sharing flag**
- **Eligibility status by month for all months applicable to the program (ESRD, Aged, Dual, Disabled)**
- **Truncated costs for those beneficiaries with truncated claims cost by eligibility status**

- **Flag indicating if prescription drug data provided**
- **Institutional status**
- **Provide institution's name, address and phone number for beneficiaries institutionalized,**
- **Hospice status**

THE MEMBER SUMMARY REPORT (TABLES 2-1 THRU 2-6)

CMS provides this report which contains six tables, each detailing different classification statistics to describe an ACO's assigned beneficiaries. The reports provide only a minimum amount of information in addition to some elements which are limited in use. With some additional data elements and drill down capability, the reports would be substantially more beneficial.

RECOMMENDATIONS: MEMBER SUMMARY REPORT

Table 2-4 should be reconfigured to allow drill down to specific beneficiary HICNs if the eligibility type for each beneficiary cannot be added to the Assignment Report, as discussed above.

Table 2-6 could be reconfigured to use more current diagnoses in the analysis (prior 12 months) and the inclusion of beneficiary detail.

EXPENDITURE/UTILIZATION REPORT

This quarterly report shows experience statistics (expenditure and utilization) for the ACO, all MSSP ACOs, and national Medicare FFS (expenditure only). This package is generally delivered 1-2 months after the close of the quarter and is based on information from the preceding 12 months that ended in the specified quarter. The expenditure portion of the report shows beneficiary years, annual expenditures by enrollment type, and expenditures by service type (IP, SNF, etc.) per beneficiary per year. All expenditure information has been completed, annualized, and truncated, according MSSP rules.

The utilization portion of the report contains annual utilization per 1,000 statistics for common health plan measures (e.g. inpatient readmissions, hospitalizations, ER visits, imaging events, etc.), and displays this information for the ACO and all MSSP ACOs.

The Expenditure/Utilization Report is critical for ACOs. It is currently the best report for estimating trends in utilization and absolute costs. However, the CCLF is incomplete, as currently provided, due to the program parameters. Thus, ACOs must rely on the Expenditure/Utilization Report to measure and report overall ACO progress. Continuous feedback is essential to keeping physicians and ACO governing and funding bodies informed about the performance of the program.

The changes in methodology which caused a substantial variance in the 2Q13 Expenditure/Utilization Report compared to 1Q13 Report and to prior Reports, have created substantial challenges with provider engagement and commitment. These reports are the primary source used by ACOs to report program performance to governance and physicians. The uncertainty inserted through the change in methodology has generated a credibility challenge which impacts motivation and engagement (both of which are keys to success).

The existing grouping/definition of costs in the Expenditure/Utilization Report is not publicly documented. Providing the calculation methods and field specifications to ACOs would allow the ACOs to better understand the reports and more effectively compare results to other information sources.

RECOMMENDATIONS: EXPENDITURE/UTILIZATION REPORT

1. The rolling-12 format, as currently provided, is helpful but would be substantially improved with the addition of reporting discrete quarters. The discrete quarters would need to be reported for both the current reporting quarter and the immediately preceding quarter, to allow measurement of claims run-out and so that ACOs can true-up their internal projections.

2. Provide drill down capability by providing a pivot table or other means. For example: If the Expenditure/Utilization Report were provided via an Excel Pivot table, the user could double click the reported value for 30-Day All-Cause Readmissions per 1,000 Discharges and a new sheet would open with the field level detail creating that entry. In this way the user can better understand how the report value was arrived at as well as use the detail to identify opportunities for improvement.

3. Provide details on the coding and classification used for the calculation of costs and utilization. For example within the Component Expenditures per Assigned Beneficiary: What diagnostic and service codes are used to establish costs for the inpatient expense line?

4. Separate the inpatient cost by type of inpatient admission. For example, Medical, Surgical, Psychiatric, Observation, etc. See the sample layout in Exhibit A.

5. Since IME and DSH component costs are not included in the benchmark or expenditure calculations for MSSP ACOs, these elements could reasonably be moved to the footnote section of the report. In the current position, the values simply introduce the opportunity for calculation errors.

6. Additional detail in the Institutional (Hospital) Outpatient section would be very helpful. For example: Diagnostic, OP surgical, Therapies, ER, etc. See the sample layout in Exhibit A.

7. Part B Physician Supplier section of Component Costs would be more helpful if expenditures were sub-grouped into logical categories such as: office visits, surgical procedures, diagnostic testing, etc. and separated by primary care and specialist. See the sample layout in Exhibit A. Please also note there is occasional confusion created when CMS reports refer to "Part A" or "Part B" without also making clear whether making reference to benefit category (Part A benefits or Part B benefits) or claim type (HCFA-1500 vs UB-92).

8. Skilled Nursing Facility costs are broken out but this has limited usefulness without additional data and a clear description of what costs are included. Redesigning the Post-Acute Care section of Component Cost to a) separate costs from Inpatient and b) detail costs into logical sub-categories would be beneficial. See the sample layout in Exhibit A.

9. Any changes to reports should be accompanied by detailed explanations including illustrative examples where applicable, such as occurred with the Q213 Reports.

10. Please consider restating Expenditure/Utilization for periods prior to 2nd Quarter 2013. The change in methodology indicated a substantial shift (negative) in trends. This shift has been defended by CMS as a mere change in methodology. The changes in methodology, the negative impact on trends, and incomplete communication have combined to erode physician confidence and engagement. In the interest of making the program successful, we encourage restatement of the prior periods using the new methodology.

11. Please provide a reconciliation pathway or methodology between the Expenditure/Utilization report and the CCLF data. Items to include:

    o Attributed beneficiaries who have not been contacted (beneficiary counts, person years, claim dollars)
    o Opt-outs (beneficiary counts, person years, claim dollars)
    o IME/DSH dollars
    o Substance Abuse dollars
    o Completion dollars
    o Truncation dollars

CLAIMS AND CLAIM LINE FEED (CCLF)

CMS provides monthly data feeds to each MSSP ACO. The feeds include Medicare Part A and B data for beneficiaries who are assigned to the ACO and have not opted out of data sharing. Data related to substance abuse claims and diagnoses are also not included in the feeds. Part D data is provided for individuals enrolled in a private part D plan. The initial data feed contains claims information starting a year prior to the ACO start date. Subsequent feeds contain approximately one month of additional paid claims, provided in ten separate files, intended to be appended to the initial data feed.

Due to the excluded populations and their associated data, the detailed CCLF data is inherently incomplete and the CCLF effectively provides detailed claims data for a sub-population of an ACO's beneficiaries. The Expenditure/Utilization reports include all assigned beneficiaries for the specified rolling twelve month, but do not provide enough detail to create workable solutions. ACOs are effectively caught between comprehensive but general data (Expenditure / Utilization reports) and specific but limited-in-breadth data (the CCLF). ACOs are able to identify that cost and quality problems exist, but are unable to access sufficient detail to create solutions. Both views are required but neither is sufficient for the purposes of the Three Part Aim. ACOs need to be able to tie the two reports together in order to accomplish this important work.

We are fully aware that CMS' intended use of the CCLF data is that it be limited for beneficiary-specific information. CMS should note that, regardless of the intended use, many ACOs uses this data to assess total medical expenditures, financial projections and emerging trends. The Expenditure/Utilization reports are neither sufficiently detailed nor frequent enough for this purpose. Assisting ACOs in using the CCLF for measurement of cost, quality and utilization management purposes would be a worthy use of CMS resources.   In addition to the recommendations provided below, providing the Expenditure/Utilization reports on a more detailed (as discussed elsewhere and modeled in Exhibit A) and on a monthly basis would provide ACOs with a more complete and continuous view of the information needed to manage the ACO's beneficiaries.

RECOMMENDATION: CCLF DATA FILES

- Two populations and one cost component are excluded from the CCLF: 1) beneficiaries who have not been given the opportunity to opt out of data sharing, 2) beneficiaries who have opted out of data sharing, 3) the claim records associated with substance abuse treatment. We respect the right of these beneficiaries to not share their data; however ACOs need information on all attributed beneficiaries. We recommend providing the cost and claim data for these excluded components, but doing so with de-identified records. There are multiple options to suppress the beneficiary identity and also retain the associated claims and cost information. In this way the beneficiary's identity would be protected, but the claims detail would improve care management opportunities for the population as a whole.

- To calculate utilization rates and cost rates, a population denominator is required. Because the population provided with the Expenditure/Utilization Report is based on Person Years, and no detail is provided to allow ACOs to reconcile Person Years with the Assigned Beneficiary report, we cannot definitely determine the number of Person Years (Population denominator) in the CCLF file. Assumptions can be made, but the variance on those assumptions is wider than the variance in quarter-to-quarter changes in both the Expenditure/Utilization Report and the Assigned Beneficiary report. The net result is a significant level of uncertainty which erodes credibility and confidence.

   To aid the ACOs in calculating an accurate population denominator, CMS should provide a file for each beneficiary included in the CCLF, detailing their historical monthly membership for every month included in the CCLF. Relatedly, the file could also include the beneficiary's ESRD status and dual-eligibility status for each historical month. Providing this information would give the ACOs a more accurate view of the beneficiary's status at the point in time their claims were incurred, whereas as the current methodology only provides a snapshot of the beneficiary's status in the current month.   This companion file should be fully reconcilable with the Beneficiary Assignment reports (including suggested changes as discussed above).

- Other additions to the CCLF files that would greatly aid the efforts of the ACOs include:

   o The original reason for entitlement (OREC) code in the Beneficiary Demographics table, as discussed above.

- Allowed units of service in both the Part A revenue code table and the physician claims table. Currently both tables contain a column for allowed units; however the column is populated solely with zeroes.

- Original admission date for inpatient, hospice, and SNF claims that span multiple billing cycles. This would allow the ACOs to more accurately calculate distinct confinements and total length of stay for those claims.

- Include in the CCLF file the billing TIN for all part A and B services included in the report. The current report includes the billing TIN for part B but only the NPI for part A services.

- Add the modifiers associated with service codes. In the current CCLF files no modifiers are provided for CPT codes, substantially limiting analysis and interpretation.

DATA RECONCILIATION AND MISCELLANEOUS OTHER REPORTING ISSUES

ANNUAL RECONCILIATION

CMS will provide an annual reconciliation for each performance period for each MSSP ACO. This reconciliation will contain two important pieces of information: updated benchmark and money transfers either to the ACO or to CMS based on the shared savings calculation. Currently, as discussed elsewhere in this document, the ACOs are unable to reconcile the data and calculations that CMS performs. The annual reconciliation is no different. The ACOs request CMS provide full data transparency on all calculations while acknowledging that CMS will need to adhere to certain precautions due to privacy issues.

UPDATED BENCHMARK

The updated benchmark will be calculated based on a ACOs historic benchmark, with each enrollment type risk adjusted to account for changes in the risk profile of the ACO-specific population relative to the historic benchmark period. National increments, by enrollment type, will be calculated by CMS based on nationwide fee-for-service (FFS) Medicare experience. These national increments will be added to the risk adjusted historic benchmark and then weighted by the ACO distribution of membership by enrollment type, to arrive at the updated benchmark.

CMS has built in measures to prevent overly favorable risk adjustment which could be possible through aggressive coding initiatives. Conversely, we feel it appropriate that CMS build in additional measures to prevent overly negative risk adjustment that may occur due to risk scores assigned in the newly enrolled population.

IMPROVE HISTORICAL DATA FOR NEW ACOS

ACOs and Shared Savings Contractors are by definition resource constrained compared to health plan counterparts. Health plans (MA or otherwise) are paid administrative costs in a concurrent fashion. MSSP ACOs simply are not paid any administrative costs (other than the few advance funded MSSP contractors). As such, efficient and effective use of the available resources is an imperative.

CMS' political prerogative to withhold patient identifiable data until after the data sharing opt out period should not constrain CMS from supplying provider-identified, beneficiary -anonymous claims history at contract inception. This information will allow all ACO models (networks in particular) the ability to stratify specific providers who provide the greatest opportunity for improved outcomes and cost performance. Conducting the process of allowing beneficiaries to opt-out of data sharing creates a minimum 90 day delay before the beneficiary level data is reasonably available. Waiting the 90+ days for the data sharing opt-out process is tantamount to wasting 90 days or fully one quarter of the performance period.

This data offers an overarching benefit, particularly for those providers whose beneficiaries disproportionately choose to opt out of data sharing or do not have certified EMRs where detailed patient registries can be created. Provider-identified, beneficiary-anonymous claims data should accompany the assignment file on no less than a quarterly basis. We believe providing this data is consistent with the privacy concerns that CMS has illuminated in the preamble to the regulation and while not perfect, provides a much improved operating environment for the allocation of the finite resources available to the ACO.

ELIGIBILITY VERIFICATION PROCESS AND FEEDBACK

ACOs need beneficiary addresses and other data upon assignment in order to efficiently communicate and prepare care plans. After alignment, the success of the ACO is largely dependent on timely knowledge of patient encounters with providers both in and out of the ACO in order to coordinate care.

ELIGIBILITY DATA AT ALIGNMENT

Upon assignment, an ACO best practice is to gain the address information for assigned beneficiaries to use an eligibility ping to the CMS contractor for eligibility verification. The data contained in the return file includes not only the address on file, but several other important information elements such as life time maximums, and other useful data points.

Unfortunately, this activity carries a direct hard cost to the ACO paid to the eligibility vendor. As all of this information is resident in CMS, we are asking that CMS provide the same information in the initial assignment file.

In addition to the data set in the response to the eligibility check, the following status elements would allow the ACO to improve the care of the individual, health of the population and control cost growth: Enrollment Type, Institutional Status, and HCC score and specific co-morbidities. It serves no purpose, and is indeed counterproductive to everyone's goal, to delay providing this information to the ACO.

<u>ELIGIBILITY CHECK FEEDBACK</u>

NAACOS has proposed separately to CMS an Inquiry Notification System (INS) that would serve as a secure, point-of-service notification system allowing member ACOs the opportunity to know when a beneficiary's eligibility is being checked by a provider (a typical precursor to inpatient and post-acute service). This would offer the ACO real time or near real time opportunity to intervene in the coordination of care, redirection to more appropriate setting, application of clinical guidelines, and engagement with providers who may not be participating with the ACO. This can easily be accomplished by leveraging daily data feeds from the HIPAA Eligibility Transaction System (HETS). A clearinghouse for ACO aligned beneficiaries would monitor the eligibility checks from all Medicare providers and notify ACOs when one of their member patients may be seeking or receiving services. We ask that CMS provide direct access to the HETS historical files to establish a notification process to the ACO

AUDITABLE DATA FOR PERFORMANCE VALIDATION

Notwithstanding the data needed to engage in care management, CMS should make available the data used to establish the benchmark and determine financial performance. Often the combined impact of "opt out" and Substance Abuse claims, not reported for various reasons, will account for greater than 20% of spending. This unknown variable overwhelms the results of all care coordination efforts.

This is a first order conflict with the duty of the Board of Directors to act in a fiduciary fashion. No Board could possibly accept the determination of performance where 20% plus or minus variance of performance is expected. This much variance exceeds factors determining economic viability.

In addition, CMS does not provide enough transparency into sources of data, calculation methods, classification and grouping criteria and numerous other elements which would allow an ACO to replicate the reported results. This level of variability and lack of transparency substantially exceeds the Federal Government's own standards validation and auditing purposes, throughout private/government arrangements as well as within the ACO program itself.

We request that a validation process be established by CMS sufficient to support the standards an independent auditor would apply. The validation process should apply to at least Beneficiary Assignment reports, Expenditure Utilization reports, CCLF data, benchmark development and performance determination.

The validation process might be modeled on common audit thresholds. For example, a number of beneficiary test cases (5% of the assigned, data sharing population) that would allow an ACO to reproduce individual cost and utilization results as determined using the CCLF. These results could be compared against individually provided beneficiary cost and utilization results as determined by CMS. This would allow us to gain confidence in both the data provided by CMS but also their own reporting processes.

SUMMARY

The National Association of ACOs has convened a Task Force to examine the data and reports MSSP ACOs receive from CMS. The task force worked for 8 weeks in evaluating the current provision of data and reports and has identified a number of areas for improvement. In conducting this evaluation, NAACOS was solely guided by the need of the MSSP ACOs to receive timely and accurate data so that they can improve the care of the Medicare Beneficiaries and lower costs. The "data partnership" between ACOs and CMS is probably the most important element underlying the success or failure of the MSSP Program. NAACOS recognizes that the program is still evolving but believes that after more than 18 months, CMS needs to recalibrate its data and reporting program and do so quickly. We have provided a number of recommendations that should be easy to implement and have huge value to the ACOs. There are many other CMS ACO policies such as alignment rules, benchmark calculation and trending, and quality measures that are not addressed in this paper.

We have identified nine recommendations that we hope can receive prompt attention from CMS:

1. Beneficiary Assignment reports - Inclusion of dropped beneficiaries and substantial data field additions to the Table 1-1.

2. Member Summary Reports – Additional Beneficiary data is needed or Tables 2-2 to 2-6 if data elements cannot be added to Table 1 above.

3. Expenditure/Utilization report – 11 different recommendations about timing, coding rules, more detail in some cases, more grouping in others. See full section for details.

4. Claims and Claims Line Feed (CCLF) – Include additional categories of beneficiaries, additional claims de-identified of the beneficiary, add a new file of the denominator that CCLF was generated from, include additional data fields like admission dates and service code modifiers.

5. Provide with each CCLF file a member month denominator so that utilization rates can be calculated.

6. Data Reconciliation – Improve transparency on the Annual Reconciliation, Updated Benchmark and Trending.

7. Historical Data for New ACOs - Supply provider identified beneficiary anonymous claims history data at contract inception and not wait for beneficiary opt-out.

8. Eligibility Verification Process and Feedback – Add address and other data variables to the alignment files and establish an eligibility inquiry feedback to ACOs for their beneficiaries.

9. Auditable Data Validation – Establish with ACOs a process whereby they are provided samples of their individual beneficiary cost data that are used in determining their performance benchmark.

NAACOS Task Force on CMS ACO Data White Paper

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SAMPLE LAYOUT OF EXPENDITURE/UTILIZATION REPORT

Facility Cost – Part A claim types

Inpatient/Institutional

Category	Admits	Adm/1000	Total Cost	Cost/Admit	Cost PPY
Medical Admits					
Surgical Admits					
Observation stays					
Skilled Nursing and Transitional Care					
Rehab Admits					
Hospice					
Other Inpatient Admits (Psych, LTAC, etc)					

Outpatient Facility

Category	Cases/Units	Cases/K	Total Cost	Cost/Case	Cost PPY
Surgical encounters					
Diagnostic encounters					
MRI					
CT					
Other Radiology					
Other Diagnostic					
ER Visits					
% ER Admitted					
Home health					
Other OP (Part A type)					

Physician Services – Part B claim types

Primary Care Physicians

Category	Encounters	Enc/1000	Total Cost	Cost/Enc	Cost PPY
Office encounters					
Hospital visits					
ER visits					
Admission / discharge					
Procedures					
Radiology services					
Lab services					
Rx / Inj / Supplies					
Other					

Specialist Care Physicians

Category	Encounters	Enc/1000	Total Cost	Cost/Enc	Cost PPY
Office encounters					
Hospital visits					
ER visits					
Admission / discharge					
Procedures					
Radiology services					
Lab services					
Rx / Inj / Supplies					
Other					

Other Physician Services

Category	Encounters	Enc/1000	Total Cost	Cost/Enc	Cost PPY
Pathology					
Hospitalist					
Anesthesia					
Radiology					
Emergency					
Other					

Other Part B Items

Category	Encounters	Enc/1000	Total Cost	Cost/Enc	Cost PPY
PT/OT/other therapy					
DME					
Transportation					
Other					

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