ROBERT "BO" RYALL
President and CEO

June 6, 2011

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

Re: CMS-1345-P, Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations

Dear Dr. Berwick:

On behalf of our 101 member hospitals, health systems and other healthcare organizations, and the more than 40,000 Arkansans employed by those organizations, the Arkansas Hospital Association (AHA) appreciates the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) proposed regulation on Accountable Care Organizations (ACOs) under the Medicare Shared Savings Program created by Section 3022 of the Patient Protection and Affordable Care Act (ACA).

Arkansas hospitals are committed to accountable care, and many have entered into arrangements within the current regulatory structure to further this goal. For this reason, our members have eagerly awaited the issuance of the proposed rules for ACOs because they hoped that this new, flexible model would help their continuing efforts to better coordinate care to further improve healthcare quality and efficiency. However, the content of the proposed rules has decreased the level of excitement among our members. The AHA is concerned that, as proposed, the ACO structure may not be viable for Arkansas hospitals.

We know that CMS wants to establish a successful program that benefits the Medicare program, healthcare providers, and most importantly, patients. Therefore, we look forward to working with you to achieve that aim. The following are our concerns about the rule as proposed:

Financial Issues

The goal of the ACO care model is to change the current system of care by establishing an improved, patient-centered system in which the entire provider team is incentivized to act as one body in making decisions. In order to achieve true accountability, ACO participants must achieve a level of integration and collaboration that typically is not found in existing organizational structures. The costs of this transformation are extremely high. These costs include necessary changes and improvements in information technology and the infrastructure

needed to collect and analyze provider and patient data, developing and implementing care management strategies, and adding personnel to operate the ACO effectively.

Although CMS's proposed rule estimated an average $1.8 million as the necessary ACO investment, the American Hospital Association recently released a study showing that the actual costs would be significantly higher – for a 200-bed single hospital, $11.6 million and for a 1,200-bed, 5-hospital system, $26 million. For this reason, we suggest that CMS provide up-front funding for ACO formation.

In addition, even with up-front funding from CMS, many healthcare organizations will be unable to recover the initial start-up costs and the ongoing costs of ACO operation under the proposed ACO financial structure.

- While we appreciate that CMS provided two models for shared savings, even the less risky "Track 1" model has too much risk to encourage the participation of smaller organizations or those that have not already taken significant steps toward integration. The Track 1 structure is designed to encourage the participation of organizations less experienced with integration or risk-sharing models. However, requiring Track 1 ACOs to bear financial risk for losses in the third year likely will prevent these types of organizations from participating. The ACO is an untested structure, and many organizations will need more than two years to become operationally viable as an ACO. Allowing these organizations time to develop without imposing a down-side risk is appropriate in this context just as it was in the Physician Group Practice demonstration.

- Although the proposed rule states that the sharing rate is 50% for Track 1 and 60% for Track 2, the application of the quality score to lower the sharing rate actually makes these rates the ceiling with many providers sharing at a rate substantially below those stated in the proposed rule. An ACO's sharing rate will always be lower than the stated rates unless it has a perfect 100% on all 65 quality measures. Generally, achieving the 80th percentile for a quality measure is considered a high score, but if an ACO hits the 80th percentile on its quality measures under this proposed rule, its sharing rate will be decreased proportionately. For this reason, we propose that CMS make these rates minimum sharing rates and use the quality scores to award additional shared savings up to 80% for Track 1 and 90% for Track 2. In this way, providers are given a financial incentive to invest in quality improvement.

- We also urge CMS to set the minimum savings rate (MSR) at 1% or 2% regardless of the ACO's size or its Track. The MSR is set at 3.9% for the smallest ACOs in Track 1, making it much harder for smaller ACOs to achieve shared savings. Over one-third of Arkansas hospitals are small, rural facilities, so our hospitals are more likely to be a part of these smaller ACOs. The high MSR for small Track 1 ACOs is a significant disincentive for smaller organizations to participate.

- As proposed, the shared savings payment from CMS would be delayed during the claims run-out period. After the expiration of this run-out period, CMS would then need additional time to analyze claims and perform the additional calculations and evaluations to determine the shared savings amount. This means that there will be a significant delay in an ACO's receipt of its payment from CMS. In fact, with a six month run-out period, the ACO's payment may be delayed by over a year. This delay in payment will discourage participation in this project.

- Likewise, the 25% withhold also serves as a disincentive to participation. As noted above, start-up and operating costs for an ACO will be significant. Delaying payment of one-quarter of the shared savings bonus potentially creates significant cash flow problems and will require ACOs to look elsewhere for needed capital while waiting for this payment from CMS.

- Because the risk profile of the population assigned to the ACO could change dramatically over the three-year ACO agreement period, we urge CMS to risk adjust for the severity of an ACO's population at least annually.

Assignment of Beneficiaries

CMS proposes to retrospectively assign beneficiaries to an ACO based upon a perceived risk of disparate treatment by providers. Our members share CMS's goal of improved care coordination for all patients; however, we respectfully suggest that retrospective assignment of beneficiaries is not the best approach for making ACOs a success. The AHA believes that it is crucial for effective health management of the beneficiary population that prospective assignment be allowed for the ACO program. With prospective assignment, the ACO can better determine the needs of the patient population, and develop appropriate patient outreach programs to identify and target high-risk individuals and engage beneficiaries in their own care. This approach also will allow the ACO to have access to relevant patient data on a real time basis to make identify opportunities for care improvement.

In assigning beneficiaries to the ACO, our members also feel that it is important to expand the definition of "primary care" to include specialists that provide care management and coordination for patients. For example, one of our hospital members stated that the rheumatologists on its Medical Staff are very engaged in managing overall patient care.

Quality Standards

The AHA and its members are dedicated to providing excellent care to Arkansas patients, and we agree that quality measurement is an important part of the ACO initiative. However, we urge CMS to consider changes to its proposed approach to ACO quality.

As noted above, CMS proposes to evaluate ACOs on 65 quality measures beginning in year 1 of the ACO program. Not only is the number of measures daunting for providers, but the

measurement and collection process will be extremely burdensome. Many of the providers who will be crucial participants in an ACO currently do not have the technology in place to track these measures. Establishing this infrastructure will be part of the ACO development process.

In establishing this new care delivery model, we ask CMS to consider a phased-in approach to quality measures, focusing on a core set of measures for the initial phase, then gradually adding other metrics over time. This would allow ACOs to focus on these core measures while they go through the "growing pains" of establishing a new patient care delivery structure. This approach has been very successful in the existing hospital quality reporting program, leading to dramatic improvements in quality measures within relatively short time periods. In choosing the quality measures, we support the extensive and well-conceived comments of the American Hospital Association in its comment letter setting forth suggested quality measures that keep in mind the cornerstones of the ACO program and allow the program to start with a focused, concise list of quality measures.

Governance and Operations

The requirements in the proposed rule for the makeup of an ACO's governing board are confusing and potentially raise fiduciary duty concerns. CMS requires at least 75% of the governing body to be held by ACO participants, each of whom must have "appropriate proportionate control" over governing body decision making. This implies that each participant will be acting to benefit himself/herself and not the ACO as a whole. However, this notion of corporate governance does not comport with fiduciary duty principles, which require that members of an ACO governing board should be acting on behalf of the ACO and not on behalf of the provider or providers he/she represents.

While the AHA agrees that it is crucial for each of the providers participating in an ACO to have a meaningful voice in clinical operations and care delivery, we do not believe that CMS's proposed limitations on board membership are necessary. There are a number of factors that may determine the makeup of a governing body and voting rights of its members. These factors may include, without limitation, the community within which the ACO operates, the capital contribution of the various entities involved, and the tax status of the participants. Each ACO will need the flexibility to consider these and other relevant factors in making its governance decisions.

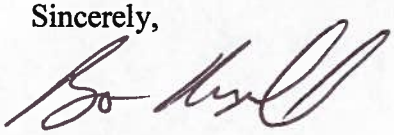
With regard to general operations, we believe that ACOs should be able to add participating providers during the three-year ACO agreement period. It is not unusual for a hospital or other organizations to add a group of physicians during the course of a year. CMS intends to assign beneficiaries annually, so it seems logical to also allow participating providers to be added annually.

We also ask that CMS reconsider the proposed requirements for prior approval of all ACO communications with beneficiaries that are related to ACO operations or functions, as well as marketing activities, and address this issue in the context of issuing guidelines on the required

notification of beneficiaries regarding the provider's participation in the ACO program. It is unlikely that ACOs will be marketing to beneficiaries since there is no enrollment process. Even if ACOs decided to market to beneficiaries, the prior approval requirement is overly burdensome. Any concerns could be addressed by the issuance of guidelines for beneficiary communications.

Once again, we thank you for the opportunity to comment on this proposed rule. If you have any questions, please feel free to contact me directly.

Sincerely,



Bo Ryall

BR/ae