

May 24, 2011

VIA ELECTRONIC MAIL AND FEDERAL EXPRESS

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, DC 20201.

Re: Proposed Rule - Medicare Shared Savings Program: Accountable Care Organizations

Dear Dr. Berwick:

We write to you in conjunction with The Academy Advisors, a policy coalition of which many of us are members, to express our initial thoughts, concerns and solutions regarding the proposed rule for the Medicare Shared Savings Program. We are Chief Executive Officers of Leading Health Systems, a term we use to describe the leading providers of integrated healthcare services in the United States. In addition to providing integrated care delivery, Leading Health Systems are dedicated to patient and community care, and are on the leading edge of medical research, education and training.

We understand and appreciate the complexity of the task which the Centers for Medicare and Medicaid Services ("CMS"), along with the Federal Trade Commission ("FTC"), the Department of Justice ("DOJ"), and the Internal Revenue Service faced in drafting the proposed rule and the related guidance. As leaders in providing integrated care, we are strong supporters of the Accountable Care Organization ("ACO") concept as envisioned in the Patient Protection and Affordable Care Act ("PPACA"). Further, we are committed to a partnership with CMS to provide care coordination involving collaboration among providers and suppliers and the sharing of information across the continuum of care directed toward improving health outcomes, lowering costs and increasing quality of care.

Our Leading Health Systems have been enthusiastic about a partnership with CMS that will lead to an efficient patient centered care transition. We are encouraged by the increased flexibility shown by the Center for Medicare and Medicaid Innovation in the announcement May 17, 2011 of the Pioneer ACO model, and hope this increased flexibility will continue and broaden in the Medicare ACO program. We are firm believers in integrated care and the concept of accountable care, and we appreciate your work to make the necessary changes that will allow us to participate.

As presently drafted the proposed rule insufficiently advances the dual goals of cost reduction and improved patient outcomes because of excessive focus on process, regulatory regime and enhanced risk to providers. In the spirit of constructive suggestions, we believe that our health systems will be much more likely to participate in the Medicare ACO program if CMS, DOJ and FTC focus extensively on changes to the following aspects of the policy proposals:

1) **Retrospective Attribution:** Other successful capitation models are based on both the patient and provider understanding the relationship. We recommend prospective attribution because it puts the patient in a more powerful position to influence the care process and it offers the provider the opportunity to design a care plan including preventive care.

2) **Start-up Capital Expenditures:** A recent study by the American Hospital Association estimated start-up costs of \$11.6– \$26.1 million. Our experience is that with a more narrow initial focus on fewer quality measures, combined with prospective attribution and reduction of the numerous administrative burdens, start-up costs can be reduced.

3) **Shared Savings Percentages:** Increasing provider participation is a shared goal by CMS, providers, and consumers. We recommend three methods—lower the savings threshold from 2%, reduce the Minimum Savings Rate (“MSR”) for a Medicare ACO with lower enrollment, and increase the percentage of savings which is shared with the ACO after the savings threshold is met.

4) **Number and Calculation of Quality Metrics:** We fully agree that quality metrics are important for patients, CMS and providers. Instituting 65 measures in year 1 is a substantial practical constraint. There is precedent for CMS phasing in quality measures over time, which is our recommendation.

5) **Antitrust Guidance and other barriers (Stark/Anti-Kickback, etc.) to providing integrated care:** This is an area of great concern to providers and governmental agencies. We encourage CMS to continue to work with the FTC, DOJ, and IRS to reduce the very significant barriers to ACO participation, clearly communicating and emphasizing the criticality of a successful Medicare ACO program.

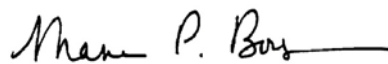
We feel that these issues compose the foundation of the ACO rule. Adjustments and modifications to these are likely to determine the ultimate success of the Medicare ACO program. Initiating a Medicare ACO will result in numerous financial, structural and technological hurdles for healthcare providers, even for integrated systems such as those we operate. We feel that participation from the leading integrated health systems, such as those signing this letter, will increase if the magnitude of the challenges of establishing and operating an ACO are more fully reflected in the regulations.

Each of our health systems anticipates providing a comment letter to CMS, either individually or in collaboration with the AHA, AAMC or another policy group, specifically setting forth what we believe to be the positives and shortcomings in the proposed rule. However, we believe that it is important to step forward now with our thoughts and reaction regarding the ACO proposed rule as drafted. We do this with the optimism that CMS will focus on making the Medicare ACO program a success for patients, providers, and for all who participate in the U.S. healthcare system.

Yours sincerely,



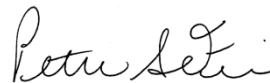
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