American Hospital Association

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Transmitted electronically

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

Dear Dr. Berwick:

On behalf of the American Hospital Association's (AHA) 5,000 member hospitals, health systems and other health care organizations, I am writing to share an independent analysis (attached) of the steps and level of investment required to prepare an organization to be accountable for the care of a defined population. I believe you may find this analysis useful as the Centers for Medicare & Medicaid Services (CMS) considers modifications to the proposed regulations for the Medicare Shared Savings Program.

The intent of the Medicare Shared Savings Program is to promote significant delivery system reform through the formation of Accountable Care Organizations (ACOs). ACOs have been heralded as a promising model for improving the quality of care and reducing unnecessary costs through coordination and collaboration among providers. The concept envisions a transformation in the way that care is organized and delivered across the continuum. This study, *The Work Ahead: Activities and Costs to Develop an Accountable Care Organization*, identifies a total of 23 different capabilities that the case study sites indicated must be developed across four categories to achieve this transformation: 1) network development and management; 2) care coordination, quality improvement and utilization management; 3) clinical information systems; and 4) data analytics.

The analysis indicates that the per organization investment required to put in place and sustain the elements necessary for success is considerably higher – $11.6 to $26.1 million – than the $1.8 million estimated by CMS in its proposed rule for start-up and one year of operating expenses. CMS based its estimates on the experience of the Physician Group Practice Demonstration sites, which already had many of the required elements in place, such as well-developed hospital-physician relationships, electronic health records, and previous experience with pay-for-performance programs. Drawing only from this experience underestimates what might be required for a more typical provider organization. **As we will discuss further in our**

forthcoming comment letter, CMS should adjust the shared savings rate in recognition of these costs in order to encourage and enable participation in this important program.

This study was prepared for the AHA by McManis Consulting, a management consulting firm that works with health care organizations on strategic planning, performance improvement, relationship management and other initiatives. The study is based on a series of case studies completed prior to the release of the proposed rule and, therefore, does not include estimates of the costs of meeting requirements specific to the Medicare Shared Savings Program (e.g., the reporting of 65 quality measures, achieving specific levels of meaningful use, etc.). The individual case study reports can be found at www.aha.org/ACOcasestudies.

We appreciate the opportunity to share this information and look forward to working together to ensure that the Medicare Shared Savings Program is constructed to encourage the maximum number of participants while still achieving savings for the Medicare program. If you have any questions, please contact Caroline Steinberg at AHA at (202) 626-2329 or csteinberg@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President, Policy

cc: Ms. Marilyn Tavenner, Principal Deputy Administrator
Mr. Jonathan Blum, Deputy Administrator and Director, Center for Medicare

Enclosure