American Hospital Association

Liberty Place, Suite 700
325 Seventh Street, NW
Washington, DC 20004-2802
(202) 638-1100 Phone
www.aha.org

Submitted electronically to: advpayACO@cms.hhs.gov

June 17, 2011

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

Advance Payment Initiative for Accountable Care Organizations entering the Medicare Shared Savings Program

To Whom It May Concern:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 42,000 individual members, the American Hospital Association (AHA) commends the Centers for Medicare & Medicaid Services (CMS) for considering an Advance Payment Initiative for potential Accountable Care Organizations (ACOs) that are considering participating in the Medicare Shared Savings Program (MSSP). We thank CMS for the opportunity to provide suggestions on how the agency can partner with providers to make the investment necessary to become an ACO.

We support the CMS Innovation Center's concept of the Advance Payment Initiative to test whether and how pre-payment of a portion of future shared savings through monthly installments could increase participation in the MSSP. We encourage CMS to be flexible in:

- estimating the appropriate monthly amount that should be disbursed;
- determining how the reconciliation process between the pre-payments and the calculation of shared savings would be implemented; and
- establishing the process by which nascent ACOs would pay back the pre-payments if adequate shared savings were not achieved.

We fully understand and support the goal of reducing annual per capita expenditures; however, several experienced organizations that participated in previous CMS demonstration projects, including the Physician Group Practice (PGP) demonstration, reduced expenditures but did not

receive a shared savings bonus. In the PGP demonstration, for example, the parameters CMS used to calculate the shared savings bonus were too ambitious to allow many of the participants to share in savings. The AHA submitted detailed recommendations in its June 1 response to CMS' proposed regulation for the MSSP to suggest ways to improve the balance between reducing expenditures and sharing in savings.

Formation of an ACO will require significant upfront investment, and we urge the CMS Innovation Center to combine the Advance Payment Initiative with a grant program to offset the extensive investment needed to form an ACO, particularly in the case of small and/or rural hospitals and other organizations. We encourage CMS to consider investments beyond pre-payment of future bonuses because ACOs will need to make investments that go well beyond what they will potentially earn in shared savings bonuses. At the direction of the AHA, McManis Consulting recently completed four case studies to assess the capabilities required to be successful as an ACO and the associated costs. These four case study organizations vary in size and type, including a large health system, a physician-only group practice, a single hospital community system and an independent practice association affiliated with a hospital system. Additional information on each of the case studies is available at www.aha.org/ACOcasestudies. These four case study organizations reside in four distinct geographic areas and represent different models for ACO development. McManis Consulting identified 23 dimensions and costs related to establishing an "ACO-like" organization (see Attachment).

These case studies provide the supporting research for a report documenting the costs of becoming an ACO, which we have made publicly available.[1] **Estimates by McManis Consulting have determined the combined start-up and first-year ongoing costs are much higher than CMS estimated. Specifically, for a small ACO, costs were estimated to be $11.6 million; costs for a medium ACO were estimated to be $26.1 million.**

Table 1: Estimates of ACO Start-up and Ongoing Costs for Year 1

Estimate of ACO Investment	Average
CMS (based on a range of 75 to 150 ACOs)	$1,800,000
McManis (200-bed, single hospital system with 80 primary care physicians and 150 specialists)	$11,600,000
McManis (1200-bed, five-hospital system with 250 primary care physicians and 500 specialists)	$26,100,000

Note: McManis Consulting's estimates are based on case studies and include start-up and ongoing costs for a typical year. Some costs already may have been incurred or be allocable to other budgets.

[1] www.aha.org/ACOcasestudies

We ask CMS to consider also offering grant money in specific areas to offset the extensive investment that is needed. It is unlikely that an ACO, especially those with smaller numbers of aligned beneficiaries, will earn the amounts suggested above through the shared savings bonus. Therefore, each potential ACO will need access to capital in different areas depending on the organization. We recommend that CMS establish grant mechanisms through the Innovation Center in the dimensions listed in Appendix A. For example, costs under dimension 11 – care coordination and discharge management for a small ACO – is estimated to be $1 million on an ongoing basis and $3 million for medium ACO. We encourage CMS to make grants available for testing innovative care coordination and discharge management strategies that offset all or a portion of these ongoing costs. Further, we encourage CMS to align these grant opportunities with other initiatives underway in the Innovation Center, including the *Partnership for Patients* and the *Community Care Transitions Program*.

While we believe that advance payments and/or grants could help organizations address the infrastructure development costs for certain ACOs, it would not replace the need for major changes to the MSSP in the final rule. An advance payment program and grants could make the MSSP more attractive, but significant improvements to the rule, such as those recommended in the AHA's MSSP comment letter, are necessary to make the program attractive and operationally viable.

The AHA strongly supports the delivery of accountable care, and we appreciate the Innovation Center's proposal to implement the Advance Payment Initiative as a way to increase participation in the MSSP. Thank you for your consideration of our suggestions. If you have any questions, please contact Lisa Grabert, senior associate director of policy, at (202) 626-2305 or lgrabert@aha.org.

Sincerely,

/s/

Linda E. Fishman
Senior Vice President, Public Policy Analysis & Development

Attachment

Attachment: ACO-like Activities and Costs

SUMMARY: ACTIVITIES AND COSTS TO ESTABLISH AN ACO-LIKE ORGANIZATION

	Prototype A: (200 bed, 1-hospital system 80 PCPs, 150 specialists)		Prototype B: (1,200 bed, 5-hospital system, 250 PCPs, 500 specialists)	
Activity	**Start up Costs**	**Ongoing (Annual) Costs**	**Start up Costs**	**Ongoing (Annual) Costs**
Group I. Network Development and Management				
1. Providing ACO management and staff	$550,000	$1,150,000	$600,000	$3,200,000
2. Leveraging the health system's management resources	$250,000	$200,000	$300,000	$250,000
3. Engaging legal and consulting support	$350,000	$125,000	$500,000	$125,000
4. Developing financial and management information support systems	$500,000	$80,000	$500,000	$160,000
5. Recruiting/acquiring primary care professionals, right sizing practices	$400,000	$800,000	$800,000	1,600,000
6. Developing and managing relationships with specialists	*	*	*	*
7. Developing and managing an effective post-acute care network	*	*	*	*
8. Developing contracting capabilities	$150,000	$150,000	$150,000	$150,000
9. Compensating physician leaders	$75,000	$75,000	$190,000	$190,000
Group II. Care Coordination, Quality Improvement and Utilization Management				
10. Disease registries	$75,000	$10,000	$150,000	$20,000
11. Care coordination and discharge follow-up	$150,000	$1,000,000	$300,000	$3,000,000
12. Specialty-specific disease management	–	$150,000		$300,000
13. Hospitalists	$80,000	$160,000	$160,000	$320,000
14. Integration of inpatient and ambulatory approaches in service lines	*	*	*	*
15. Patient education and support	–	$100,000	–	$100,000
16. Medication management	–	$100,000	–	$100,000
17. Achieving designation as a patient-centered medical home	$100,000	$15,000	$150,000	$25,000
Group III. Clinical Information Systems				
18. Electronic health record (EHR)	$2,000,000	$1,200,000	$7,050,000	$3,500,000
19. Intra-system EHR interoperability (hospitals, medical practices, other)	$200,000	$200,000	$400,000	$200,000
20. Linking to a health information exchange (I IIC)	$150,000	$100,000	$200,000	$200,000
Group IV. Data Analytics				
21. Analysis of care patterns	$210,000	$210,000	$450,000	$450,000
22. Quality reporting costs	$75,000	$75,000	$100,000	$100,000
23. Other activities and costs	–	$100,000	–	$100,000
TOTAL	**$5,315,000**	**$6,300,000**	**$12,000,000**	**$14,090,000**

**Costs are primarily management and staff and are included in previous elements (1,2 and 3).*