GEISINGER

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May 12, 2011

Donald Berwick, MD, 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.

Dear Dr. Berwick:

On behalf of the multi-specialty groups participating in the Physician Group Practice (PGP) Demonstration Program, we are writing to you today regarding Section 3022 of the Affordable Care Act's notice of proposed rule-making (NPRM) for the Medicare Shared Savings Program/Accountable Care Organizations (ACOs).

We sincerely appreciate the time and effort you and your staff have dedicated to the drafting and coordination of the ACO NPRM. The timelines associated with the implementation of this section have always been considered challenging. Including the input of the other federal agencies must have made this task even more daunting.

Furthermore, we support the concept of ACOs as envisioned in the statute because of the need to ensure that patients, over time, receive the best and most efficient care possible. To do so, requires more coordination and collaboration among providers and suppliers than is the case in much of our healthcare system today.

However, as presently proposed, we ALL have serious reservations about the economics and the complexity of the Medicare Shared Savings Program/ACO NPRM. All of our organizations are planning to individually respond with our own respective concerns, but broadly, the "Shared Savings" model/NPRM has the following aspects that are problematic:

- There is downside risk during the initial 3-year term, unlike the recently concluded PGP Demonstration project. Such downside risk is compounded by significant investment cost on the part of the ACO.
- Savings are measured net of 2% threshold for the one-sided risk model. Additionally, the Minimum Savings Rate (MSR) is set at high levels for ACOs with lower enrollment.
- Limits placed on accounting for beneficiary acuity level that is documented and appropriate will dilute true savings realized by the ACO, and is a disincentive for management of patients with complex care needs.
- There are a large number of quality measures, especially new quality metrics in several domains, that go into effect starting year one. As an example, *on average*, it costs about $30,000 just to program a single new quality metric. This NPRM has more than 60 new ones, which equates to nearly $2,000,000 for each organization. The excellent results produced by the PGP demonstration are evidence of the benefits of a careful expansion of quality measures.

- o Retrospective attribution places limits on the ACO's ability to bend the cost curve. It impedes optimal patient engagement, timely program planning and course correction, and compounds underlying issues of claims lag and financial settlement.
- o The logistics associated with Medicare beneficiaries' opt-out of the ACO program is simply not practical. We believe this would lead to beneficiary and physician confusion on the terms of engagement.

As currently proposed, ACOs have a greater potential for incurring losses under either track, than for generating savings. This risk-reward imbalance makes it difficult, if not impossible, for internal decision-makers to accept the financial design.

There are a number of other organizational and operational issues that we will address separately in our own individual comments. However, these broad categories reflect our most serious concerns related to participation in the ACO program, and if left unaddressed, we will be unable to participate.

We look forward to working with you and other federal policymakers on this matter, to offer suggestions for improving the current proposed rules and achieving our shared goals for patients and providers alike.

Sincerely,

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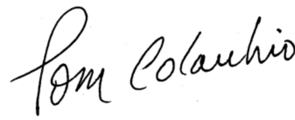
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