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how to get there...*

April 28, 2011

Dr. Donald Berwick, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
7500 Security Boulevard
Baltimore, MD 21244-1850

RE: File code CMS-1345-P

Dear Dr. Berwick:

ProForma Healthcare Solutions, LLC (PFHCS), welcomes the opportunity to comment on the Centers for Medicare & Medicaid Services' (CMS) Proposed Rule on executing the Patient Protection and Affordability Act's (PPACA) Section 3022: Medicare Shared Saving Program (MSSP) released to the public on March 31, 2011 (hereafter "Proposed Rule"). We appreciate your staff's hard work to deliver these proposed definitions, particularly with the many distractions and competing demands for your agency's time.

Accountable Care Organizations (ACOs) appear to be a very promising way to re-align physician financial incentives towards improvement of the quality of patient care while reducing the costs of delivering these services to the CMS system. Further, we believe that the definitions provided for ACOs will provide important guidance for providers attempting to undertake their formation.

Rural communities face unique health care issues, including geographic isolation, limited/insufficient technology infrastructure, discontinuity or fragmentation of care, a higher dependence on public health care programs, and a higher rate of chronic disease. Addressing health disparity is a key goal of the PPACA legislation and CMS' ACO Definitions. However, as designed, the Proposed Rule, and the Rural Exception Rule, may have the unintended consequence of deterring rural sole community providers from participating in benefits of such a program.

Based on collaboration with our rural healthcare provider clients, we are aware of several stakeholder concerns about the Proposed Rule that need to be brought to your attention. These include:

- The Rural Exception Rule indicates that rural healthcare providers that wish to form an ACO that will have a projected market share of between 30% and 50% will automatically be granted Protection Zone status from the DOJ without review. A rural community Sole Provider that has over 50% of the existing market share, but demonstrates no inherent market power, will still be required to endure the delay and expense of a full anti-trust review prior to approval for ACO formation;





- The reference in the Proposal Rule to OBRA 1981, Stark 1, that physician self-referral practices will be strictly enforced even when a rural ACO acquires all specialists offering said services in the expanded area of practice with or without exclusivity;
- The two-year transition timeline from the one-sided risk model to the two-sided risk model for already financially weak rural providers is not feasible. In our experience, rural providers in the poorest jurisdictions have made very limited investments in IT and lack any regional Connectivity. Without this underlying infrastructure, achieving the targeted savings thresholds through true integrated healthcare is unlikely;
- The average \$1.75MM required for formation of the ACO entity is a significant hurdle. Most rural community Sole Provider hospitals will be subject to the phasing out of the Disproportionate Share Hospital (DSH) program in 2014. Reductions in operational costs and business investments, like ACOs, are imminent for sustainability;
- A 501(c)3 organization's participation in an ACO with for-profit partners could put that charitable not-for-profit status at risk. And, because the Proposed Rule holds bonus payouts, savings and bonuses may exceed the organization's contributions to the ACO in any subsequent tax year forcing review of that status. Further, this income will be treated by the IRS as Unrelated Business Taxable Income and subject to tax.

PFHCS strongly supports both the concept of an ACO and CMS moving ahead expeditiously with the program. Given the potential for rural ACOs to scale integrated healthcare and expand their patient pool from isolated, chronically ill patient segments into broader, more average patient risk pools that will be less expensive to underwrite, we commend the approach. We must counter the expansion of ACOs from healthy urban populations that selectively integrate rural providers to improve their measures and profits. We need to find ways to incent ACO formation in the most remote and poor rural areas where the impact will be greatest. In our experience, there are several interim steps that CMS can take to allow this to happen and we would welcome the opportunity to discuss it further.

PFHCS appreciates the opportunity to comment on the Proposed Rule. We also value the ongoing cooperation and collaboration between CMS and the PFHCS staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions or require clarification of our comments, please feel free to contact John F. Ellingson, PFHCS' Partner for Regulatory Affairs at 678 520 8368.

Sincerely,

ProForma Healthcare Solutions

Joseph M. Quattlebaum
Partner, ProForma Healthcare Solutions, LLC
cae/jmq

