December 3, 2010

Dr. Donald M. Berwick
Administrator
Centers for Medicare & Medicaid Services
200 Independence Avenue, SW
Suite 314-G
Washington, D.C. 20201

Subject: File Code CMS-1345-NC (Accountable Care Organizations)

Dear Dr. Berwick:

On behalf of the American Physical Therapy Association’s (APTA) 78,000 member physical therapists, physical therapists assistants and students for physical therapy, I am pleased to share our comments on the Centers for Medicare and Medicaid Services (CMS) Request for Information Regarding Accountable Care Organizations and the Medicare Shared Savings Program, published in the Federal Register (75 Fed. Reg. 70165).

The goal of an ACO is to increase access to care, improve the quality of care and coordination of care, and ensure efficient delivery of care by rewarding providers who are doing their part to control costs and improve quality. Physical therapists are committed to providing high-quality timely care, and to the promotion of evidence-based and patient-centered practice. In this letter, we address specific questions raised by CMS in the Request for Information below.

What Policies or standard should we consider adopting to ensure that groups of solo and small practice providers have the opportunity to actively participate in the Medicare Shared Savings Program and the ACO models tested by CMMI?

The Patient Protection and Affordable Care Act calls for the creation of an ACO program administered by CMS by January 1, 2012. The statute specifies that the following forms of organizations may become an ACO: 1) physicians and other professionals in group practices; 2) physicians and other professionals in networks of practices; 3) partnerships or joint venture arrangements between hospitals and physicians/professionals; 4) hospitals employing physicians/professionals; and 5) other forms that the Secretary of
Health and Human Services may determine appropriate. An “ACO Professional” is defined under statute to include a doctor of medicine, doctor of osteopathy, physician assistant, nurse practitioner, and clinical nurse specialist.

There are many health care professionals, such as physical therapists, that were not identified in the statute as “ACO Professionals.” However, we strongly believe that for an ACO model to be successful, it will be essential that physical therapists and other health care professionals and providers be included as part of the model. The success of the ACO model in fostering clinical excellence while effectively managing the costs will hinge on its ability to have a broad spectrum of physicians, health care professionals and other providers form linkages to facilitate the coordination of care delivery throughout different settings.

In addition to practicing in hospitals, skilled nursing facilities and institutional settings, many physical therapists furnish services in small office based practices, similar to physician practices. It will be important for these small physical therapy private practices as well as the post-acute care facilities to have the opportunity to participate in the ACO models. Therefore, we strongly urge CMS to recognize physical therapists as professionals who may participate in the ACO model and share in the savings. According to the statute, the Secretary of HHS has the authority to recognize other forms of ACO models. CMS should also enable providers to participate in more than one Accountable Care Organization.

To encourage ACO development and the participation of small practice providers, additional resources should be provided up-front. CMS could provide grants that would enable physicians, physical therapists, and other providers to finance the start up costs associated with creating an ACO. Because the “shared savings” model only provides for potential savings at the back-end, these grants will be important to encourage the ACO development.

Other barriers faced by small practice include the small size of their patient panels, limited access to capital, health information technology, and infrastructure needs. Physicians and hospitals are eligible to receive incentive payments for adoption of electronic health records used in a meaningful way. These incentives will be helpful in the establishment of ACOs. However, other providers, such as physical therapists, skilled nursing facilities, and home health agencies are not eligible to receive these incentive payments. CMS and Congress should take measures to address these limitations by allowing a broader array of providers to qualify for incentive payments.

The process of attributing beneficiaries to an ACO is important to ensure that expenditures, as well as any savings achieved by the ACO, are appropriately calculated and that quality performance is accurately measured. Having a seamless attribution process will also help ACO’s focus their efforts to deliver better care and promote better health. Some argue it is necessary to attribute beneficiaries before the start of a performance period, so the ACO can target care coordination strategies to those beneficiaries whose cost and quality information will be used to assess the ACO's
performance; others argue the attribution should occur at the end of the performance period to ensure the ACO is held accountable for care provided to beneficiaries who are assigned to it based upon services they receive from the ACO during the performance period. How should we balance these two points of view in developing the patient attribution models for the Medicare Shared Savings Program and ACO models tested by CMMI?

It is important for beneficiaries to know if their providers are operating under the new incentive structure of the ACO and for providers to know if the care of the patient they are treating will be attributed to them. For the program to be effective, beneficiaries will need to be engaged in their own care management, and therefore it will be important to be knowledgeable about their placement. There is a need for mutual accountability on the level of the patient and the provider. This means that assignment to the ACO would need to be prospective. The beneficiaries who are assigned to the ACO should be educated about the services that the ACO will offer and about their ability to go to providers outside the ACO if they choose to do so. In addition, beneficiaries should have the ability to make a request that they not be assigned to an ACO.

The major challenge to prospective attribution will be determining placement of new Medicare beneficiaries in the ACO. Prospective assignment uses claims data from a prior year to make the assignment. These individuals will not have a claims history that could be used to determine ACO placement and that could be used to evaluate the ACOs success in improving quality.

In order for an ACO to share in savings under the Medicare Shared Savings Program, it must meet a quality performance standard determined by the Secretary. What quality measures should the Secretary use to determine performance in the Shared Savings Program?

It will be important for ACOs to report on a set of quality measures that ensures that the beneficiaries receive high quality, coordinated care, while controlling costs. These measures will need to be set forth so that there is no stinting on care in an effort to lower costs to save money.

Any quality measures established for ACOs should be nationally accepted, validated measures. These measures should be vetted by credible, independent entities that allow meaningful participation in the process from all relevant stakeholders.

Process measures, structural measures, patient experience measures and outcome measures will all be important measures for ACOs. The use of these measures will help to ensure that the ACOs do not cut costs and thereby achieve savings by jeopardizing quality of care. Any outcome measures used in a system must be risk adjusted to account for factors, such as patient severity of illness, comorbidities, functional limitations, age, gender, cognitive status, availability of a caregiver, and prognosis that may influence the outcomes of care. Risk adjustment is important to ensure that ACOs are not discouraged from treating patients who might lower their quality scores.
As ACOs are established, it is important to ensure that the quality benchmarks established and how they are interpreted and reported is standardized nationwide. The measures will also have to be applicable to different care providers and span care settings to accommodate the set of providers included in an ACO.

With respect to physical therapy, currently there are process measures that are used under the PQRI program. ACOs should also consider how physical therapy services can improve quality of care by reducing preventable readmissions to hospitals and by avoiding costly surgeries. Costs can be reduced considerably if a more conservative course of care is followed, that involves the initiation of physical therapy before costly diagnostic tests for conditions, such as low back pain. For example, a measure of how frequently the ACO beneficiaries undergo a course of physical therapy care prior to surgery would be useful. We believe that ultimately in the future it will be beneficial to transition from process measures to reliable outcome measures that would measure functional status.

CMS should also establish regulations that require services furnished by ACOs be provided by qualified personnel. For example, physical therapy services should be furnished by a physical therapist or a physical therapist assistant under the supervision of the physical therapists. An evaluation of the need for physical therapy and the establishment of the therapy plan of care should be performed by a physical therapist. The independent clinical decision making of the physical therapist should also be recognized within the ACO.

A record of the patient experience will also be important for the ACO to report. Patients will be more likely to remain in an ACO if they know that their provider’s payments depend, in part, on the patient’s views on the quality of the care provided. Tools such as the Consumer Assessment of Healthcare Providers and Systems (CAHPS) Patient Satisfaction Survey could be used to gather information regarding patient satisfaction.

APTA appreciates your consideration of these comments. For ACOs to succeed, CMS needs to establish regulations that result in ACO models that coordinate patient care, incorporate a wide variety of provider types (e.g. physicians, hospitals, physical therapists, etc) and provide high quality care. If you need any additional information, please contact Gayle Lee at 703-706-8549 or gaylelee@apta.org. Thank you.

Sincerely,

R. Scott Ward, PT, PhD
President