

AMERICAN ACADEMY OF CHILD & ADOLESCENT PSYCHIATRY

Council

President

Laurence L. Greenhill, M.D.

President-Elect

Martin J. Drell, M.D.

Secretary

James C. MacIntyre, II, M.D.

Treasurer

William Bernet, M.D.

Chair, Assembly

of Regional Organizations
of Child and Adolescent Psychiatry
J. Michael Houston, M.D.

Past President

Robert L. Hendren, D.O.

Tami D. Benton, M.D.

Paramjit T. Joshi, M.D.

Christopher J. Kratochvil, M.D.

Louis J. Kraus, M.D.

Alice R. Mao, M.D.

D. Richard Martini, M.D.

Yiu Kee Warren Ng, M.D.

Melvin D. Oatis, M.D.

Guy K. Palmes, M.D.

Gabrielle L. Shapiro, M.D.

Jerry M. Wiener Resident Member

Karimi Mailutha, M.D.

John E. Schowalter Resident Member

Glen P. Davis, M.D.

Executive Director

Virginia Q. Anthony

Journal Editor

Andres Martin, M.D.

AACAP News Editor

Won Jung Kim, M.D., M.P.H.

Program Committee Chair

Neal D. Ryan, M.D.

Robert L. Stubbs

Resident Fellow to AMA 1100

Kayla Pope, M.D.

3615 Wisconsin Avenue, NW
Washington, DC 20016-3007
202.966.7300 800.333.7636
Fax 202.966.2891
Email: executive@aacap.org
<http://www.aacap.org>

December 3, 2010

Donald M. Berwick

Administrator

Centers for Medicare & Medicaid Services

Department of Health and Human Services

Room 445-G

Hubert H. Humphrey Building

200 Independence Ave, SW

Washington, DC 20201

Re: File Code CMS-1345-NC; Request for Information Regarding ACOs
and the Medicare Shared Savings Program

Dear Administrator Berwick:

The American Academy of Child and Adolescent Psychiatry (AACAP) appreciates the opportunity to provide our comments to the request for information regarding accountable care organizations (ACOs) and the Medicare Shared Savings Program. Our comments to the seven questions follow.

AACAP is a medical membership association established by child and adolescent psychiatrists in 1953. Now over 8,000 members strong, AACAP is the leading national medical association dedicated to treating and improving the quality of life for the estimated 7-12 million American youth under 18 years of age who are affected by emotional, behavioral, developmental and mental disorders. AACAP's members actively research, evaluate, diagnose, and treat psychiatric disorders and pride themselves on giving direction to and responding quickly to new developments in addressing the health care needs of children and their families.

AACAP has created a guide on collaborative mental healthcare between primary care physicians (PCPs) and child and adolescent psychiatrists (CAPs) acknowledging the severe shortage of child and adolescent psychiatrists and therefore PCPs are often the de facto provider for many children with mental health needs and consultation is often needed and in more severe cases coordinated care is required. The concept of ACOs will likely encourage more coordination between PCPs and specialists, however unless there are incentives for specialists to join an ACO, particularly those

with a severe shortage, many children will be left without needed quality care.

What policies or standards should we consider adopting to ensure that groups of solo and small practice providers have the ACO models tested by CMI?

There are two sides to this issue: getting solo/small practices involved in ACOs that may already exist in their area and getting solo/small practices to create their own ACOs, particularly in areas where other ACOs may not currently exist.

To ensure solo/small practices' participation in current and new ACOs, CMS should:

Require standardized and published credentialing and privileging requirements of the ACO.

This would be similar to credentialing/privileging for hospitals. An important factor in the assurance of quality treatment of an individual patient is that an appropriately qualified physician is responsible for the patient's admission and ongoing treatment. The AACAP is especially concerned that there are caregivers to provide high quality treatment of children and adolescents with mental illnesses. In order to assure quality of medical staff, membership should be limited to licensed, qualified physicians. The overall quality of services provided by an ACO is the responsibility of an organized medical staff actively involved in monitoring, evaluating, and modifying the various processes involved in the provision of treatment. Standardized and published requirements will help practices determining their own "fit" within the ACO and to weigh the pros and cons of joining.

Provide incentives for specialty physicians to join. Primary care and other physicians in the ACO presumably receive a financial reward if overall healthcare costs decrease but some sub-specialties, such as child and adolescent psychiatry, may find little opportunity to make an impact on the overall costs and therefore not receive an incentive. One possible situation would be to provide reimbursement for those small practices that do provider-to-provider collaborations prior to initial appointments. Once a patient sees a child and adolescent psychiatrist or other specialist, they often want to continue treatment with that provider. Another possibility is to require any ACO contracting with CMS, particularly those that are primary care or pediatric based, have members from all specialties ensuring proper treatment for the entire continuum of care a patient may need. They would also need to make sure they have enough specialists to meet the needs of their beneficiaries. This would require ACOs to market themselves to those specialties that are missing from or lacking in their organization and encourage the ACO to create incentives to have these specialists join.

Modify the existing fee-for-service payment structure to enable physicians to be paid for desirable services and avoid financially penalizing them for reducing unnecessary services.

Shared savings programs alone do not represent true payment reform; they are merely another form of a pay-for-performance bonus on top of a fundamentally broken payment system. CMS needs to make changes to the existing fee-for-service system so that physicians can be adequately paid in a timely fashion for currently unreimbursed and under-reimbursed services that will improve care for patients and save money. With shared payment plans physicians may be forced to lose money in the long run with long lags in calculating and paying out these bonuses.

Create innovative programs to encourage formation of new ACOs. To encourage solo/small practices to possibly form a new ACO, especially in regions such as rural areas where an ACO may not already exist, there are several possibilities, but overall it would probably take a lot of education from CMS to providers about the benefits of creating this type of organization. There would also have to be additional incentives such as bonus payments for initially forming because it is unlikely that cost savings would be evident early on and therefore limit the possibility for any payments through that mechanism. Another possibility is for Medicaid to “create” their own ACOs in the rural areas by pulling together the providers in the region like Virtual Physician Organizations that exist in some areas already. Local Medicaid would oversee the ACO, at least in the beginning, and provide support, education and incentives until the ACO is sustainable independently.

Many small practices may have limited access to capital or other resources to fund efforts from which “shared savings” could be generated. What payment models, financing mechanisms or other systems might we consider, either for the Shared Savings Program or as models under CMMI to address this issue? In addition to payment models, what other mechanisms could be created to provide access to capital?

There are two sides to this issue: getting solo/small practices involved in ACOs that may already exist in their area and getting solo/small practices to create their own ACOs. The issue of capital and resources are slightly different for each scenario. For example, for those interested in joining an existing ACO, a likely expense would be electronic health systems that allow them to communicate within the ACO. This could be handled through the money already set aside for practices acquiring electronic health systems, or the ACO itself may provide either the capital or the electronic program itself for free or through some kind of “lease” based on something like volume.

This system could also work for those solo/small practices interested in joining together to create an ACO. However, with increased overhead expenses in forming a new organization, one possibility is to phase-in payment programs concentrating on quality measures in the beginning with less emphasis on cost-savings. A lack of initial funding opportunities for creating ACOs will be a deterrent unless there are loans, loan guarantees, and technical assistance programs initiated to help small physician practices make the investments needed to become ACOs. It will be important to educate banks and other commercial lenders about how these practices will have access to new revenue streams to repay the loans. A loan guarantee program, similar to a small business administration loan, will assist small practices in obtaining financing from commercial lenders. Venture capital programs between private funds and the government focusing on healthcare could also be formed to help finance ACO creation. Both small business and venture capital programs could work with CMS to educate practices on funding options available to them, to educate them on the benefits to joining or forming an ACO, and to educate them on the business and risk management sides of running these organizations.

Regardless of how the ACOs and practices get their initial funding, it will not be sustainable for some groups unless there is accurate and adequate reimbursement to the physicians. CMS should create payment systems that enable ACOs to be paid immediately for key services that are not currently paid, e.g., phone calls and email communications with patients and other physicians, use of nurse care managers to provide education and self-management support for patients with

chronic disease. CMS must ensure that coding and reimbursement accurately reflects the work being done, particularly for the large amount of consultative and collaborative work that would occur with primary care and some specialties, such as child and adolescent psychiatry. An ideal system would pay for specialists for specific times to be available to a larger group of primary care physicians or pediatricians that would help establish proactive collaboration into limited practice schedules.

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 ACOs 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 aligned 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?

Beneficiaries should be attributed to the ACO at the beginning of the performance period, with clear guidelines from CMS on physician accountability, if any, for those beneficiaries who are only under their care a portion of the performance period. Not only should beneficiaries have the right to know if they've been assigned to an ACO (or any program that has an incentive structure), but it would help all specialties identify care goals, establish methods for measuring success, and create a robust evaluation process rather than specific goals becoming lost in the more general review of cost savings and general clinical outcomes. Without active patient support and participation, the ability of physicians to help patients improve their health and reduce the use of unnecessary and duplicative services is limited. There should be clear requirements that will ensure strong quality oversight. These include: transparent membership in an ACO in which any savings benefits return to providers; written procedures shared in writing with the beneficiaries for the appeal and redress of care felt to be inadequate; creation of a group of stakeholders that includes consumers (patients and families) that will oversee quality measures and address any gaps in care.

How should we assess beneficiary and caregiver experience of care as part of our assessment of ACO performance?

Both caregivers' and beneficiaries' experiences should be assessed by a anonymous satisfaction surveys, with certain measures required of all ACOs. Feedback from patients and their families is vital to the process and surveys should be conducted. CMS should work with ensure there is adequate funding for the development, testing, and implementation of appropriate patient and provider surveys. The ACA does not require public reporting of ACO performance information, and we urge that the results of the survey should be made publicly accessible in a timely manner, i.e., within three months after the survey's completion. There is currently as much as a year's lag time in the public reporting of many health care related performance measures, making the results dated and potentially misleading. Ideally, beneficiaries should participate in the

establishment and as part of an oversight committee or review board that will review these results and provide direct input on improving ACO and physician performance.

The Affordable Care Act requires us to develop patient-centeredness criteria for assessment of ACOs participating in the Medicare Shared Savings Program. What aspects of patient-centeredness are particularly important for us to consider and how should we evaluate them?

Patient-centeredness will require involvement of the beneficiary at each phase of their treatment process, including assessment, treatment planning, implementation, monitoring, and outcome valuation. Specific areas to look at and to create criteria for are: the patient's right to be involved in making decisions regarding providers and others involved in the treatment team; encouragement of the patient to express preferences, needs, priorities, and disagreements; patient active collaboration in the treatment plan development and in identifying desired goals and outcomes; patients should be given the best knowledge and information to make decisions; patients make joint decisions with their treatment team; patients participate actively in monitoring treatment outcomes and modifying treatment. Their input also needs to inform decision-making at the policy and systems levels of the ACO, which will help ensure patient needs are being met.

Physicians need the flexibility to customize care for a particular patient in a way that works effectively for that patient, rather than being forced to provide a particular type of care simply because that is what will be paid for. For example, a physician should be able to be paid for answering a patient's phone call if that will provide more timely and effective assistance than an office visit. CMS should make changes to the fee-for-service system so that physicians will be paid upfront for currently unreimbursed and under-reimbursed services that will improve care for patients and save money. Physicians should also not be penalized for accepting unusually sick patients, those who need multiple systems of care or for customizing a patient's care to meet their unique needs.

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?

ACOs should choose to implement nationally-recognized quality measures, such as from the National Quality Foundation (NQF), the Physician Consortium Performance Initiative (PCPI), and the Children's Health Insurance Program Reauthorization Act (CHIPRA), that are pertinent to the practice, the composition of their beneficiaries, and the goals set by the ACO. Core measures on prevention and health promotion, management of chronic conditions (including, but not limited to, ADHD, autism, and other mental health conditions), and family experiences of care should be required in all ACOs overseeing pediatric care. However, many subspecialties, including child and adolescent psychiatry currently lack measures or a data collection and reporting system that addresses their scope of practice. CMS should work with national organizations like NQF to ensure there is adequate funding for the development, testing, and implementation of appropriate measures, including those designed to evaluate an ACO's commitment to promoting pediatric patient safety. Reporting requirements should be phased in as physicians become comfortable with current requirements and as new measures become

available to better ensure that physicians have the opportunity and resources to participate on a widespread basis. CMS should outreach to individual subspecialty groups for specific recommendations, specifically those for children and adolescents.

What additional payment models should CMS consider in addition to the model laid out in Section 1899(d), either under the authority provided in 1899(i) or the authority under the CMMI? What are the relative advantages and disadvantages of any such alternative payment models?

AACAP does not have any specific model to recommend at this time but cautions that that no payment model should discourage either unintentional “adverse selection” or “cherry picking” of patient populations by the ACO. Also, the criteria for participation in a payment model should be clearly defined in advance, and any provider that meets the eligibility requirements should be permitted to participate. The criteria should avoid major capital investments that preclude small physician practices from participating.

In conclusion, AACAP strongly feels that the design and application of a shared savings program should recognize that the reward structure meets the needs of providers, patients and families and not serve to restrict their commitment to providing high quality and cost-effective care. Investments in programs that foster opportunities for groups of solo and small practices to participate in ACOs should be aggressively explored and, as the rules and regulations promulgating the development of ACOs emerge, they should not favor participation by large health systems or hospital-dominated networks.

Thank you for the opportunity to comment. We would be happy to speak with you further about our comments. Please contact Kristin Kroeger Ptakowski, Director of Government Affairs and Clinical Practice at kkroeger@aacap.org, 202-966-7300, ext 108.

Sincerely,



Laurence Greenhill, M.D.
President