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June 5, 2011
Donald Berwick, MD
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Room 445-G, Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, DC 20201

Re: Medicare Program; Medicare Shared Savings Program: Accountable
Care
Organizations; Proposed Rule CMS-1345-P; 76 *Fed. Reg.* 19,528

Dear Administrator Berwick:

The American Academy of Child and Adolescent Psychiatry (AACAP) appreciates the opportunity to provide our comments concerning the Centers for Medicare and Medicaid Services (CMS) proposed rule on *Medicare Shared Savings Program: Accountable Care Organizations (ACO Program)*.

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.

Although these regulations are for the Medicare program, AACAP members are also general psychiatrists and treat adults. We also are aware that there are Medicaid demonstration projects currently underway and that these regulations may influence them. 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. 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 in specialties with a severe shortage, many children will be left without needed quality care.

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Processes to Promote Evidence-Based Medicine, Patient Engagement, and Coordination of Care

Process to Promote Evidence-Based Medicine

AACAP supports CMS's decision to not establish any more specific criteria for evidence-based medicine requirements. However, we would like to request that there be some monitoring of their promotion of evidence based medicine. For instance an ACO could track rates of polypharmacy (two antidepressants, two antipsychotics), and track rates of psychotherapy for children receiving psychiatric medications besides ADHD drugs.

Processes to Promote Patient Engagement

Proactive efforts are critical to educate and encourage beneficiaries to understand the change in healthcare delivery and their rights. For example, it is important for them to understand that they will be using a primary care physician as a medical home, can select specialty physicians, hospitals, and other providers that coordinate effectively with their primary care medical home and each other, engage in shared decision making processes with physicians about appropriate treatments for their conditions, and participate in other types of programs developed by their physicians that can maintain and improve their health at an affordable cost. Education efforts should be developed in cooperation with physicians and launched as soon as possible and well in advance of the initiation of the ACO program on January 1, 2012. Where possible, "health literacy" should include giving patients/families information about the costs of their treatments and about the costs of available alternative treatments. Providing parents with a patient information sheet like "Depression: Treatment Options" with a list of self-help strategies, medicines and psychotherapy would seem to serve that function in a reliable method.

Process to Promote Coordination of Care

Due to the lack of child and adolescent psychiatrists and the need for primary care to treat some children and adolescent with mental illnesses in their offices, AACAP is most concerned with coordinated care requirements. There have been many child and adolescent psychiatry and pediatric collaborative care programs developed around the country to address the access issue, and we have learned that there must be financial support for the care manager role in a primary care provider's office—without financial support it won't happen. Telehealth can be a tool for assisting care coordination, but by itself its use does not improve care coordination. We are not clear whether the ACO pay for someone either centrally or within the PCP's practice to follow up with families to see that they are connecting/following through with care that providers feel they need to access and ask for clarification on this.

Patient Centeredness

AACAP is pleased with most of the patient centeredness criteria established by CMS. We would like some clarification regarding the "patient involvement in ACO governance" criteria, and more specific language and the adoption of a family advisory council directly reporting to the governing board. Family representation should be ethnically diverse and represent various

patient populations, including psychiatric illness. Some suggested language: “At the level of the organization’s bylaws, ACO’s shall establish a patient/family advisory council with a clear written mandate. The advisory council shall report directly to the Governing Board.”

We are concerned that small entities might be disincentivized to participate in the program. For example, the use of electronic health record software can be too costly for small entities. There should be additional financial incentives to assist with some of the administrative set up and monitoring for small entities.

Definition of Primary Care Services

CMS’s concern that this proposal may not adequately account for primary care services delivered by specialists, especially in certain areas with shortages of primary care physicians and that it may make it difficult to obtain the minimum number of beneficiaries to form an ACO in geographic regions where such primary care shortage is a concern. AACAP recommends a metric be developed to reflect the ratio of PCPs to beneficiaries for any ACO. In the case where the metric indicates a shortage of PCPs, it will be in the spirit and interest of the ACO concepts of coordination and integration of care to permit specialists to perform PCP services within a single ACO. These PCP services will be performed for beneficiaries within one and only one ACO, while specialists should be allowed to continue performing specialty services to all ACOs to which they belong. While administratively somewhat complex, such a threshold seems, to me, a necessary safety mechanism to preserve the viability of the ACO concept. PCP shortages a very real and must be recognized and objective metric appears to me the best way.

Beneficiary Assignment

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.

AACAP supports the proposed rule’s allowance for specialists to belong to more than one ACO. However, some sub-specialties, such as child and adolescent psychiatry, may find little opportunity to make an impact and decide to not participate in ACOs. We recommend providing reimbursement for those small practices that do provider-to-provider collaborations prior to initial appointments. We also recommend requiring 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.

Quality and Other Reporting Requirements

Proposed Quality Measures to Assess Quality of Care and for Use in Establishing Performance Standards

As the current proposal does not cover children and adolescents in any of the measures and you “cannot consider measures that do not substantially cover the same patient populations, processes, or outcomes addressed by the existing measures outlined in this proposed rule,” we do not currently have any comments on including or excluding any of the proposed measures. However, we do support CMS’s efforts to develop a single quality measure set that could be used across a wide variety of payers, including Medicaid, the Children’s Health Insurance Program and Special Needs Plans. There are some children’s mental health measures already endorsed by the National Quality Forum that could be used in this measures set, and we anticipate there will be more in the future.

Proposed Quality Measures Data Submission

We support the current data submission requirements, as long as they do not cause undue burdens to providers, and look forward to the inclusion of certified EHR technology in the future to help streamline the process.

Quality Reporting Standards

Although no system is perfect, we support Option 1, Performance Scoring, and agree with weighing all domains equally to determine performance. We feel that Option 1 will incentivize ACOs to work on continuous quality improvement and rewards those who make that effort. We also feel that our membership is one that would be affected by ACOs of different compositions that would benefit from equal weighting of domains, but also the emphasis that all areas are key to quality, and that it would be inappropriate for CMS to make such a determination. Additionally, we support the reporting level as the performance standard for the first year.

Incorporation of Other Reporting Requirements

We are concerned about the ability of many primary care physicians, either adult or pediatric, to be ready to meet the meaningful use criteria for EHRs by the start of the second year. Currently, CMS is only seeing 57% of eligible professionals participating in the PQRS (in 2009), which has been around longer than the EHR incentives and requires substantially less financial and other commitments from providers. Though internists and family physicians are the most frequent participants in the current PQRS and eRx programs, it is unclear if data shows that they have adopted sufficient EHR users current reporting has not necessarily been through an EHR. Although most of the EHR meaningful use quality requirements are designed for primary care physicians and it therefore could be assumed that they would be the first to adopt the use of EHR, we still recommend that more information be gathered and provided as to current PCP use of EHRs prior to establishing a potentially adverse minimum threshold.

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,

A handwritten signature in cursive script that reads "Laurence Greenhill M.D.".

Laurence Greenhill, M.D.
President