

May 31, 2011

Donald S. Clark, Secretary
Federal Trade Commission
Office of the Secretary
Room H-113 (Annex W)
600 Pennsylvania Avenue, NW
Washington, DC 20580

Submitted electronically

Subject: Proposed Statement of Antitrust Enforcement Policy Regarding ACOs Participation in the Medicare Shared Savings Program, Matter V100017

Dear Secretary Clark:

On behalf of our 78,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments on the Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program, jointly issued by the Federal Trade Commission and the Antitrust Division of the Department of Justice and published in the April 19, 2011 *Federal Register*. APTA's goal is to foster advancements in physical therapy practice, research, and education. The mission of APTA is to further the profession's role in the prevention, diagnosis, and treatment of movement dysfunctions and the enhancement of the physical health and functional abilities of members of the public.

APTA strongly supports initiatives to improve the quality of patient care and to ensure access to high quality care. We are committed to encouraging physical therapists to participate in the innovative delivery reforms authorized under the Affordable Care Act (ACA), such as ACOs.

APTA commends the Federal Trade Commission (FTC) and the Antitrust Division of the Department of Justice (the "Agencies") on the issuance of a proposed statement of antitrust enforcement policy regarding ACOs that clarifies the antitrust analysis of providers that seek to become ACOs. The work of the Agencies to ensure that ACOs' opportunities for innovation are maximized while also protecting Medicare beneficiaries and commercially insured patients from potential anticompetitive harm will be critical as these new entities form. We applaud the Agencies for their extensive guidance and their vigilant efforts to ensure that harmful practices are stopped and beneficial ones are allowed.

In the proposed statement of antitrust enforcement policy regarding ACOs, the Agencies discuss the rule of reason analysis that they use to evaluate agreements among competing health providers that are financially or clinically integrated and accomplish procompetitive benefits. Under this analysis, they evaluate whether the collaboration is likely to have substantial anticompetitive effects, and whether the potential procompetitive efficiencies are likely to outweigh those effects on balance. In the statement, the Agencies state that they determined that CMS's proposed eligibility criteria for ACOs are broadly consistent with the indicia of clinical integration that they have set forth in previous Health Care Statements. Therefore, organizations meeting the CMS criteria for approval as an ACO are reasonably likely to be bona fide arrangements intended to improve quality and reduce costs.

The Agencies also set forth an antitrust safety zone for ACOs that have a combined share of 30 percent or less of each common service in each participant's Primary Service Area (PSA) (with a special exception provided for rural areas). According to the proposed safety zone policy, any hospital participating in the ACO must be non-exclusive to the ACO, and to meet the rural exception the ACO participants must be non-exclusive. In addition, any ACO that includes a participant with a greater than 50 percent share in its PSA of any service that no other ACO participant provides (a "dominant provider"), such dominant provider must be non-exclusive to the ACO for the ACO to fall within the safety zone. Lastly, the Agencies would require mandatory antitrust review of ACOs exceeding the 50 percent PSA share threshold for any common service.

The APTA supports the use of the rule of reason analysis and the Agencies' focus on the "indicia of clinical integration" in determining whether an ACO is likely to improve quality. As the Agencies conduct such rule of reason analyses and otherwise monitor ACO marketplace behaviors, we believe there are a number of things that should be kept in mind.

Anti-competitive: Influence of Physicians that are Referral Sources

While we support the rule of reason treatment, we have specific concerns in light of the potential influence of physicians that are referral sources. The Statement focuses almost entirely on concerns that ACOs could be over-inclusive. APTA recognizes that this is a legitimate concern because ACOs that are too large can exercise market power; however, another important concern is that ACOs can have anticompetitive effects because they are under-inclusive. They could potentially exclude from their membership certain classes of providers which could have the effect of reducing consumer choice and quality, and increasing costs. While ACOs in a competitive market normally would not have the incentive to exclude efficient and high quality providers, if they are controlled by one group or class of providers (e.g. physicians), they might exclude non-physician independent providers who are a competitive threat. There is a long history of this occurring through actions that physicians have taken to exclude non-physician providers, such as nurse midwives, nurse anesthetists and chiropractors. While our comments are focused on this issue with respect to physicians who seek to exclude independent physical therapists, we urge the FTC to address such concerns generally.

Physical therapists practice in a wide variety of inpatient and outpatient settings, including hospitals, skilled nursing facilities, home health agencies, rehabilitation agencies, physical therapists' private practice offices, physician offices, and schools. It is critical for any delivery and payment reform policies that are implemented to enable physical therapists, including those who work in small practices, to participate effectively. While it is clear from the ACA requirements for the Medicare Shared Savings Program that Congress intended primary care physicians to play a key role in ACOs, the role of other providers is also critical. Improving the quality of care while also decreasing costs will require participation by all providers.

One potential concern we have with the ACO models, many of which will be built around a hospital and/or physicians, is that a hospital may choose a larger physician group practice that provides physical therapy services to participate in the ACO over a smaller specialized practice, such as a physical therapist private practice. This decision may be based on the larger physician group's importance to the hospital as a referral source. Unlike physicians, physical therapists generally do not function as a primary referral source to the hospital. We are deeply concerned that because physicians are large referral sources for hospitals while physical therapists are not, an ACO which is dominated by a hospital and its medical staff may vote to exclude physical therapists, regardless of the economic savings or quality of the physical therapist practice. The hospital will fear alienating their referral source, and the physicians would rather lose one cent on the ACO incentive than one dollar on their own direct fees. As a result, certain classes of providers, such as small physical therapist private practices, could be excluded from ACO participation, and we believe that such exclusions could raise anti-competitive concerns. This would defeat the efficiency enhancing goals of the ACOs.

We note that there has been a long history of problems relating to physician-owned physical therapy arrangements. Physicians can bill for outpatient therapy services under their physician Medicare enrollment number as "incident to" their physician service or may bill enroll the therapists independently under their own billing number and have them reassign payments to the physician groups. These arrangements have resulted in the overutilization of physical therapy services as there is a financial conflict of interest that is inherent in the physician-owned physical therapy arrangements or business models. Studies have demonstrated that physician-owned physical therapy arrangements have a significant adverse economic impact on consumers, third-party payers, and physical therapists.¹ Specifically, a 2006 report by the Department of Health and Human Services' Office of the Inspector General (OIG)² showed that physical therapy billed directly by physicians represents a large and growing percentage of Medicare's total expenditures for these services. The OIG found that 91% of PT billed by physicians and allowed by Medicare did not meet Medicare guidelines which resulted in a significant amount of improper payments. In addition, Medicare claims from 2002 to 2004 were analyzed and aberrant

¹ Mitchell JM, Scott E. Physician ownership of physical therapy services: Effects on charges, utilization, profits, and service characteristics. *JAMA*. 1992; 268:19-23; Swedlow A, Johnson G, Smithline N, Milstein A. Increased costs and rates of use in the California Workers' Compensation System as a result of self-referral by physicians. *N Engl J Med*. 1992;327:1502-1506; Office of the Inspector General, Department of Health and Human Services. 1994.

² *Physical Therapy in Physician's Offices*, no. OEI-02-90-00590. Washington, DC: OIG and OIG, Physical Therapy Billed By Physicians (May 1, 2006).

patterns of billing and unusually high volumes of claims were identified. In a report issued in August 2009, the OIG examined physician “incident to” services billed in 2007 under the Medicare program, and found that 49 percent of rehabilitation therapy services (including primarily therapeutic exercise, massage therapy, ultrasound therapy, therapeutic activities, and electrical stimulation) performed by non-physicians were furnished by staff not trained as therapists that the OIG found to be unqualified.³

In addition to inherent conflicts of interest that exist within physician-owned physical therapy arrangements, physician referral to services within his/her office, or to those with whom he/she may have a financial interest, limits the consumer’s right to choose his/her physical therapist. The consumer may not recognize this loss of choice, as no other option is offered. APTA has heard of numerous instances where the physician refuses to send the patient to an outside practice for physical therapy services. In sum, while incentives under the Medicare Shared Savings Program may differ from those under current payment policies, it remains true that individual ACO participants would continue to be paid under traditional Medicare fee-for-service payment rules, and thus physician-owned physical therapy arrangements could still pose risks for Medicare beneficiaries and for the physical therapy marketplace.

In the Medicare Shared Savings proposed rule, CMS states that the ACO governing board should have proportionate representation from its ACO participants in order to give a voice to all providers and suppliers. We believe that this is a key element when analyzing an ACO for anti-trust implications. However, the Agencies should be alert to the potential that the ACOs could have physicians on their governing board that own physical therapy arrangements. This may result in an unlevel playing field should these physicians attempt to exclude their competitors, such as physical therapy private practices, from participation in the ACO or attempt to impose unreasonable barriers to Medicare beneficiary receipt of services from such practices. Such exclusion or barriers could make it very difficult for small physical therapist practices to compete in the market. The FTC should make clear that ACOs that have such physicians on their boards will be expected to demonstrate the absence of anticompetitive conduct by contracting widely with non-physician providers who can achieve the cost and quality goals.

Market Power and Dominance of Hospitals

There is also a concern that hospitals participating in an ACO could have considerable power and could choose to provide all inpatient and outpatient therapy services through their hospital and choose not to send their ACO beneficiaries to any other entities that provide physical therapy services. This once again would result in an unlevel playing field, which is not what Congress intended in drafting the ACA. Rather, Congress clearly wanted to allow for a range of different entities to participate in the ACOs, including small practices. We strongly urge the Agencies to ensure that they do everything possible to guard against anti-competitive actions by ACOs, including the inappropriate exclusion of providers and suppliers, such as physical therapists in private practice, rehabilitation agencies, home health agencies, skilled nursing facilities, etc. APTA believes that Medicare beneficiaries and the health care marketplace as a whole will be

³ Office of the Inspector General, Department of Health and Human Services. 2009. *Prevalence and Qualifications of Nonphysician Who Performed Medicare Physician Services*, no. OEI-09-06-00430. Washington, DC.

better served if Federal policies expect ACO participants to include all types of providers, not just hospital-dominated networks. We, therefore, urge the Agencies to design their guidance and ACO monitoring activities with this in mind.

A large majority of patient care today is provided by physicians, physical therapists, and others who practice in small independent groups. The APTA believes that it is important for providers to continue to practice in this way and to collaborate with others to improve the quality of care while also remaining independent. Therefore, the Agencies' enforcement of a level playing field is critical.

Effectively Measuring Quality

While promising in many aspects, ACOs are still in their infancy; therefore caution should be exercised to ensure that payment incentives do not distort decision-making or hinder access to services. APTA believes that it is important for safeguards to be built into the program, particularly those related to quality. There should be a robust set of quality measures that apply to ACOs to reduce any financial incentives to decrease utilization unnecessarily, which could ultimately result in lower quality care. This should include measures aimed at ensuring that patients have appropriate access to rehabilitation services and quality measures that detect inappropriate underutilization.

Quality will be a key factor in determining whether ACOs' benefits outweigh their potential harms. It will be essential when determining whether the benefits outweigh the risks to have meaningful quality measures for ACOs that are focused not only on process, but also outcomes of care. Ideally, such quality performance measures should capture the full range of outcomes. This is particularly important with respect to rehabilitation which is aimed at restoring function. As an example, applying a quality measure to a patient that has had a hip replacement that only focuses on patient mortality would not capture the full range of relevant information for patients with hip replacements, such as patient function after surgery. We are concerned that quality measures are not well developed in a number of areas, particularly outcomes measures. In addition, the CMS proposed rule relating to ACOs does not include quality measures that would be meaningful in determining whether patients received and benefitted from rehabilitation services.

Conclusion

In closing, we respectfully request that the Agencies institute a system under which they continually assess the compliance of ACOs with the anti-trust laws during their three year contractual period. In addition, we request that the Agencies provide guidance to providers, suppliers and other stakeholders on methods in which the health care community can share information with the Agencies regarding potential violations. When reviewing ACO applicants, the Agencies should routinely look at whether the ACO has unreasonably excluded a class of provider from its participating providers.

The APTA appreciates the opportunity to work with the Agencies to ensure that a legal and regulatory framework is in place that enables hospitals, physicians, physical therapists and other

providers to work together to improve the quality of care through ACOs and other innovative models of care. We appreciate the Agencies' efforts through this proposed Statement to strike a balance that will maximize innovation while preventing anticompetitive harmful practices. Thanks for your consideration. If you need additional information, please contact if you need additional information or have questions regarding our comments, please contact Roshunda Drummond-Dye at (703) 706-8547 or roshundadrummond-dye@apta.org.

Sincerely,

R. Scott Ward, PT, Ph.D.
President

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