



The Texas Physician's Accountable Care Guide

Volume I

By Julian D. ("Bo") Bobbitt Jr., JD



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Physicians Caring for Texans

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Author:

Julian D. ("Bo") Bobbitt Jr., JD

Editor:

Ellen Terry, Communications Manager
TMA Client Services



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About the Author

Julian D. (“Bo”) Bobbitt Jr., JD’s practice focuses on providing strategic general counsel and regulatory guidance for health care organizations. He is involved in business planning, resolution of complex legal and health policy questions, and advanced negotiations for these clients. The legal issues involve antitrust, Stark, and federal and state antikickback laws, managed care contracting, federal legislative and regulatory advocacy, and HIPAA and related privacy and security laws. His practice is concentrated on representing clinically integrated hospital and physician organizations, physician-owned health information technology companies, accountable care organizations, patient-centered medical homes, health information exchanges, and nonprofit and professional associations to achieve process, outcomes, and cost improvements in health care delivery. He has extensive experience in developing and drafting accountable care shared savings and other pay-for-performance contracts. Mr. Bobbitt received his law degree from the University of Virginia in 1977, and a bachelor of arts degree from the University of North Carolina in 1973.

Mr. Bobbitt has spoken nationally to both legal and medical audiences and written in both legal and medical journals concerning health law and policy issues. He is credited nationally for authoring a leading guide to accountable care, *The ACO Guide: How to Identify and Implement the Essential Elements for Accountable Care Organization Success*, from which physicians, health care providers, and medical communities are developing accountable care networks.

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Course Objectives

Upon completion of this enduring material, readers should be able to:

- ◆ Develop specific strategies toward forming an ACO, or joining an existing ACO; and
- ◆ Utilize examples for how to successfully apply for the Medicare Shared Savings Program.

Audience

This course is appropriate for physicians in all specialties.

CME Instructions

This copy of *The Texas Physician's Accountable Care Guide* is complimentary.

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Contents

INTRODUCTION.....	1
ONE How to Identify and Implement the Essential Elements 2	2
for ACO Success	
Purpose of This ACO Guide	2
What is an ACO?	2
Why Should I Care?	4
Are ACOs Really Here to Stay?	5
TWO Essential Elements of a Successful ACO	7
Essential Element No. 1: Culture of Teamwork — Integration	8
Essential Element No. 2: Primary Care Physicians	9
Essential Element No. 3: Adequate Administrative Capabilities	10
Essential Element No. 4: Adequate Financial Incentives	12
Essential Element No. 5: Health Information Technology and Data	15
Essential Element No. 6: Best Practices Across the Continuum of Care	16
Essential Element No. 7: Patient Engagement	16
Essential Element No. 8: Scale-Sufficient Patient Population	17
THREE Successful Implementation: A Step-By-Step Guide.....	18
Where Do I Start?	18
Conclusion	20
FOUR How to Apply for the Medicare Shared Savings Program	21
MSSP Application	21
Advance Funding Application	24
Conclusion	24

Introduction

Physicians have for decades earned a living based on caring for the sick. But in the new world of health care, physicians more often will be paid based on whether they can keep their patients healthy — and must navigate a system that increasingly includes more “accountable care” payment contracts.

This strategic guide involved input from many thought leaders who have come together to form the Toward Accountable Care Consortium (TAC), an initiative of more than 40 North Carolina medical societies and organizations joined in a commitment to helping the medical community face the challenges of a changing health care environment. This guide would not have been possible without the generous support of all TAC member organizations, including significant support from the North Carolina Medical Society, as well as a substantial grant from The Physicians Foundation. We are grateful to Julian D. (“Bo”) Bobbitt Jr. of the Smith Anderson law firm, who has many years of experience providing strategic counsel regarding integrated care, for compiling this nontechnical “blueprint.”

The Texas Medical Association strives to help physicians in Texas by providing information and education on how they can best negotiate and implement value-based care payment models, and use these programs to the advantage of their practice and for the well-being of their patients. This publication, revised by TMA, provides information that can support physicians operating in this new environment, while keeping in mind the importance of maintaining physician leadership of current and future accountable care structures.

The purpose of this guide is to arm you with knowledge and confidence as you consider joining or forming an ACO.

CHAPTER ONE

How to Identify and Implement the Essential Elements for ACO Success

Purpose of This ACO Guide

Accountable care organizations (ACOs) are emerging as a leading model to address health care costs and fragmented care delivery. Virtually every private and public payer across the nation is considering implementing accountable care — federal health care legislation and Medicare regulations notwithstanding. This guide lays out a nontechnical explanation of the essential elements required for any successful ACO and practical step-by-step guidance on how to achieve each element. Because a successful ACO must be “win-win,” with every collaborative participant incentivized and empowered to achieve its optimum value-added contribution to the enterprise, these principles transcend medical specialty, employment status, payer relationship, or facility type. This guide works for you whether you are a primary care or specialty physician, or a hospital CEO. Although ACOs are still evolving and definitive predictions are impossible at this time, the goal of the guide is to give any reader a firm sense of the strengths and weaknesses of any ACO model you may encounter and confidence about whether to join one or create one. There are answers to questions about who should join, who should lead, what infrastructure will work, and the phases of development you need to follow.¹

What is an ACO?

Definitions

Former Centers for Medicare & Medicaid Services (CMS) Administrator Mark McClellan, MD, PhD, described ACOs thus: “ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall per-capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients.”²

Similarly, the National Committee for Quality Assurance, which provides voluntary accreditation for ACOs, defines them as “broad provider-based organizations that manage the healthcare needs of a defined patient population. ACOs strive to reduce costs and improve health care quality and patient experiences by aligning incentives and reducing fragmentation within the care delivery system. Regardless of structure, eligible entities must have a strong foundation of patient-centered primary care.”³

-
1. It is not the purpose of this guide to provide legal advice. Any person or organization considering participation in an ACO should seek the advice of legal counsel.
 2. Mark McClellan, MD, PhD, A National Strategy to Put Accountable Care Into Practice, *Health Affairs*, May 2010, pg. 983.
 3. National Committee for Quality Assurance, ACO accreditation program details, 2012.

Strategic note: The part of the definition relating to patient populations represents a major shift in practice orientation and may be alien to a typical physician's training and day-to-day focus. Without grasping this shift, an understanding of ACOs will remain elusive. It also is important to note what is not in the definition. No definitions specify any particular type of legal entity or arrangement (e.g., independent practice association [IPA], physician-hospital organization [PHO], employment). There is no mandatory organizational form for an ACO.

The Medicare Shared Savings Program (MSSP) final rule⁴ that CMS released in 2015 codifies an interesting definition emphasizing structure in contrast to those above focusing on function. It says an ACO is “a legal entity that is recognized and authorized under applicable State, Federal, or Tribal law, is identified by a Taxpayer Identification Number (TIN), and is formed by one or more ACO participants(s) (sic) that is (are) defined at §425.102(a) and may also include any other ACO participants described at §425.102(b).”⁵ Participants in Medicare ACOs work together to manage and coordinate care for Medicare fee-for-service beneficiaries.

ACO participants establish a mechanism for shared governance that provides all participants an appropriate, proportionate control over the ACO's decisionmaking process.

Affordable Care Act requirements

ACOs eligible for the MSSP under the Affordable Care Act (ACA) of 2010⁶ must meet the following criteria:

- ◆ Have established structures for reporting quality and cost of health care, leadership, and management that include clinical and administrative systems, receipt and distribution of shared savings, and shared governance;
- ◆ Be willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it;
- ◆ Have a minimum three-year contract;
- ◆ Have sufficient primary care physicians and providers to have at least 5,000 patients (Medicare fee-for-service beneficiaries) assigned;
- ◆ Have processes to promote evidence-based medicine, patient engagement, and coordination of care; and
- ◆ Be able to demonstrate patient-centeredness criteria, such as individualized care plans.

The 2015 Medicare final rule and three other related documents involving five federal agencies amplify these ACA requirements. Chapter 2 of this guide is devoted to the Medicare Shared Savings Program.

How is it different from a medical home?

The patient-centered medical home emphasizes strengthening and empowering primary care to coordinate care for patients across the continuum. It is complementary to the ACO and can become the core of an ACO, but it is different in two main respects: (1) **Financial incentives:** The medical home lacks the shared accountability feature; it does not have financial incentives, such as shared savings, motivating physicians and providers to work together to deliver the highest quality care at the lowest cost with the greatest patient satisfaction. (2) **Specialists/hospital linkage:** Although there are medical home-only ACOs, a typical ACO tends to have relationships with select specialists and hospitals across the continuum of care for the targeted initiative.

4. 80 *Fed. Reg.* 32691, June. 9, 2015.

5. 42 CFR §425.20 — Definitions.

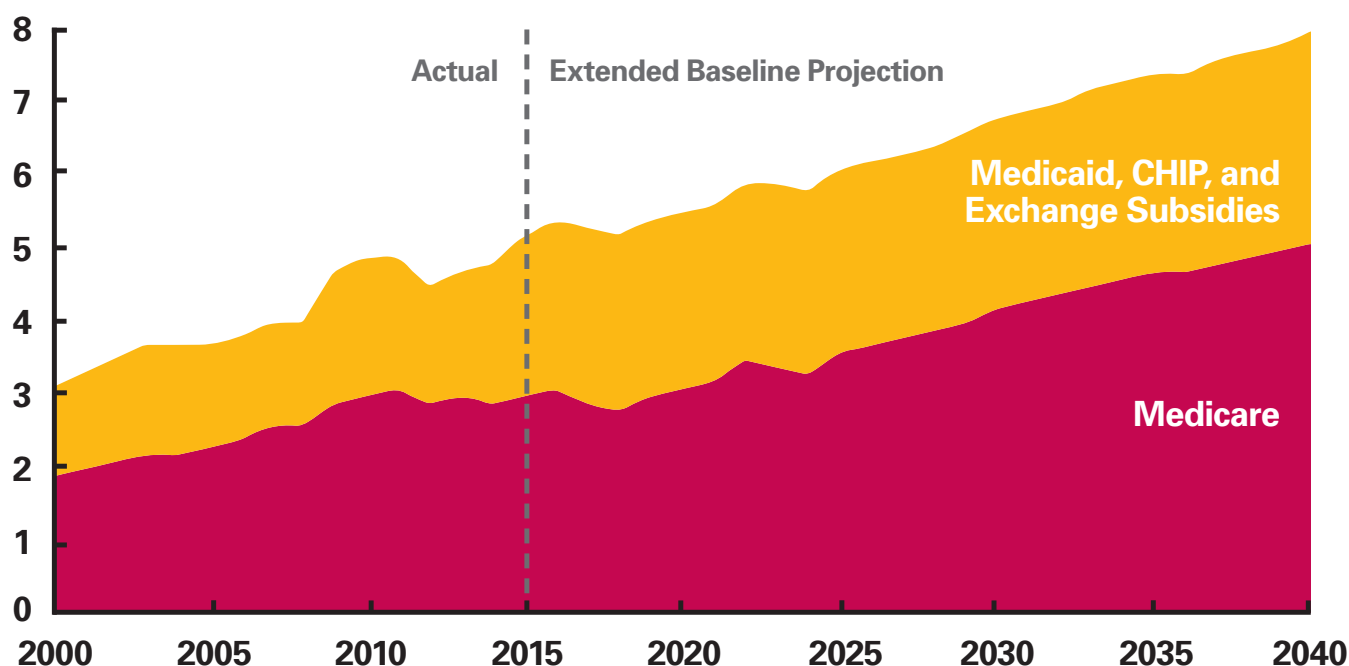
6. Section 3022 of the Patient Protection and Affordable Care Act of 2010 (amends Title XVIII of the Social Security Act [42 USC 1395 et seq.]).

Why Should I Care?

Health spending was unsustainable even before coverage expansion of the 2010 federal health reforms. A rough estimate of the amount the United States can collect in taxes and other revenue is 19 percent of gross domestic product, but Medicare and Medicaid are predicted to consume 8 percent of GDP by 2040, and health care costs will consume 25 percent of GDP (see Fig. 1). In other words, health care alone will cost more than we collect.⁷ By 2080, absent drastic change, Medicare and Medicaid will claim 22 percent of GDP, and spending for health care will consume 46 percent of GDP.⁸

Fig. 1. Federal Spending on the Major Health Care Programs, by Category

Percentage of Gross Domestic Product



Critics of the current payment system cite the 2009 *New Yorker* article in which Atul Gawande, MD, compared Medicare spending in McAllen and El Paso, and described various payment incentives in traditional health care as support for change. The idea of achieving reform through the accountable care model gained momentum after Dr. Gawande's 2015 update in *The New Yorker* on spending in McAllen: "Between 2009 and 2012, [McAllen's] costs dropped almost three thousand dollars per Medicare recipient. Skinner projects the total savings to taxpayers to reach almost half a *billion* dollars by the end of 2014. The hope of reform had been simply to 'bend the curve.' This was savings on an unprecedented scale" (emphasis in original).⁹

The Congressional Budget Office report on the ACO's predecessor, the bonus-eligible organization, includes this rationale: "[P]roviders have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists."¹⁰

7. Congressional Budget Office, *The 2015 Long-Term Budget Outlook*, pgs. 42-44.

8. Congressional Budget Office, *Long-Term Budget Outlook*, June 2009, pg. 35.

9. Atul Gawande, The Cost Conundrum, *The New Yorker*, June 1, 2009; see also, Atul Gawande, Overkill, *The New Yorker*, May 11, 2015.

10. Congressional Budget Office, *Budget Options, Volume I: Health Care*, December 2008, pg. 72.

These dysfunctions in our current system, for which the ACO is seen as a partial remedy, receive much of the blame for the high cost of our country's health care system. Citing data from the Organization for Economic Cooperation and Development, the Peter G. Peterson Foundation asserts that Americans pay about twice as much per capita on health care as do our peers in other advanced nations, yet our health outcomes are no better.¹¹

Because of the crisis, drastic efforts at health care cost reform seem inevitable. Private insurers see it, too. As reported in *The Dallas Morning News*: “Bert Marshall, president of Blue Cross Blue Shield of Texas, said he hopes to recruit physicians to cost savings by giving them access to the insurance company's data on the prices charged by hospitals, drugs, imaging centers and diagnostic labs.

“ ‘A lot of physicians ... tell me they have no idea what things cost, whether it's a pharmaceutical or a procedure. So let's empower them,’ Marshall said. ‘Let them look at the cost of a hip or a knee replacement at one hospital or another, and then select the site that provides the most value.’ ”¹²

The goal of the ACO marketplace incentives is to flatten the cost curve without rationing care, imposing new taxes, or cutting physician and provider payment. The upward spending trends show that doing nothing is not an option, and the alternatives — rationing care, imposing new taxes, or cutting payments — appear unacceptable. In short, there is no “Plan B.”

Are ACOs Really Here to Stay?

If somehow they can repeal Obamacare, won't this go away?

No. Federal health reform has three prongs: (1) expand coverage such as individual and employer mandates and no preexisting condition exclusions; (2) fraud control; and (3) waste controls, e.g., ACOs, bundled payments,¹³ hospital value-based purchasing,¹⁴ the Center for Medicare & Medicaid Innovation (CMS Innovation Center).¹⁵

Many experts think that expanding coverage in our broken system has made health care even more unsustainable, because the expansion has occurred in large part without an accompanying increase in cost savings. As noted, the trend lines indicate that costs, even without health reform, will bankrupt our resources, and the value-based payment movement was well underway before the federal legislation was passed. After support by both houses of Congress and both Republicans and Democrats, on April 16, 2015, President Obama signed the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to replace the long-maligned Sustainable Growth Rate formula for Medicare payments. We now have federal legislation supported by both parties to move to value-based payment. MACRA introduced the Merit-Based Incentive Payment System (MIPS) and alternative payment models (APMs). MIPS combines the Physician Quality Reporting System, the Value-Based Payment Modifier program, and the Medicare and Medicaid Electronic Health Record Incentive Programs into a single program. APMs, such as ACOs and bundled payment programs, will receive incentive

11. Peter G. Peterson Foundation *Healthcare Primer*, Sept. 27, 2013.

12. Jim Landers, Landers: Big names in health care create a new payment model for doctors, *The Dallas Morning News*, Feb. 9, 2015.

13. “Bundled payment is a single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or provide a given treatment.” Suzanne Delbanco, The Payment Reform Landscape: Bundled Payment, *Health Affairs Blog*, July 2, 2014.

14. The hospital value-based purchasing program rewards acute care hospitals with incentive payments for the quality of care they deliver. “Value-based purchasing is part of the quality incentive program established through the Affordable Care Act to help drive down costs while promoting high-quality care for Medicare beneficiaries.” Sabriya Rice, Reform Update: Some question the value of value-based purchasing, *Modern Healthcare*, Aug. 11, 2014.

15. The Center for Medicare & Medicaid Innovation was established by section 1115A of the Social Security Act (as added by section 3021 of the Affordable Care Act). Congress created the CMS Innovation Center for the purpose of testing “innovative payment and service delivery models to reduce program expenditures ... while preserving or enhancing the quality of care” for individuals who receive Medicare, Medicaid, or Children's Health Insurance Program benefits.

payments based on value.¹⁶ Increasing awareness of problems with the fee-for-service system has resulted in a growing number of initiatives that have common features: accountability at the medical community level; transparency to the public; flexibility to match local strengths to value-enhancement opportunities; and shifting to paying for value, not volume.

Isn't this capitation revisited?

You may fairly ask, "Isn't this the 'next big thing' to save health care, like capitation? Won't it fizzle away like that did?"

ACOs with shared savings are unlike capitation in several crucial ways. First, in the ACO context, the payments are commonly only bonus payments in addition to fee-for-service payments. In contrast, in the capitation model, the physician or provider usually is paid a fixed amount per patient per month. In the shared savings-only models, there is no downside risk.

Second, vital administrative capabilities, data measurement capability, identified common metrics, severity adjustment, and electronic health information exchange (HIE) sophistication were not present in the capitation era.

Strategic note: Though many experts propose that newly formed ACOs assume financial risk through financial penalties, or partial or whole capitation, this author's 15 years of clinical integration experience strongly suggest that *if an ACO has the option, it will not accept downside risk until it has two or three consecutive years of meeting budget estimates. Please note, however, that this discussion is not intended as an indicator of the future success or failure of any ACO. Those considering an ACO should consult with the appropriate experts, including legal and accounting experts.* There are just too many new partners, roles, moving parts, untested data metrics, and variables beyond the control of the ACO. Even taking a smaller share of the savings pool to recognize the absence of downside risk may be worth considering in lieu of accepting the responsibility of unanticipated medical expenses without the tools to control them. While having some "skin in the game" may be a logical way to incentivize accountability for providing value, thrusting that on an unready health care system could do more harm than good.

Can't I wait until things get clearer?

With hospitals and physicians having lots of other things on their plates, and this bearing a resemblance to other reforms that never quite panned out, a wait-and-see attitude might at first seem reasonable. However, as the next chapter describes, successful ACO creation will require deep transformational change, and that takes time, effort, and commitment. The changes will have less to do with infrastructure and technology than culture. This is as true in integrated systems with a fully employed medical staff as it is with other models. From the Healthcare Financial Management Association (HFMA): "Given the major cultural differences between hospitals and physicians, achieving clinical integration is one of the most difficult challenges that either party will ever undertake. ... Organizations that have not yet started down this path in earnest will need to move much more aggressively to prepare for the post-fee-for-service world."¹⁷ You cannot wait to plan. Being unprepared is not an option. But there is a difference between having a plan and implementing a plan. If you are a hospital CEO or in a particular specialty, you may want to wait until value-based payment has reached the tipping point relative to fee-for-service before you actually implement your plan.

16. Centers for Medicare & Medicaid Services, Delivery System Reform, Medicare Payment Reform, & the MACRA (accessed March 10, 2016).

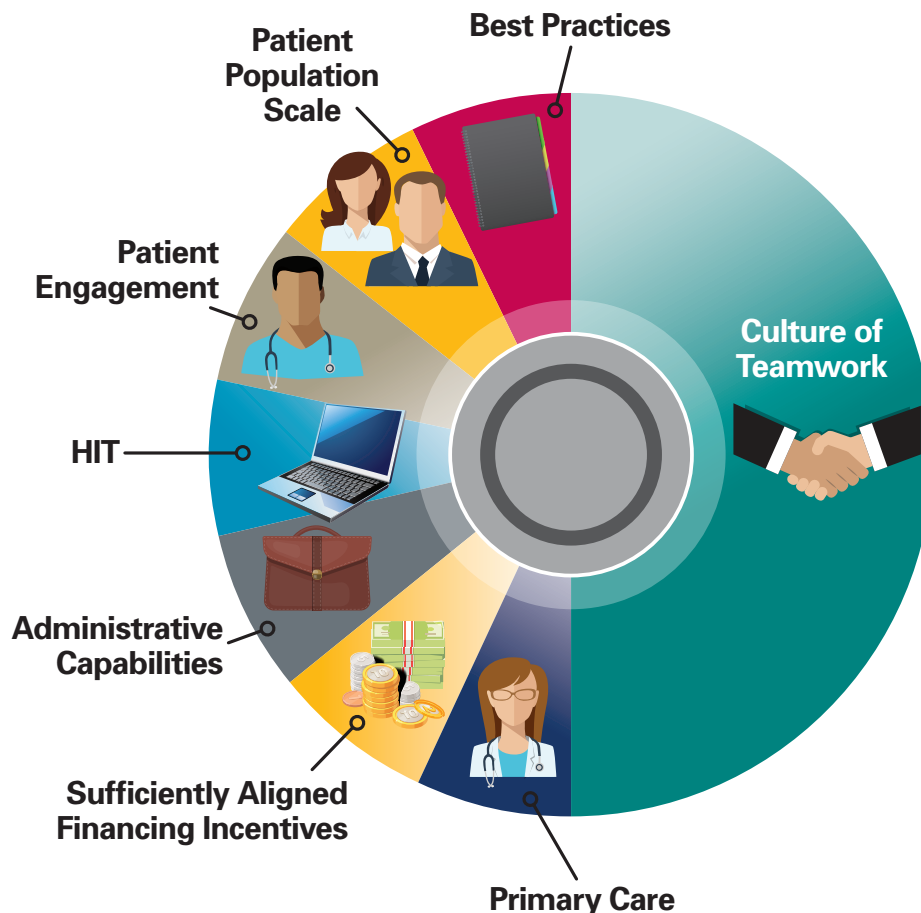
17. Gary Edmiston and David Wofford, Physician Alignment: The Right Strategy; the Right Mindset, Healthcare Financial Management Association, Dec. 1, 2010.

CHAPTER TWO

Essential Elements of a Successful ACO

Any successful ACO comprises eight essential elements (see Fig. 2). All eight are required. You cannot skip a step. Because element No. 1 is not as objectively verifiable, it is counterintuitive that the most vital element is by far the most difficult element to obtain: the creation of an interdependent culture of mutual accountability committed to higher quality and patient satisfaction at the lowest cost. “[C]linical transformation has less to do with technical capabilities and more with the ability to effect cultural change” (HFMA).¹⁸

Fig. 2. The Eight Essential Elements of a Successful ACO



18. Id.

Essential Element No. 1: Culture of Teamwork — Integration

The most important element, yet the one most difficult to attain, is a team-oriented culture with a deeply held, shared commitment to reorganize care to achieve higher quality at lower cost. A fully functional ACO will catalyze the transformation of health delivery.

Challenges for physicians

Physician attitudes favor autonomy and individualism over collaboration. These attitudes are inculcated in clinical training and reinforced daily in care delivery. Payment rewards an individualistic “payment for services rendered” mentality. Physicians need to understand that the level of involvement needed to effect changes in quality and cost is much different from just banding together for contracting purposes. Physicians will have to be willing to change utilization, referral, and care-management patterns. In many settings, specialists will need to release primary control of patient care decisionmaking to the medical home primary care physician.

Physicians are justifiably cynical about “next best things.” Some already have weathered HMOs, gate-keeping, and capitation, and they have little experience with, or time for, organizational-level strategic planning.

Challenges for hospitals

Will hospitals be willing to embrace a true ACO structure, which likely will drive down hospitalization? Will they be willing to distribute shared savings as intended, to incentivize and reward those who created the savings through high-performance care delivery and improved coordination, or will they try to take any savings dollars “off the top” to make up for the lost revenue from the reduction in avoidable hospitalizations and readmissions? Will the increased market share from joining an ACO make up for the lost revenue? Exacerbating the business risks involved in sharing governance with physicians and committing without reservation to an orientation of higher quality and lower costs is a deeper cultural barrier: control. Hospitals are complex organizations, and a degree of control over operations and direction historically has been important for their viability.

“The most significant challenge of becoming accountable is not forming an organization, it is forging one.” — P. Ronning¹⁹

Strategic note: Tips on how to create a collaborative culture:

- ◆ **Find champions:** Vision comes first, but to sell that vision, you need physician leaders able to articulate a clear and compelling vision of change. They need to be champions of the transformational changes needed. In the author’s practical experience, as few as one, and rarely more than five, are needed. If a hospital is involved, the CEO needs to show commitment to the shared vision.
- ◆ **Create a credible governance structure:** The structure must have meaningful input from the various parties to have status and credibility. It must exhibit shared control. Management teams can be pairings of physicians with hospital administrators. Governance is such a point of emphasis that the Medicare Shared Savings Program final rule includes a section dedicated to this titled “Shared Governance.”²⁰
- ◆ **Establish an incentive-driven alignment:** Said hospital and health care consultant Ann Robinow: “[I]f incentives are correctly aligned, organic innovations to solve other problems can and will engage. ... Anticipated early versions of ACO payment incentives are likely to be directionally correct but unlikely to be sufficient to create the needed burning platform”²¹ — the impetus for drastic, immediate change. Compensation plans for hospital-employed physicians must not be limited to individual productivity but also have incentives for accountability for success of the ACO team.

19. Id.

20. 76 Fed. Reg. 67975, Nov. 2, 2011 (codified at 42 C.F.R. §425.106).

21. Ann Robinow in Thought Leader’s Corner, *Accountable Care News*, December 2010, pg. 9.

- ◆ **Ignite a “spiral of success”:** The following strategy could help meld team culture: An early pilot project for your ACO should be consistent with the new vision, led by champions, and cut across specialty and department lines. A multidisciplinary team decides how to collect and share data in new ways to facilitate this care initiative. The data, in paper or electronic format, are available at the point of care. Quality goes up, and there is a savings pool. New team habits begin to emerge. Small scale is OK, but it must succeed, so the “spiral of success” can start. Trust goes up, and buy-in for the next collaboration will occur more quickly.
- ◆ **Recognize employment is not a panacea.** Some might argue that the most obvious path to integration is through employment by a hospital-owned entity. This might be a feasible approach if the parties have worked together in the past, a level of trust and respect already exists, and state law allows such employment. This will not work if there are not shared goals and the control and financial incentive issues are not resolved.

Essential Element No. 2: Primary Care Physicians

What is the role of primary care in ACOs?

The highest-impact targets identified for ACOs lie in the following areas: (a) prevention and wellness, (b) chronic disease management, (c) reduced hospitalizations, (d) improved care transitions across the current fragmented system, and (e) multispecialty comanagement of complex patients. Primary care can be drivers in all of these categories.

Harold Miller of the Center for Healthcare Quality and Payment Reform concluded, “It seems clear that, in order to be accountable for the health and healthcare of a broad population of patients, an Accountable Care Organization must have one or more primary care practices playing a central role.”²² He envisions different levels of ACOs, with the core Level 1 consisting primarily of primary care practices. Level 2 would include select specialists and potentially hospitals. As the diverse patient populations fall under the ACO’s care, Level 3 expands to more specialists and facilities, and Level 4 includes public health and community social services. As noted in Chapter 4, primary care is the only physician or provider practice type or health care facility type mandated for inclusion to qualify for the MSSP.

What are the roles of specialists in ACOs?

It is becoming clear that specialists will serve important roles in ACOs. Specialists should see roles in medical home coordination of diagnosis and treatment, transitions across settings, reducing avoidable hospitalizations, and multispecialty complex patient management. Inpatient specialists can tackle hospital through-put, minimizing avoidable adverse events and readmissions, and quality improvements. Specialists intent on preserving volume at the expense of best practices have no role in an ACO.

What are the roles of hospitals in ACOs?

Hospitals are logical ACO partners for several reasons: Patients will need hospitalization, hospitals have extensive administrative and health information technology infrastructure, ACOs are consistent with hospital missions, and hospitals are often a medical community’s natural organizational hub. But the typical ACOs tend to reduce hospitalizations. As Mr. Miller observes, “The interests of primary care physicians and hospitals in many communities will not only be unaligned, but will be in *opposition* to one another” (emphasis in the original).²³ A litmus test for hospital membership (or whether to join an ACO that includes a hospital) is whether it is committed to overall increased savings, improved quality, and improved patient satisfaction for patient populations, even if hospitalization rates are reduced. It is also unacceptable if a hospital permanently seeks to capture most of the shared savings “off the top” to make up for lost revenue. A hospital at overcapacity should not have this conflict. Moreover, many hospitals see full institutional commitment to accountable care as the

22. Harold D. Miller, *How to Create Accountable Care Organizations*, Center for Healthcare Quality and Payment Reform, September 2009, p. 8.

23. *Id.*, p. 15.

best way to prepare for the future, maximize their fair share of the shared savings dollar, and grow market share. Once the shift from payment for volume to payment for value has been reached the tipping point, these conflicts should ease.

In summary, because primary care will drive so many of an ACO's most high-yielding initiatives, it is an essential element of a lasting and successful ACO.

Essential Element No. 3: Adequate Administrative Capabilities

What kind of organization can be an ACO?

The very label “accountable care organization” tends to convey an impression that an ACO must be a particular type of organization. In retrospect, it probably should have been called “accountable care system.” It is about function, not form. Similarly, a wide array of organizations may become eligible for the Medicare Shared Savings Program under the ACA and the MSSP final rule:²⁴ group practice arrangements, networks of practices, joint ventures between physicians/providers and hospitals, hospitals employing physicians, and other approved structures. There are three essential infrastructure functional capabilities: (1) performance measurement, (2) financial administration, and (3) clinical direction. A legal entity of some sort is necessary, and various choices are available.

The form ultimately chosen should be driven by what most readily facilitates achievement of the functional needs of the ACO initiatives in your community. “The ultimate goal of accountable care is to improve patient outcomes and patient satisfaction while also achieving greater cost efficiencies,” said health system change advisor and attorney Doug Hastings, JD. “The key to achieving this goal is enhanced coordination of care among diverse physicians and providers through the application of evidence-based clinical protocols and transparent measurement and reporting. **While ACO formation and ongoing structural, operational and legal issues related to ACOs are important, it is this transformation in clinical care that must remain the overriding focus of ACO development**” (emphasis added).²⁵

What are key legal issues affecting ACOs?

ACOs require collaboration, referrals, reductions in unnecessary care, and sharing of revenues among sometime competitors.

CMS' 2015 MSSP final rule updated and improved policies governing beneficiary assignment, data sharing, available risk models, eligibility requirements, participation agreement renewals, and compliance and monitoring. The rule announced the intent to propose further improvements that would shift to basing benchmarks in part on trends in regional fee-for-service costs to strengthen ACOs' incentives to provide efficient care, and improve the long-term sustainability of the program.²⁶ A properly configured ACO should be successful in navigating this legal minefield. The principal bodies of law affecting ACOs are:

- ◆ Antitrust,
- ◆ Antikickback,
- ◆ Stark,
- ◆ Civil monetary penalties,
- ◆ Tax,
- ◆ HIPAA,

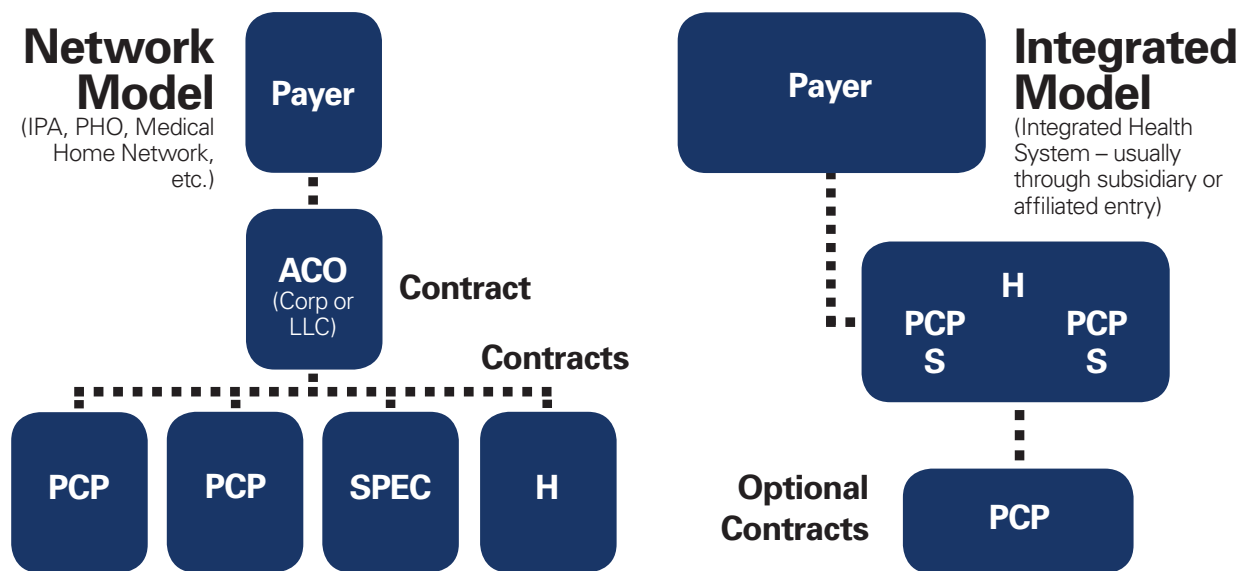
24. 76 *Fed. Reg.* 67975, Nov. 2, 2011.

25. Doug Hastings in Thought Leaders Corner, *Accountable Care News*, December 2010, p. 6.

26. CMS Fact Sheet, Finalized Changes to the Medicare Shared Savings Program Regulations, June 6, 2015 (accessed March 10, 2016); 80 *Fed. Reg.* 32691, June 9, 2015.

- ◆ Malpractice,
- ◆ Corporate practice of medicine,
- ◆ Insurance,
- ◆ Intellectual property,
- ◆ State self-referral, and
- ◆ Business.

Fig. 3. Possible Organizational Forms



Possible organizational forms

1. Network models (see Fig. 3):

- ◆ Independent practice association — An IPA is basically an umbrella legal entity, usually a limited liability company, for-profit corporation, or nonprofit organization, that has physician participation contracts with hospital-employed and independent physician practices. Payers contract with the IPA. These structures became familiar in the fee-for-service and capitation eras, and the form is still suitable for the accountable care era. However, the IPA now needs to have ACO-level infrastructure as described in this guide. It is particularly dependent on robust health information exchange, as the continuum of care is more “virtual” because the physicians and providers are independent. The participation agreements are different, too. The physician or provider agrees to undertake the responsibilities agreed upon by the ACO and accept some type of performance-based incentive, like shared savings, in addition to fee-for-service. The IPA can have any combination of specialists, primary care, hospital, and tertiary care participating contracts. An IPA is owned by physicians. Legal issues of note in IPAs involve antitrust and self-referral laws, insurance regulation, HIPAA, malpractice, and Stark law.
- ◆ Physician/hospital organization — The PHO is very similar to an IPA; the main difference is that the PHO is organized by physicians and a hospital or health system (as member) and includes a hospital participation contract. The same requirements and caveats apply. Note: Texas law contains specific requirements for physician nonprofit health organizations.²⁷

27. See Special Requirements for 162.001(b) Health Organizations, 22 Tex. Admin. Code §177.5. Also, see 22 Tex. Admin. Code Chap. 177.

- ◆ **Medical home-centric model** — Under this variation, an umbrella entity is owned by medical home practice members or networks. It contracts with payers, initially for the medical-home-related primary care services, but includes accountable care financial arrangements and performance measurement capabilities. It broadens the scope of initiatives and patient populations by adding select specialists and hospitals through contractual arrangements. These may be sub-ACO arrangements whereby the contract is with a PHO or hospital ACO. The same requirements and caveats of the other network model forms apply.

2. Integrated model (see Fig. 3): With this variation, the hospital, health system, foundation, or multispecialty clinic employs, rather than contracts with, the physician. It may own, capitalize, and control the ACO, with physicians on advisory committees. The health information technology and other infrastructure are within the controlling entity. It may have contracts with independent physicians, providers, and facilities if necessary to round out the breadth, depth, and reach of services needed to accomplish its initiatives.

Note: Texas law generally prohibits the corporate practice of medicine.²⁸ Questions regarding ACO structure, including questions relating to physician employment, should be addressed by legal counsel.

Essential Element No. 4: Adequate Financial Incentives

Isn't this the same as insurance?

No. An insurance company assumes the financial risk of coverage when a person gets ill or has an accident requiring medical care. Accountable care risk is accountability for the cost and quality of treatment of patients once they become ill. This gets fuzzy when one remembers that the ACO will be responsible for an entire patient population, especially as it assumes more risk, as in full capitation. However, this distinction is why the ACO performance expectations need to be severity-adjusted.

What are the types of financial incentive models for ACOs?

There are three tiers: upside-bonus-only shared savings, a hybrid of limited-upside and limited-downside shared savings and penalty, and full-upside and full-downside capitation.

Shared savings model (see Fig. 4): If the ACO enhances or maintains quality and patient satisfaction, and there are savings relative to the predicted costs for the assigned patient population, then the ACO shares portion of those savings (commonly 50 percent according to some surveys and the Medicare Shared Savings Program final rule).²⁹ This is stacked on top of the physician's fee-for-service payments. To maximize incentivization, the savings pool should be divided in proportion to the level of contribution of each ACO participant. This aligns incentives of all ACO participants to keep patients as well as possible and ensure ill patients receive optimum care in a team environment across the care continuum. If primary care has especially high medical home management responsibility, this may be accompanied by the addition of a flat per-member/per-month payment.³⁰

Some of the savings pool distributions should be used to maintain the ACO infrastructure, but as much as possible should go to reward physicians, providers, and facilities for the extra time and attention devoted to patient management and technology investments. As mentioned, it should not go to pay affected physicians or hospitals for reduced revenues under fee-for-service for reductions in volume. A strength of this model is that it is easy to understand and transition to, since it builds upon the familiar fee-for-service system. That is also its weakness, since fee-for-service payment still rewards volume, not value. This shared savings model has been criticized as being "asymmetric" or "one-sided," with no consequence if there are higher costs or no care

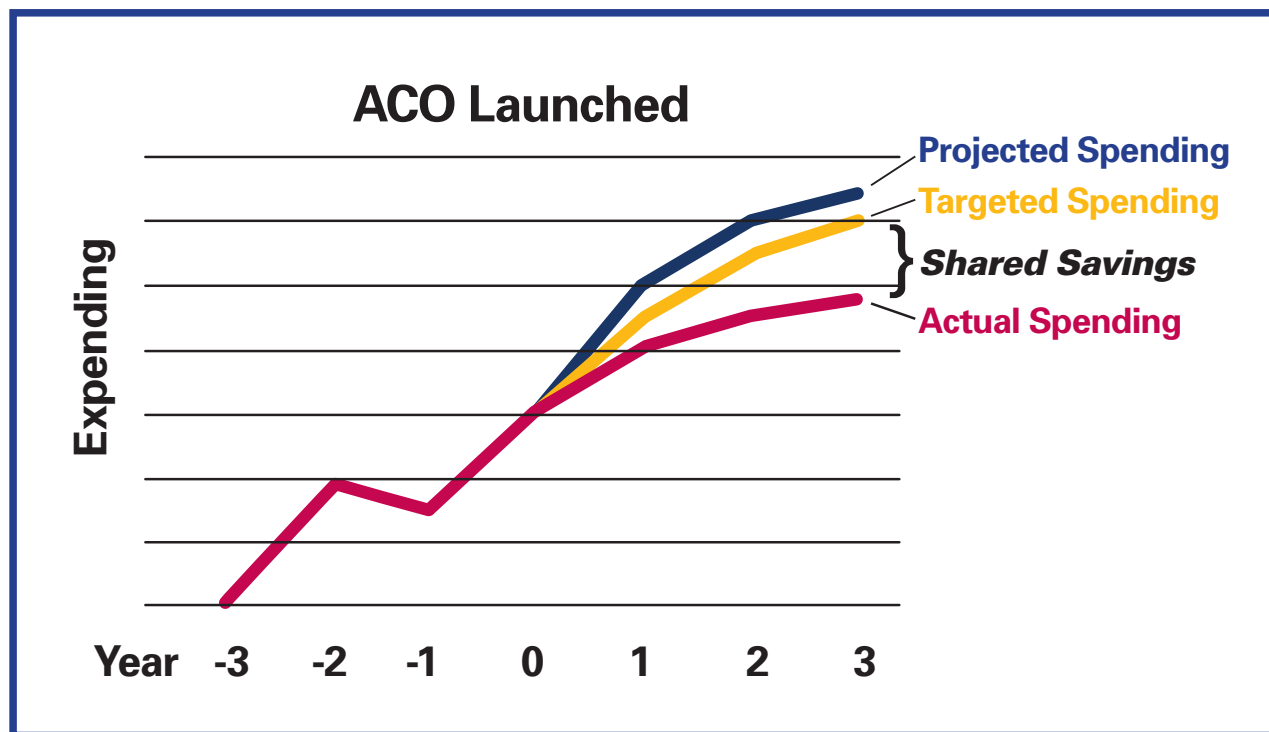
28. See, e.g., Texas Medical Board, FAQs for Licensees, "What is the 'corporate practice of medicine'?"

29. See 80 *Fed. Reg.* 32692-32845, June 9, 2015.

30. See Suzanne Delbanco, The Payment Reform Landscape: Payment for Non-Visit Functions and the Medical Home, *HealthAffairs Blog*, May 6, 2014.

improvement. Another problem is that there is by necessity a lag time to measure the “delta,” or the difference between the actual costs and the expected costs, so the ACO is uncertain whether there will be revenues. The delay saps the incentive to adhere to the ACO’s best practices and coordination.

Fig. 4. The Shared Savings Model



Courtesy of the Brookings Institution

Strategic note 1 on how to calculate shared savings: Although the concept is simple — the ACO gets 50 percent of the difference between what the costs for the population turned out to be versus what the costs would have been if the ACO were not in place — DO NOT try to calculate this by comparing your population costs year to year. It might work the first year but will be inappropriate after that. Having to beat your performance from the prior year, every year, is like calling an Olympic medalist a failure for not breaking his or her world record the next time out. In some CMS demonstration projects, relatively unmanaged counties were picked as the control populations. Another option is to use an actuary who can predict the medical costs for your region or comparable community and use that actuarially valid projected amount as your unmanaged (i.e., non-ACO) “comparable.” CMS has chosen a variation of this latter approach for calculation of the MSSP savings.³¹

Strategic note 2: Be patient before taking on risk. Do not repeat the disaster of the '90s, when physicians and providers took on risk without proper technology, infrastructure, best practices, or experience.

Based on the author’s experience, it may be appropriate for those who are considering further development of an ACO to come within a certain percentage of their predicted costs (for example, 5 percent \pm) for several consecutive years (for example, three years) before leaving the shared-

31. 76 Fed. Reg. 67985-67988, Nov. 2, 2011.

savings upside-only model. There are risks in any of these models, and those involved should carefully consider all risks before taking them on.

You may have unexpected costs over which you have no control. You likely will want to improve your health information exchange, include relevant data elements, and see which of your ACO physicians and providers “get it.” In our experience, fears are overblown that lack of downside risk will deter performance improvement. To the contrary, a meaningful bonus payment is very motivating, as much a recognition of and respect for the clinical leadership of the physicians as it is a recognition of the benefit of dollars involved. Individual distributions that differ based on performance determined by peers is also a “grade” that high-achieving individuals work hard to earn.

Savings bonus plus penalty model: As with the shared savings model, physicians and providers not only receive shared savings for managing costs and hitting quality and satisfaction benchmarks but also are liable for expenses that exceed spending targets. This model is called “symmetric” or “two-sided,” and the bonus potential is increased to balance the accountability for exceeding preset goals. Fee-for-service payment is retained. This resembles the “two-sided” model mentioned in the MSSP final rule.³²

Capitation model: A range of partial capitation and full capitation models is possible. Fee-for-service payments are replaced by flat payments plus potential bonuses and penalties. Only seasoned and truly clinically integrated ACOs should attempt this level of risk. Yes, the upside is higher, but the disasters of the '90s should not be forgotten.³³

Is this the same as bundled payment or episode-of-care payment?

ACO incentives can be aligned with these and other payment experiments under consideration. An “episode-of-care” payment is a single amount to cover all the services provided to a patient during a single episode of care. When that episode payment covers physicians or providers who would have been paid separately under fee-for-service, that is a “bundled payment.” Such a payment mechanism that excludes payment for treatment of avoidable readmission or hospital-acquired infections motivates better care. These approaches do not incentivize prevention and medical-home coordination to avoid the episode in the first place.

Meaningful use regulations incentives: We include the Medicare payments under the meaningful use program (i.e., the CMS Medicare & Medicaid Electronic Health Record Incentive Programs) as an ACO financial incentive because the basic health information exchange within your ACO likely will qualify the ACO's physicians for the Stage 2 and Stage 3 meaningful use incentives.³⁴ Generally speaking, if an ACO can establish its data flow needs relatively soon as outlined in this guide, there may be a better likelihood that the federal government may help finance the ACO's health information technology needs.

32. 76 *Fed. Reg.* 67986-67987, Nov. 2, 2011 (codified at 42 C.F.R. §425.606).

33. See Centers for Medicare & Medicaid Services, Financial Alignment Initiative (accessed March 10, 2016); Bob Herman, CMS to Unveil First Group of Next Generation ACOs “Soon,” *Modern Healthcare*, Oct. 14, 2015.

34. 75 *Fed. Reg.* 44314 (July 28, 2010).

Essential Element No. 5: Health Information Technology and Data

What data?

ACO data are usually a combination of quality, efficiency, and patient-satisfaction measures. They will usually have outcomes and process measures. Nationally accepted benchmarks are emerging. An ACO has three categories of data needs:

Baseline data: This is often overlooked. To compare anything, there needs to be a beginning reference point. Can you collect costs and quality data? Who owns them now? Who collects them? Do you trust that entity to be accurate and objective? Are there variables outside your control affecting your performance scores (i.e., patient noncompliance)? What financial incentives/penalties are tied to each? Use the data to perform a “gap analysis”: Where are your local quality-and-cost numbers outliers to the ideal? This tells you where your “low-hanging” fruit may be. Match those outlier opportunity areas with the particular strengths of the physician and provider array of your ACO, and you have your priority initiatives or targets.

Performance data: In the value-based payment era, it will not be enough to provide exceptional cost-effective care; you must prove it. A practical way to determine your ACO's needed performance data is to start by selecting the ACO's targeted initiative as mentioned above. Then select from emerging nationally recognized quality and efficiency metrics (e.g., those of the National Quality Forum, the National Committee for Quality Assurance, or the Physician Consortium for Performance Improvement, or the Medicare Shared Saving Program's required quality metrics), if they apply. Even if they do apply, convene a multispecialty committee of clinicians to vet their clinical validity. This committee will recommend performance benchmarks from scratch if national standards are not yet available for all of the care pathways of your initiative. They should address quality, patient satisfaction, and efficiency. They need to be severity-adjusted. Obviously, if and when a third-party payer, including CMS, sets the performance benchmarks, that payer should be part of the performance array. Many payers want to allow local flexibility and clinical leadership in metric-setting.

Data as a clinical tool: Once the ACO has selected targeted care initiatives, the organization will determine best practices across the care continuum. The appropriate ACO committee will then usually subdivide each pathway into each component and assign clinical leadership, decision support, and data prompts, and embed relevant clinical data into each step at the point of care. ACOs are discussing virtual workstations and data dashboards. Coordination with downstream physicians and providers will be optimized with the real-time sharing of upstream care results and scheduling.

Strategic notes: (1) The ACO should periodically grade itself internally against the performance benchmarks to create an ongoing quality/efficiency/satisfaction improvement loop. This not only will hone the contributions of the ACO initiatives, but also will prepare the ACO to increase its financial rewards once the performance results drive a savings pool or bundled payments. Gaps relative to ideal highest-value care should be flagged and addressed before your compensation depends on it. Clearly, clinically valid, accurately collected, severity-adjusted, and properly benchmarked data are essential for any compensation model based on performance. (2) Data that reflect a track record of high performance serve as a bargaining tool when payment is being negotiated, even fee-for-service payment. (3) Use data first to target the “low-hanging fruit,” high-impact, value-added initiatives in your area best suited to your specialty or facility. Next, use data to collect evidence of your performance. Participants will need specific baseline, performance, and clinical data elements to meet objectives, maximize their measured contribution, and thus reap a meaningful reward from the savings pool.

The Medicare Shared Savings Program final rule provides details

The list of ACO quality measures was revised for 2015 based on several factors, such as clinical guideline changes, harmonization with other CMS programs, a shift from process-of-care measures to outcome-based measures, and reducing the burden of data collection. Although the total number of measures remains at 33, CMS has removed five ACO reported measures, added four claims-based measures and one survey measure, and updated the electronic health records measure to reflect 2015 CMS program changes.³⁵

HIE capability

Your ACO will need health information exchange capabilities sufficient to move the data across the continuum in a meaningful way. This HIE is aligned with the meaningful use measures. It must be able to aggregate data from multiple sources into user-friendly formats with decision support and relevant data that follow the patient to maximize chances of success in the ACO's targeted initiatives. It needs to minimize the data collection burden on workflows.

Essential Element No. 6: Best Practices Across the Continuum of Care

Another essential element of a successful ACO is the ability to translate evidence-based medical principles into actionable best practices across the continuum of care for the selected targeted initiative or initiatives. An ACO may start out with a single patient population (i.e., morbidly obese patients) or disease-state (i.e., diabetes).

The five identified high-impact target areas for ACO initiatives are:

- ◆ Prevention and wellness;
- ◆ Chronic disease (75 percent of all U.S. health care spending, much of it preventable);
- ◆ Reduced hospitalizations;
- ◆ Care transitions (across our fragmented system); and
- ◆ Multispecialty care coordination of complex patients.³⁶

The richest “target fields” from this array will vary by specialty and type of facility, as well as patient mix. Looking at these suggested initiatives, it is no wonder why primary care is emphasized as key for ACOs, since it could play a significant role in every area. The ACO should match its strengths against the gaps in care in the ACO's market to identify the most achievable goals.

Essential Element No. 7: Patient Engagement

Without patient engagement, an ACO will not fully meet its potential. Unfortunately, many of today's health care consumers erroneously believe that more is better. On the other hand, patient noncompliance with doctors' orders is a problem, especially regarding chronic diseases and lifestyle management. It is difficult to accept a compensation model based on input on improved patient population health when that is dramatically affected by a variable outside of your control: patient adherence. Currently, asking a patient to be a steward of his or her own care puts a fee-for-service payer at a competitive disadvantage. But patient engagement is part of patient-centeredness, which is required by the ACA for an ACO to qualify for the Medicare Shared Savings Program.³⁷

35. See, e.g., 76 *Fed. Reg.* 67889-67890, Nov. 2, 2011.

36. See, e.g., athenahealth, *Succeeding as an ACO: A 6-Step Guide for Health Care Organizations*, July 2013.

37. Section 3022 of the Patient Protection and Affordable Care Act of 2010 (42 U.S.C. §§1395, et seq.). See also 76 *Fed. Reg.* 67976, Nov. 2, 2011 (codified at 42 C.F.R. §425.112[a][1]).

What can an ACO do to engage patients?

Patients need better information at a societal level and also at the medical home point of care.

The patient compact: Some ACOs engage the patient through a compact, or agreement. It may involve a written commitment by the patient to be responsible for his or her own wellness or chronic care management, coupled with rewards for so doing, education, tools, self-care modules, and shared decisionmaking empowerment. The physicians will need to embrace the importance of patient involvement and hold up their end of the engagement bargain.

Benefit differentials for lifestyle choices: The financial impact of many volitional patient lifestyle choices is actuarially measurable. A logical consequence of the patient choice could be a benefit or financial differential reflecting at least partially these avoidable health care costs.

Essential Element No. 8: Scale-Sufficient Patient Population

It is OK, even desirable, to start small; to “walk before you run,” so to speak. However, what is often overlooked is the need for a minimal critical mass of patients to justify the time and infrastructure investment for the ACO. The MSSP requires that the ACO have a minimum of 5,000 beneficiaries assigned to it.

Strategic note: Some ACOs commence activities through a single pilot, or demonstration project, without assigning a sustainable patient population to it. It can debug the initiative and test-run the ACO early enough to fix problems before ramping up. If it succeeds, it may be much easier for the ACO champions to gain buy-in from others.

The elements do come together and mesh. Culture dominates. Each one can be built. These are not mysterious. They are doable. It will be hard. Once the ACO organizers embrace the opportunity in this change, achieving all the elements for sustainable success is quite feasible. In addition, if you are evaluating a previously organized ACO, there are clear indicators regarding these essential elements that will predict reliably its likelihood of success.

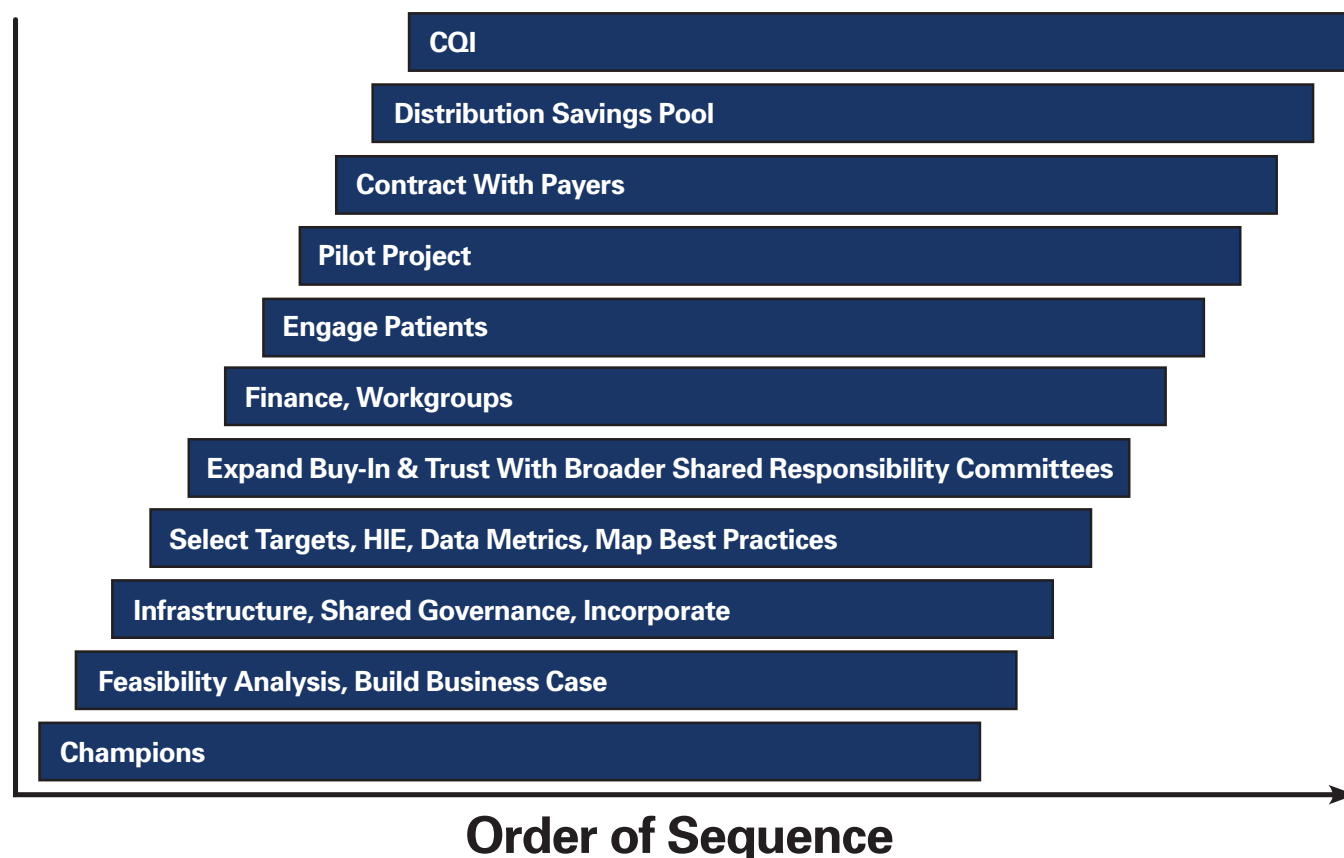
CHAPTER THREE

Successful Implementation: A Step-By-Step Guide

Where Do I Start?

You now may be saying: “I know what an ACO is, why it is important, and how to identify ones that will succeed. However, how do I build one? Where do I start? I know where I need to go now, but how do I get there?” The creation of an ACO follows basic business planning and start-up principles. Expert advice on ACO development is uniform. The following is a step-by-step guide to building an ACO.

Step-By-Step Guide



- 1. Informed champions:** Perhaps even ahead of this first step may be the need for some ACO information available to plant the seed of awareness with a few local champions. These champions, whether hospital CEO, family physician, or neurosurgeon, will need to invest their “sweat equity” to get up to speed (the main purpose of this ACO guide). The champions need to reach beyond silos and see whether cultural compatibility is possible.
- 2. Strategy formulation/gap analysis:** Next, a small core group should honestly assess where they are and where they need to go. What is the target market (e.g., chronic disease, Medicaid, the elderly)? Does an ACO make sense? What do we target? How do we make sure this is fair and successful so that we get buy-in? Some experts recommend a phased approach starting with primary care; then adding select specialists and hospitals around targeted high-impact initiatives; then adding a comprehensive panel; then, finally, including public health and social services. Other experts recommend matching the natural strengths of the ACO with the greatest gaps in care for the local area. Then they would have the ACO model a strategic business case, to create a roadmap to development. How will it achieve all of the eight essential elements listed in Chapter 2? Keep the team very small at this stage.
- 3. Clear vision:** The organizing group needs to have credibility and will need to unite around a clear and compelling shared vision.
- 4. Clinical integration:** Through shared decisionmaking and champion leadership, build capabilities of a clinically integrated organization. Review the plan for presence of the eight essential elements. One example is the 100-percent, physician-owned and -led ACO in McAllen, Rio Grande Valley Health Alliance, LLC.
 - a. Start with your initial targeted initiatives.
 - b. Establish best practices for the continuum of care for all physicians and providers involved with that type of patient.
 - c. Subdivide the best practices into component parts and assign clinical leadership responsibility for each.
 - d. Identify which clinical data sets and decision support tools are needed at each step.
 - e. Assign performance metrics and financial accountability for same.
 - f. Determine health information technology technical requirements.
 - g. Determine best financial tools to incentivize desired behavior by all involved (i.e., share savings with predetermined performance benchmarks and distribution methodology).
- 5. Structural foundation.** Choose the legal entity approach and formal governance structure most appropriate to your culture and business plan. It must be driven by the form most likely for the success of the ACO, not controlled by success for any particular stakeholder. Establish membership criteria and a shared decisionmaking structure. Design and undertake training. Develop payer strategy and contract terms. Do return-on-investment predictive modeling to estimate savings and quality benefits. Create credible value talking points for all stakeholders. If you choose to participate in the Medicare Shared Savings Program, make sure you meet all the structural requirements, which are not onerous.
- 6. Expand buy-in:** Broaden structured involvement. Create a multidisciplinary integration committee with health information technology, best practices, patient engagement, and finance subcommittees.

- 7. Accountability function:** Develop data metrics, measurement capability, and sophisticated financial administration capabilities to manage financial shared savings distribution. Set performance targets. Normalize data. Make sure your performance-based incentives target your ACO objectives.
- 8. Start small:** Start with a demonstration or pilot project.
- 9. Contract with payers:** Once ready, contract to provide integrated accountable care services on a shared savings basis, at least initially, for your target patient population. The patient population scale must be adequate to achieve economies of scale. Consider a Medicare ACO as part of a broader strategy. (See Chapter 4 for a blueprint on applying to the Medicare ACO and Medicare ACO advance payment model programs.)
- 10. Assess and improve:** Assess results of the process. Make adaptations to create a constant quality improvement loop. Collect and distribute the savings pool roughly in proportion to contributions to it.

Conclusion

The accountable care organization holds great promise to address many of the ills of America's health care system. However, it will require new skill sets, collaboration partners, technology, and systems. It will require a radically different approach to shared accountability. The goal of this ACO guide is to demystify ACOs for all stakeholders and to provide some tools and confidence to allow health care leaders to take prudent risks for greater success than they otherwise would have.

CHAPTER FOUR

How to Apply for the Medicare Shared Savings Program

America's largest payer, Medicare, has committed to the ACO model, with a minimum 50-percent sharing of savings to ACO physicians and providers on top of fee-for-service payments. It may be totally or partially physician-driven, and only primary care physicians are required. To promote physician-only ACOs in nonmetropolitan areas, CMS will prefund them through the advance payment model. This level of sustainable funding through ongoing shared savings distributions could help “pay for” your ACO operations that can in turn be used for Medicaid, private payer, or other patient population engagements. **The applications are generally consistent with the principles and strategies of this *Texas Physician's Accountable Care Guide*, a useful reference in responding to substantive portions of the applications.**

To review: CMS established the Medicare Shared Savings Program to facilitate coordination and cooperation among physicians and health care providers through ACOs to improve the quality of care for Medicare beneficiaries, while reducing unnecessary costs. In addition, the ACA established the CMS Innovation Center to test innovative care and service delivery models, including the “advance payment model.” This chapter will help ACOs navigate the Medicare Shared Savings Program and advance payment model application process.

MSSP Application

Applying to the MSSP requires ACOs to submit a significant amount of information. As a result, organization, information gathering, and timing will all be critical for ACOs wishing to participate. The application process involves the following seven tasks: (1) identify timelines and deadlines, (2) create and form the ACO, (3) file a Notice of Intent to Apply, (4) obtain a CMS user ID, (5) prepare and execute participation agreements, (6) prepare the application, and (7) file the application with CMS.

- 1. Identify timelines and deadlines.** Due to the sheer volume of information they must submit with the MSSP application, ACOs should begin the application process at least three months in advance. ACOs interested in applying should review CMS' MSSP website to identify all relevant deadlines. The ACO then should create a checklist to ensure that all documents, forms, and applications are timely filed. The remaining list of tasks set forth below may serve as a useful template in creating such a checklist.
- 2. Create and form the ACO.** ACOs applying to the MSSP must ensure they are properly organized or incorporated under applicable state laws. Newly formed ACOs will need to file articles of organization or articles of incorporation with the applicable secretary of state. Newly formed ACOs also will need to obtain an employer identification number from the Internal Revenue Service.³⁸

38. 76 *Fed. Reg.* 6797, Nov. 2, 2011 (codified at 42 C.F.R. §425.104).

The ACO must have an identifiable governing body, such as a board of directors, with responsibility for oversight and strategic direction of the ACO. The ACO must ensure that its participants have at least 75-percent control of the governing body, and at least one member of the governing body must be a Medicare beneficiary. In addition, the governing body must have a conflict-of-interest policy that: (a) requires each member of the governing body to disclose relevant financial interests, (b) provides a procedure to determine whether a conflict of interest exists and sets forth a process to address any conflicts that arise, and (c) addresses remedial action for members of the governing body who fail to comply with the policy.³⁹

Finally, the ACO must appoint officers. At a minimum, such officers must include an executive officer, a medical director, and a compliance officer. The leadership responsibility of the executive officer (such as a president, CEO, or executive director) must include the ability to influence or direct the ACO's clinical practices to improve efficiency, processes, and outcomes. The medical director must oversee the clinical management of the ACO. The compliance officer must be responsible for addressing compliance issues related to the ACO's operations and performance. The ACO will need to appoint all such officers before applying for the MSSP.⁴⁰

3. **File Notice of Intent to Apply.** Before applying to the MSSP and advance payment model, ACOs must file a Notice of Intent to Apply with CMS. ACOs should be aware that the filing deadline for the notice will be approximately three months before the filing deadline for the MSSP application (based on the author's experience). While all ACOs that wish to apply to the MSSP must file the notice, filing it does not obligate the ACO to complete the application process. **Thus, ACOs that are even remotely interested in the MSSP should consider submitting a Notice of Intent to Apply to preserve the opportunity to later submit the MSSP application.**
4. **Obtain a CMS user ID.** CMS currently requires all interested ACOs to file the MSSP application online using CMS's secure web portal, the Health Plan Management System (HPMS); CMS will not accept paper applications. To use HPMS, the ACO must obtain a user ID and password using the CMS Form 20037 Application for Access to CMS Computer Systems. After filing, the ACO will receive an email from CMS with instructions for completing the form, along with the deadline for filing. The individual who will be preparing the MSSP application for the ACO should file the Form 20037.
5. **Prepare and execute a participation agreement.** The ACO must enter into a participation agreement with CMS for a period of not less than three years. In addition, ACOs applying to the MSSP must have participation agreements with their participating physicians through their medical practices. At a minimum, the practice-level participation agreement must include: (a) an explicit requirement that the ACO participant will comply with the requirements and conditions of the MSSP, (b) a description of the ACO participants' rights and obligations in and representation by the ACO, (c) a description of how the opportunity for shared savings or other financial arrangements will encourage ACO participants to adhere to the ACO's quality assurance and improvement program and evidence-based clinical guidelines, and (d) remedial measures that will apply to ACO participants in the event of noncompliance with the requirements of their agreements with the ACO. The ACO will need to submit its signed participation agreements with each

39. 76 *Fed. Reg.* 67976, Nov. 2, 2011 (codified at 42 C.F.R. §425.106[c], [d]).

40. See, e.g., 76 *Fed. Reg.* 67976, 67980, Nov. 2, 2011 (codified at 42 C.F.R. §§425.108, 425.300).

41. 76 *Fed. Reg.* 67977, Nov. 2, 2011 (codified at 42 C.F.R. §425.200(a)).

42. 76 *Fed. Reg.* 67978, 67979, Nov. 2, 2011 (codified at 42 C.F.R. §425.204(c) and §425.210(b)); 80 *Fed. Reg.* 32835, June 9, 2015 (codified at 42 C.F.R. §425.116); and, see 2016 Medicare Shared Savings Plan Application form, questions 27a and 27b), downloadable from the CMS How to Apply webpage (accessed March 11, 2016).

of its participants when it applies to the MSSP. As a result, ACOs will need to prepare their participation agreements well in advance of the application filing deadline and ensure adequate time to collect signed copies from participants.⁴³

- 6. Prepare the application.** As noted above, CMS now requires ACOs to file the MSSP application online using HPMS. To ensure a smooth online application process, however, ACOs should prepare all application materials in advance. The ACO should first download and review the MSSP application template from the MSSP website and use this document to assist in collecting and organizing contact information and other background information from ACO participants.

The ACO will also need to prepare a list of its participants, including the taxpayer identification number for each. To avoid delays in the application process, the ACO will need to confirm that each participant's name and taxpayer identification number listed in the MSSP application match exactly what is listed in the Medicare Provider Enrollment, Chain, and Ownership System. In addition, the ACO will need to prepare an organizational chart showing names of the participants, governing board members, committees and committee members, and officers.⁴⁴

A significant portion of the MSSP application consists of certain narrative responses the ACO must complete. These narratives include descriptions of: (a) the ACO's history, mission, and organization; (b) how the ACO plans to use shared savings payments; (c) how the ACO will use and protect Medicare data; (d) how the ACO will require its participants to comply with and implement its quality assurance and improvement program; (e) how the ACO defines, establishes, implements, evaluates, and periodically updates its process to promote evidence-based medicine; (f) how the ACO defines, establishes, implements, evaluates, and periodically updates its process to promote patient engagement; (g) how the ACO defines, establishes, implements, evaluates, and periodically updates its process and infrastructure to support internal reporting on quality and cost metrics; and (h) how the ACO defines, establishes, implements, evaluates, and periodically updates its care coordination processes. The ACO will need to carefully review the required elements of each narrative listed in the MSSP application and ensure the responses discuss each element in detail; failure to address each required element may result in delay (or rejection) of the ACO's application. This guide may be a useful aid in preparing this part of the application.

Assuming the ACO has gathered all required information in advance, the process of filing the MSSP application through HPMS should be fairly straightforward. The ACO will first need to submit its contact information and complete certain attestations to ensure that it meets all applicable requirements of the MSSP. The ACO will then submit supporting documentation (including the organizational chart, executed agreements, narratives, and other documentation described above). Before uploading this documentation, the ACO will need to review the MSSP application reference table for instructions regarding file names and other HPMS uploading requirements.⁴⁵

Finally, the ACO will need to complete the CMS Form 588 Electronic Funds Transfer Authorization Agreement and sent it to CMS using tracked mail, such as certified mail, Federal Express, or United Parcel Service.

3. 80 *Fed. Reg.* 32835, June 9, 2015 (codified at 42 C.F.R. § 425.116).

44. 80 *Fed. Reg.* 32836, June 9, 2015 (codified at 42 C.F.R. § 425.118).

45. See the 2016 Medicare Shared Savings Program Application form, questions 2.b, 8, 14, 21.a, 33, 36, 37, and 38-40, downloadable from the CMS How to Apply webpage (accessed March 11, 2016).

Advance Funding Application

In addition to the MSSP application, ACOs that wish to receive advance funding from the CMS Innovation Center also must complete a separate application, the advance payment model application. Readers should check the periodic availability of CMS funding opportunities, such as the ACO investment model.

Conclusion

With this Medicare ACO roadmap, you should not feel concerned about successfully applying for the Medicare Shared Savings Program. The questions in the application track nicely the principles and suggested models contained in this guide. If you have done the spadework to bring together the eight essential elements, then, hopefully, you will have gone a long way toward completing the application.