



ACCOUNTABLE CARE GUIDE FOR NEUROLOGISTS

Preparing Neurologists for the
Approaching Accountable Care Era



ACKNOWLEDGMENT

This strategic guide involved input through participation by many thought leaders of the following sponsoring organizations who have come together to form the Toward Accountable Care Consortium (“TACC”). This paper would not have been possible without the generous support of all TACC member organizations, including significant support from the North Carolina Medical Society, as well as a substantial grant from The Physicians Foundation. Special thanks to the North Carolina Academy of Family Physicians and North Carolina Society of Anesthesiologists, whose seminal ACO white papers are the underpinning of this Toolkit. We are grateful to Julian D. (“Bo”) Bobbitt, Jr. of the Smith Anderson law firm, for compiling the information in this non-technical “blueprint” format, and to Frank Benzoni of Smith Anderson, Nancy Henley, MD, of Community Care of North Carolina, and the following physician members of the North Carolina Neurological Society for their time and expertise: William Ferrell, MD, Raleigh Neurology; David Meyer, MD, Cornerstone Health Care; J. Griffith Steel, MD, CCHC Atlantic Neurology; Robert Yapundich, MD, Neurology Associates. This guide would not have been possible without the efforts of these individuals.

County / Regional Medical Societies

Cleveland County Medical Society
Craven-Pamlico-Jones County Medical Society
Durham-Orange County Medical Society
Mecklenburg County Medical Society
Forsyth-Stokes-Davie County Medical Society
New Hanover-Pender County Medical Society
Pitt County Medical Society
Rutherford County Medical Society
Western Carolina Medical Society
Wake County Medical Society

Specialty Societies

Carolinas Chapter, American Association of Clinical Endocrinology
North Carolina Academy of Family Physicians
North Carolina Chapter of the American College of Physicians

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North Carolina College of Emergency Physicians
North Carolina Council on Child and Adolescent Psychiatry
North Carolina Dermatology Association
North Carolina Neurological Society
North Carolina Obstetrical and Gynecological Society
North Carolina Orthopaedic Association
North Carolina Pediatric Society
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Carolinas Center for Hospice and End of Life Care
North Carolina Academy of Physician Assistants
North Carolina Community Health Center Association
North Carolina Medical Group Managers
North Carolina Medical Society

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INTRODUCTION

This strategic guide involved input through participation by many thought leaders who have come together to form the Toward Accountable Care Consortium (“TACC”). This paper would not have been possible without the generous support of all TACC 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 the information in this non-technical “blueprint” format.

Part One contains the necessary elements for a successful Accountable Care Organization (“ACO”) and implementation guidance that transcend specialty or facility and apply equally to all ACO stakeholders.

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

Part Two applies the principles and processes of the Guide to provide specific strategies and practical step-by-step guidance using concrete examples used by different physician specialties, including how to apply successfully for the Medicare Shared Savings Program.



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The Physician's Accountable Care Toolkit

How to Identify and Implement the Essential Elements for Accountable Care Organization Success



North Carolina  **Medical Society**
Leadership in Medicine

 **THE PHYSICIANS FOUNDATION**
Empowering Physicians
Improving Healthcare

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Toward  **Accountable Care Consortium**

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I. Purpose Of The Accountable Care Guide

Accountable Care Organizations (“ACOs”) are emerging as a leading model to address health care costs and fragmented care delivery. For example, in 2012, Accountable Care is being considered for implementation by virtually every private and public payor in North Carolina. It transcends federal health regulatory legislation and Medicare. The purpose of this ACO Guide is to bring together in one source a non-technical 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 incented and empowered to achieve their optimum value-added contribution to the enterprise, these principles transcend medical specialty, employment status, payor relationship, or facility type. This Guide works for you whether you are a primary care physician, a hospital CEO, or a specialist physician. 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 they may encounter and confidence about whether to join one or to create one. There are answers to questions about who should join, who should lead, what infrastructure will work, and the phases of development to be followed.¹

II. What Is An ACO?

A. Definitions

Former Administrator of the Centers for Medicare and Medicaid Services (“CMS”) Mark McClellan, M.D., Ph.D. described an ACO as follows: “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 (“NCQA”) included the following definition in its draft ACO criteria: “Accountable Care Organizations (ACOs) are provider-based organizations that take responsibility for meeting the healthcare needs of a defined population with the goal of simultaneously improving health, improving patient experiences, and reducing per capita costs....[T]here is emerging consensus that ACOs must include a group of physicians with a strong primary care base and sufficient other specialties that support the care needs of a defined population of patients. A well-run ACO should align the clinical and financial incentives of its providers...ACOs will also need the administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance, and organize providers around shared goals.”³ (Emphasis added.)

Strategic Note: The part of the definition relating to patient populations represents a major shift in practice orientation, and is very alien to a typical physician’s training and day-to-day focus.

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, Director of the Engleberg Center for Health Care Reform at the Brookings Institution, *A National Strategy to Put Accountable Care Into Practice*, Health Affairs (May 2010), p. 983.

³ National Committee for Quality Assurance, *Accountable Care Organization (ACO) Draft 2011 Criteria*, p. 3. (hereinafter “NCQA”).

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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 (i.e., IPA, PHO, employed). There is no mandatory organizational form for an ACO.

The final Medicare Shared Savings Program rule (Final Rule)⁴ released by CMS in 2011 contains an interesting definition emphasizing structure in contrast to the ones above focusing on function: “Accountable Care Organization (ACO) means a legal entity that is recognized and authorized under applicable State law, as identified by a Taxpayer Identification Number (TIN), and comprised of an eligible group (as defined at § 425.5(b)) of ACO participants that work together to manage and coordinate care for Medicare fee-for-service beneficiaries and have established a mechanism for shared governance that provides all ACO participants with an appropriate proportionate control over the ACO’s decision-making process.”⁵

B. PPACA Requirements

ACOs eligible for the Medicaid Shared Savings Program under the Patient Protection and Affordable Care Act of 2010⁶ must meet the following criteria:

- That groups of providers have established structures for reporting quality and cost of health care, leadership and management that includes clinical and administrative systems; receiving and distributing shared savings; and shared governance.
- Willing to become accountable for the quality, cost, and overall care of the Medicare fee-for-service beneficiaries assigned to it.
- Minimum three-year contract.
- Sufficient primary care providers to have at least 5,000 patients assigned.
- Processes to promote evidence-based medicine, patient engagement, and coordination of care.
- Ability to demonstrate patient-centeredness criteria, such as individualized care plans.

The Medicare Final Rule and three other related documents involving five federal agencies amplify these PPACA criteria. A special section devoted to the Medicare Shared Savings ACO Program is found in Part Two of the Toolkit.

⁴ 76 Fed. Reg. 67802 (Nov. 2, 2011)

⁵ 76 Fed. Reg. 67974

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.*)).

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C. How Is It Different From a Medical Home?

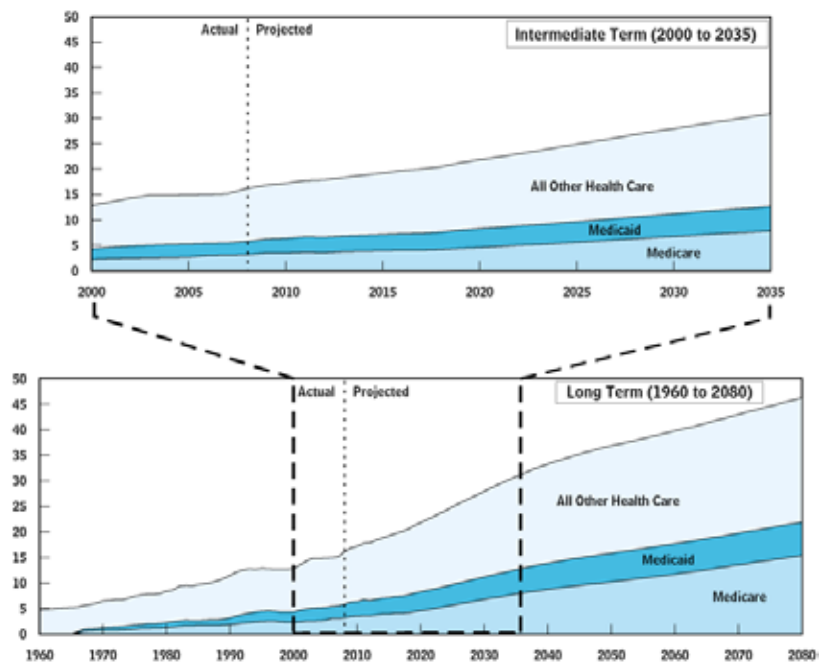
The Patient-Centered Medical Home (“Medical Home”) emphasizes strengthening and empowering primary care to coordinate care for patients across the continuum of care. It is complimentary to the ACO and can become the core of an ACO, but it is different in two main respects: (1) Financial Incentives - The Medical Home lacks the shared accountability feature in that it does not have financial incentives, such as shared savings, motivating providers to work together to deliver the highest quality care at the lowest cost with the greatest patient satisfaction. (2) Specialists/ Hospital Linkage - Even though there are Medical Home-only ACOs, a typical ACO is also different from a Medical Home in that it tends to have relationships with select specialists and hospitals across the full continuum of care for the targeted initiative.

III. Why Should I Care?

Health spending is unsustainable, even before coverage expansion of the 2010 federal health reforms. With 19% of Gross Domestic Product (“GDP”) being the rough estimate of the amount the United States can collect in taxes and other revenues, by 2035, Medicare and Medicaid are predicted to consume 13% of GDP and health care costs will consume 31% of GDP. In other words, health care alone will cost well over all we collect. By 2080, absent drastic change, Medicaid and Medicare will consume all of our tax and other revenues, and total health spending will claim 46% of GDP. The rest, defense, education, roads, etc. we can only pay for by borrowing. President Obama is the first President facing bankruptcy of the Medicare System during a term in office.

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Total Spending for Health Care Under the Congressional Budget Office's Extended Baseline Scenario



There is consensus that much of this is avoidable. The now-famous New Yorker article by Dr. Atul Gawande showing Medicare spending to be twice as high in McAllen, Texas as in El Paso, became required reading in the White House. It said: “The real puzzle of American Healthcare... is not why McAllen is different from El Paso. It’s why El Paso isn’t like McAllen. Every incentive in the system is an invitation to go the way McAllen has gone.”⁷



Article By Influential Writer Sparks Strong Debate

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.”

⁷ Atul Gawande, *The Cost Conundrum*, *The New Yorker* (June 1, 2009)

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These dysfunctions in our current system, for which the ACO is seen as a partial remedy, have been given much of the blame for our country's health care system costing 50% more as a percentage of GDP than any other in the world but ranking only 37th in overall health and 50th in life expectancy.⁸

Because of the crisis, drastic efforts at health care cost reform seem inevitable. President Obama stated it bluntly: "So let me be clear: If we do not control these costs, we will not be able to control the deficit."⁹ Private insurers see it, too. The President of Blue Cross and Blue Shield of North Carolina recently stated: "Even if federal health overhaul is rejected by the Supreme Court or revamped by Congress, the market must continue to change. The system that brought us to this place is unsustainable. Employers who foot the bill for workers' health coverage are demanding that Blue Cross identify the providers with the highest quality outcomes and lowest costs."¹⁰

Flattening the cost curve is possible through the ACO's marketplace incentives without rationing care, imposing new taxes, or cutting provider reimbursement. Doing nothing is not an option, and all these alternatives appear unacceptable. In short, there is no "Plan B."

IV. Are ACOs Really Coming?

A. If They Repeal Health Reform, Won't This Go Away?

No. Federal health reform has three prongs: Expand Coverage (individual and employer mandates, no pre-existing condition exclusions, etc.), Fraud Control, and Waste Controls (ACOs, bundled payments, value-based purchasing, CMS Innovation Center, etc.). Many experts think that expanding coverage into our broken system has made health care even more unsustainable. However, as noted, the cost curves, even without health reform, will bankrupt our resources, and the value-based reimbursement movement was well underway before the federal legislation was passed. Increasing awareness of problems with the fee-for-service system has resulted in a growing number of initiatives that have common features of 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.

B. 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, the payments are commonly only bonus payments in addition to fee for service payments.

⁸ World Health Organization, *World Health Statistics* 2009.

⁹ President Barack Obama, interview excerpt, July 23, 2009.

¹⁰ Brad Wilson, President of BlueCross BlueShield of North Carolina, *The News & Observer* (January 29, 2011).

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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 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, the 15 years clinical integration experience of this author strongly suggests that ACOs TRY NOT TO ACCEPT DOWNSIDE RISK UNTIL THEY HAVE THREE CONSECUTIVE YEARS OF MEETING BUDGET ESTIMATES.¹¹ 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 is preferred to accepting the responsibility of unanticipated medical expenses without the tools to control them. Having some “skin in the game” is clearly a logical way to incentivize accountability for providing value, but thrusting that on an unready health care system could do more harm than good.

C. 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. The changes will have less to do with infrastructure and technology than culture. This is equally true in integrated systems with a fully-employed medical staff, as it is with other models. “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.”¹² 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 reimbursement has reached the tipping point relative to fee for service before you “pull the trigger” in implementing your plan.

V. What Are The Essential Elements Of A Successful ACO?

There are eight essential elements of any successful ACO. All eight are required. You cannot skip a step. Because element one is not as objectively verifiable, it is very counterintuitive that the most vital element is by far the most difficult element to obtain will be 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.”¹³

¹¹ The Final Rule was substantially revised from the proposed regulations in that a new ACO had the option in the first term of the MSSP not to accept risk, whereas under the proposed regulations CMS would mandate acceptance of risk for the third year of the initial three-year contract. 76 Fed. Reg. 19643.

¹² Gary Edmiston and David Wofford, *Physician Alignment: The Right Strategy; the Right Mindset*, Healthcare Financial Management Association (December 1, 2010).

¹³ *Id.*

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The Eight Essential Elements of a Successful ACO



A. 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. “While strong hospital-physician alignment has always been a cornerstone of success, the necessary degree of future collaboration, partnership, and risk-sharing will dwarf what has come before it. Hospitals and physicians will have to recognize, embrace, and leverage their growing interdependence to create organizational structures and incentive models that are strategically aligned and mutually rewarding.”¹⁴

1. **Challenges for Physicians.** Physician attitudes favor autonomy and individualism over collaboration. These attitudes are inculcated in clinical training and reinforced daily in care delivery. Reimbursement rewards an individualistic “eat what you kill” mentality. Physicians need to understand that the level of involvement needed to effect changes in quality and cost is much different than 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 decision-making to the Medical Home primary care physician.

¹⁴ *Toward Accountable Care*, The Advisory Board Company (2010).

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Physicians are justifiably cynical about prior “next best things,” such as HMOs, gate-keeping, and capitation, and have little experience with, or time for, organizational-level strategic planning. But, “[I]f providers do not change their decision-making and behavior, ACOs will go the way of most PHOs and IPAs...to the bone yard. More importantly, the healthcare crisis will persist, and more drastic solutions will be mandated.”¹⁵

2. Challenges for Hospitals. Will hospitals be willing to embrace a true ACO structure, which will likely drive down hospitalization? Will they be willing to distribute shared savings as intended, to incentivize and reward those who created it 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 these business risks for 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 has been historically important for their viability.

“The most significant challenge of becoming accountable is not forming an organization, it is forging one.”¹⁶

Strategic Note: Tips on How to Create a Collaborative Culture:

- **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. 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.
- **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. As noted, shared governance is such a point of emphasis that the Final Rule includes that phrase in the definition of “Accountable Care Organization.”¹⁷
- **Incentives Drive Alignment.** “[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.”¹⁸ 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.

¹⁵ Phillip L. Roning, *Becoming Accountable*, HFMA Compendium—Contemplating the ACO Opportunity, Appendix (November 2010), p. 40.

¹⁶ *Id.*

¹⁷ 76 Fed. Reg. 67974.

¹⁸ Ann Robinow, *Accountable Care News*, The Top 3 Obstacles to ACO Implementation, (December 2010).

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- **“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 multi-disciplinary team decides how to collect and share data in new ways to facilitate this care initiative. The data, in paper or electronic format, is 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.
- **Employment Not a Panacea.** Isn't the most obvious path to integration through hospital employment? This is a feasible approach if the parties have worked together in the past and there is a pre-existing level of trust and respect. This will not work if there are not shared goals and the control and financial incentive issues are not resolved. “Current trends in physician employment represent neither a necessary nor sufficient condition for true integration; value-added integration does not necessarily require large-scale physician employment and simply signing contracts does not ensure progress toward more effective care coordination.”¹⁹

B. Essential Element No. 2: Primary Care Physicians



1. **What Is the Role of Primary Care In ACOs?** As discussed in detail in Section V.G. below, 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) multi-specialty co-management 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.”²⁰ He envisions different levels of ACOs, with the core Level One consisting primarily of primary care practices. Level Two would include select specialists and potentially hospitals. As the diverse patient populations are included, Level Three expands to more specialists and facilities, and Level Four includes public health and community social services. As noted, primary care is the only provider or health care facility mandated for inclusion to qualify for PPACA's ACO Shared Savings Program.

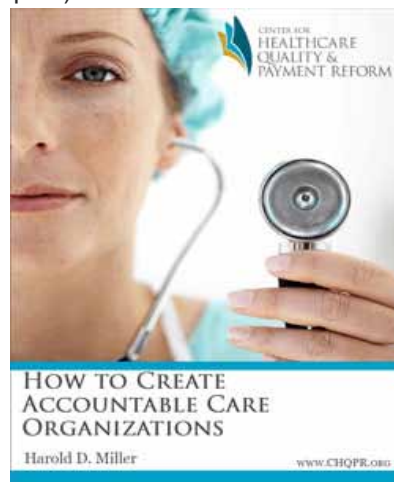
¹⁹ *Toward Accountable Care*, The Advisory Board Company (2010).

²⁰ Harold D. Miller, *How to Create Accountable Care Organizations*, Center for Healthcare Quality and Payment Reform, p. 8, (September 2009).

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2. **What Are the Roles of Specialists In ACOs?** It is becoming clear that specialists are going to serve important roles in ACOs. Given the opportunities for ACOs listed in Section V.B.1. above, specialists should see roles in Medical Home coordination on diagnosis and treatment, transitions across settings, reducing avoidable hospitalizations, and in multi-specialty 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.

3. **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 HIT infrastructure, ACOs are consistent with their 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."²¹ 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 over-capacity should not have this conflict. Moreover, many hospitals see full institutional commitment to accountable care as the best way to prepare for the future, maximize their fair share of the shared savings dollar, and grow market share. Once the tipping point of the shift from payment for volume to payment for value has been reached, these conflicts should dissolve.



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. "Accountable care absolutely must be about improving and maintaining the health of a population of patients and not just controlling costs. It must be about proactive and preventive care and not reactive care. It must be about outcomes and not volume or processes. It must be about leveraging the value of primary care and the elements of the Patient-Centered Medical Home."²²

²¹ *Id.*, p. 15.

²² Terry McGeeney, M.D., *The Patient-Centered Medical Home and the Accountable Care Organization*, <http://transformed.com/CEORports/PCMH-and-ACO.cfm>, (2010).

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C. 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.** The NCQA’s ACO criteria look to core competencies and infrastructure to implement them, but are “agnostic to organizational structure (i.e., whether or not it is led by a multi-specialty group, hospital, or independent practice association).”²³ Similarly, a wide array of organizations may become eligible for CMS Shared Savings Program under PPACA and the Final Rule:²⁴ group practice arrangements, networks of practices, joint ventures between providers and hospitals, hospitals employing providers, 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 a number of 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 goals of accountable care are to improve patient outcomes and patient satisfaction while also achieving greater cost efficiencies. The key to achieving this goal is enhanced coordination of care among diverse 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.”**²⁵

What Are Key Legal Issues Affecting ACOs? ACOs require collaboration, referrals, reductions in unnecessary care, and sharing of revenues among sometime competitors. All of these characteristics, and more, in furtherance of health policy, also happen to raise a number of challenging legal-compliance issues for a body of state and federal health care law largely premised upon the fee-for-service model. Adaptations of the most problematic laws and regulations are underway. On October 20, 2011, the Departments of Health and Human Services, Treasury, and Justice, and the Federal Trade Commission jointly released federal policies concerning implementing the MSSP in order to provide guidance. A properly configured ACO should be successful in navigating this legal minefield. The principal bodies of law affecting ACOs are:

- Antitrust
- Anti-kickback
- Stark
- Civil Monetary Penalties Law

²³ NCQA, pp. 7-8.

²⁴ 76 Fed. Reg. 67975.

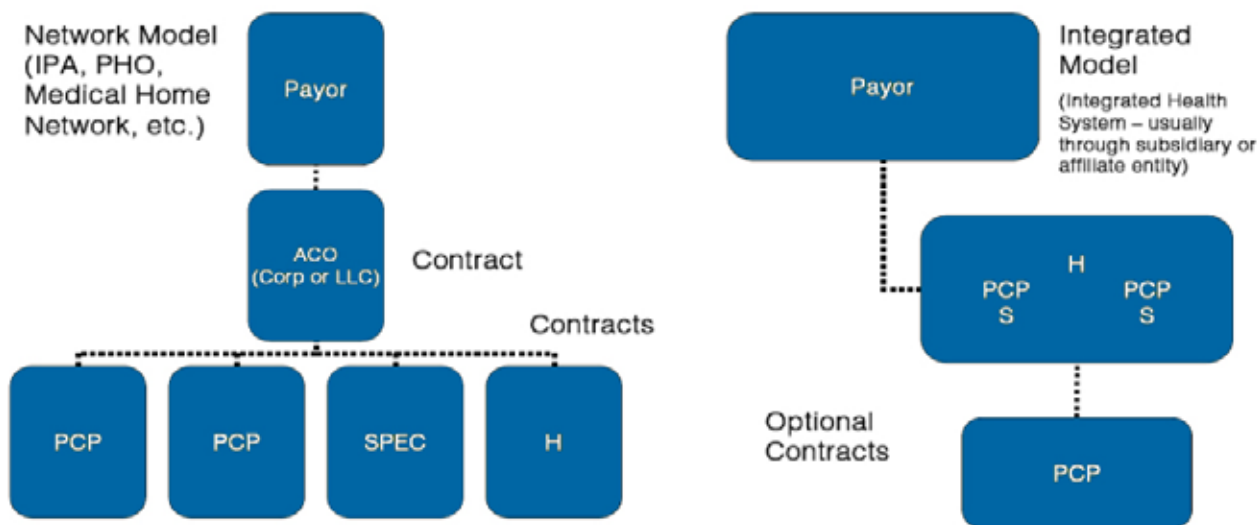
²⁵ Doug Hastings, Accountable Care News (December 2010), p. 6.

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- Tax
- HIPAA
- Malpractice
- Corporate Practice of Medicine
- Insurance
- Intellectual Property
- State Self-Referral Laws
- Business Law

For a detailed legal analysis, please review the “Accountable Care Legal Guide.”

Possible Organizational Forms



1. Network Model

a. **Independent Practice Associations (“IPAs”)** – An IPA is basically an umbrella legal entity, usually an LLC, for-profit corporation or nonprofit organization, with physician participation contracts with hospital-employed and independent physician practices. Payors 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 providers are independent. The

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participation agreements are different, too. The 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. It 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, self-referral, insurance regulation, HIPAA, malpractice, and the Stark law.

b. **Physician/Hospital Organization (“PHO”)** – The PHO is very similar to an IPA, but the main difference is that it is co-owned and governed by physicians and a hospital or health system and includes a hospital participation contract. The same requirements and caveats apply.

c. **Medical Home-Centric Model** – Under this variation, an umbrella entity is owned by Medical Home practice members or networks. It contracts with payors, 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. Community Care of North Carolina is an example of a statewide confederation of 14 Medical Home-Centric Networks.

2. **Integrated ACO Structure** – With this variation, the hospital, health system, foundation, or multi-specialty clinic employs, rather than contracts with, the physician. It may own, capitalize, and control the ACO, with physicians on advisory committees. The HIT and other infrastructure is within the controlling entity. It may have contracts with independent providers and facilities if necessary to round out the breadth, depth, and reach of services needed to accomplish its initiatives.

D. **Essential Element No. 4: Adequate Financial Incentives**



1. **Isn’t This the Same As Insurance?** No. An insurance company assumes the financial risk of whether a person gets ill or has an accident requiring medical care. Accountable care risk is accountability for higher performance 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.

2. **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.

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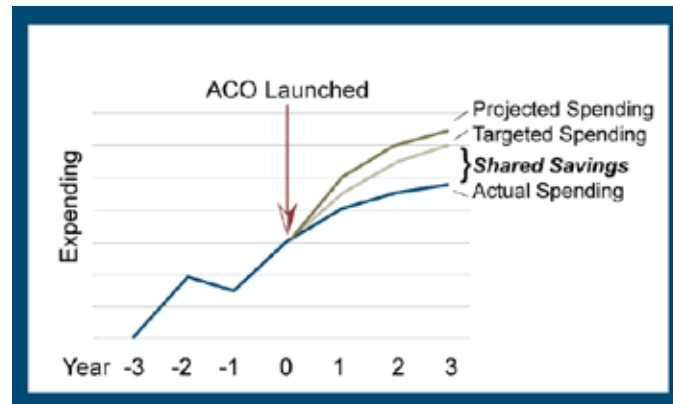
a. **Shared Savings** – If quality and patient satisfaction are enhanced or maintained and there are savings relative to the predicted costs for the assigned patient population, then a portion (commonly 50% according to some surveys and the MSSP Final Rule) of those savings is shared with the ACO. This is stacked on top of the provider’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 if ill, to 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.

Some of the savings pool distributions should be used to maintain the ACO infrastructure, but as much as possible should go to reward 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 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 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 incentivization to adhere to the ACO’s best practices and coordination.

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The Shared Savings Model



*Courtesy of the Brookings Institution

Strategic Note 1: How to Calculate Shared Savings. Although the concept is simple – the ACO gets 50% 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 do 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 if she does not break her world record the next time out. In some CMS demonstration projects, relatively unmanaged counties in other parts of the country were picked as the control populations. Another way that works is to use an actuary that can predict the medical costs for your region or comparable community and use that actuarially valid projected amount as your unmanaged “comparable.” A variation of this latter approach has been chosen by CMS for calculation of the MSSP savings.²⁶

Strategic Note 2: Be Patient Before Taking on Risk. Do not repeat the disaster of the '90s, when providers took on risk without proper technology, infrastructure, best practices, or experience. We recommend that you come within 5% ± of your predicted costs for three consecutive years before leaving the shared-savings upside-only model. You may have unexpected costs over which you have no control. You will likely want to improve your Health Information Exchange, include relevant data elements, and see which of your ACO 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 as a recognition of and respect for the clinical leadership of the physicians as it is for 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.

²⁶ 76 Fed. Reg. 67985-67988.

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b. **Savings Bonus Plus Penalty** – As with the shared savings model, providers receive shared savings for managing costs and hitting quality and satisfaction benchmarks, but also will be 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 pre-set goals. Fee-for-service is retained. This resembles the “two-sided” model mentioned in the Final Rule.²⁷

c. **Capitation** – A range of partial capitation and full capitation models are 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.

3. 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” is a single amount to cover all the services provided to a patient during a single episode of care. When that episode payment covers 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.

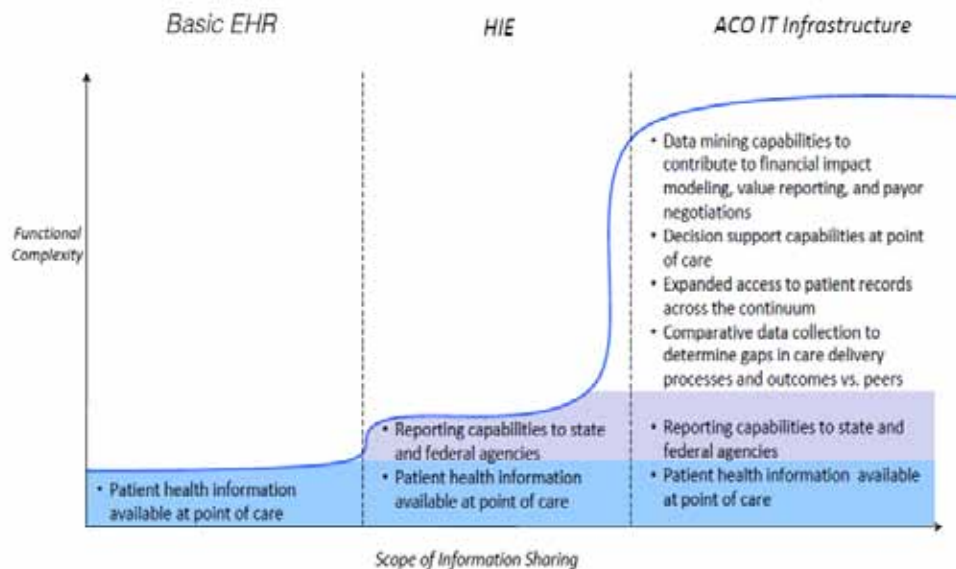
4. “Meaningful Use” Regulations Incentives. We include the “Meaningful Use” payments as an ACO financial incentive because the basic Health Information Exchange within your ACO will likely qualify the ACO’s providers for the Phase Two and Phase Three “Meaningful Use” incentives.²⁸ If your ACO can go ahead and establish its data flow needs relatively soon as outlined in this ACO Guide, you stand a good chance that the federal government will help finance the ACO’s HIT needs. See Section V.E. below for more detail.

²⁷ 76 Fed. Reg. 67986-67987.

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

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E. Essential Element No. 5: Health Information Technology and Data



1. **What Data?** ACO data is usually a combination of quality, efficiency, and patient-satisfaction measures. It will usually have outcomes and process measures. Nationally-accepted benchmarks are emerging. There are three categories of data needs for an ACO:

a. **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 it now? Who collects it? Do you trust them to be accurate and objective? Use it 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 provider array of your ACO and you have your prioritized initiatives or targets.

b. **Performance Data** – In the value-based reimbursement 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, if they apply. Even if they do apply, convene a multi-specialty 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 payor, including CMS, sets the performance benchmarks, they should be part of the performance array. Many payors want to allow local flexibility and clinical leadership in metric-setting.

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Who collects the data? Are there variables outside of your control affecting your performance scores (i.e., patient non-compliance)? What financial incentives/penalties are tied to each?

c. **Data As a Clinical Tool** – Once the ACO targeted care initiatives are selected, the best practices across the care continuum will be determined. The appropriate ACO committee will then usually “blow up” each pathway into each component and assign clinical leadership, decision support, 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 providers will be optimized with the real-time sharing of upstream care results and scheduling.

Strategic Notes: (1) The ACO should periodically internally grade itself against the performance benchmarks to create a constant quality/efficiency/satisfaction improvement loop. This not only will hone the contributions of the ACO initiatives, but also will prepare it to increase its financial rewards once the performance results drive a savings pool or bundled payments. Gaps in 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 reflects a track record of high performance serves as a bargaining tool when reimbursement is being negotiated, even in fee-for-service. (3) Use data first to target the “low-hanging fruit,” high-impact, value-add initiatives in your area best suited to your specialty or facility. Next, use data to collect evidence of your performance. There will be specific baseline, performance, and clinical data elements needed for each participant to meet objectives, maximize their measured contribution, and thus reap a meaningful reward from the savings pool.

d. **The MSSP Final Rule Provides Details** – Down from 65 in the Proposed Rule, the Final Rule requires reporting on 33 measures across your domains: patient/caregiver experience; care coordination; patient safety; preventative health; and at-risk population/frail elderly health. The goals of measure setting include seeking a mix of standards, processes, outcomes, and patient experience measures, severity adjusted and, to the extent practicable, nationally endorsed by a stakeholder organization.

e. **HIE Capability** – Your ACO will need Health Information Exchange (“HIE”) capabilities sufficient to move this data across the continuum in a meaningful way. This HIE is aligned with the Meaningful Use regulations. It will need to be able to aggregate data from multiple sources into user-friendly formats with decision support and relevant data that follows the patient to maximize chances of success in the ACO’s targeted initiatives. It needs to minimize the data collection burden on workflows.

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F. 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% of all U.S. health care spending, much of it preventable);
- Reduced hospitalizations;
- Care transitions (across our fragmented system); and
- Multi-specialty care coordination of complex patients.

“The best bet for achieving returns from integration is to prioritize initiatives specifically targeting waste and inefficiency caused by fragmentation in today’s delivery system, unnecessary spending relating to substandard clinical coordination, aggravated with the complexity of navigating episodes of care, and unwanted variations in clinical outcomes driven by lack of adherence to best clinical practice.”²⁹

As discussed earlier in Section V.B., the richest “target fields” from this array will vary by specialty and type of facility. Looking at these suggested initiatives, it is no wonder why primary care is emphasized as key for ACOs, since they 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 find the proverbial “low-hanging fruit.”

G. Essential Element No. 7: Patient Engagement



Patient engagement is another essential element. Without it, an ACO will not fully meet its potential. Unfortunately, many of today’s health care consumers erroneously believe that more is better, especially when they are not “paying” for it, insurance is. Patient noncompliance 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 payor at a competitive disadvantage. But patient engagement is part of patient-centeredness, which is required by PPACA for an ACO to qualify for CMS’ Shared Savings Program.³⁰

²⁹ *Toward Accountable Care*, The Advisory Board Company (2010)

³⁰ 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.

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What Can an ACO Do to Engage Patients?

Better information at a societal level and also at the medical home point of care.

- **The Patient Compact** – Some ACOs, such as the Geisinger Clinic, 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 decision-making empowerment. The providers 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.

H. 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, it is often overlooked that there needs to be a minimal critical mass of patients to justify the time and infrastructure investment for the ACO. PPACA’s Shared Savings Program 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 a sustainable patient population scale. It can de-bug the initiative and test-run the ACO early enough to fix problems before ramping up. This must succeed, however. If it does, it will be much easier for the ACO champions to gain buy-in from others.



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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 of 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.

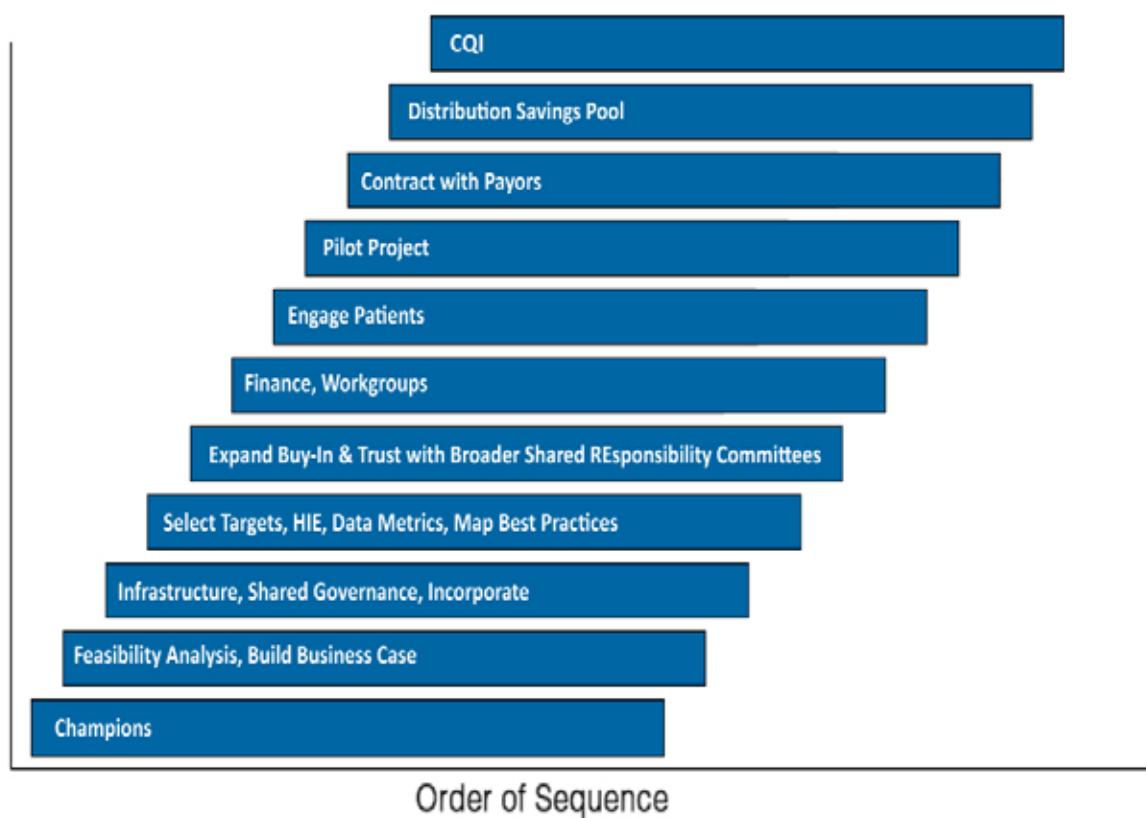
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VI. Successful Implementation – A Step-By-Step Guide

A. Where Do I Start?

OK, 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.

B. Step-By-Step Guide



1. **Informed Champions** – Perhaps even ahead of this first step may be that there needs to be 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.

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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 (i.e., 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 a comprehensive panel, and 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 8 Essential Elements? 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 decision-making and champion leadership, build capabilities of a clinically integrated organization. Review the plan for presence of the 8 Essential Elements listed in Chapter V. The TACC is creating specialty-specific strategic toolkits to assist each specialty in building in capabilities and programs to optimize that specialty's contribution to, and thus reward from, an ACO. Please see Part Two, Section II, for the completed toolkits. If yours is not present, please contact Melanie Phelps at mphelps@ncmedsoc.org to see how you and your specialty society can partner with the TACC to develop a state-of-the-art toolkit.

- a. Start with your initial targeted initiatives.
- b. From them, establish best practices for the continuum of care for all providers involved with that type of patient.
- c. “Blow up” 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 HIT 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). The TACC has engaged the law firm of Smith Anderson Blount Dorsett Mitchell & Jernigan, LLP and the health care valuation firm of HORNE, LLP to develop a multi-based shared savings distribution model for use by ACOs with multiple specialties. It will be made available by the TACC.

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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 decision-making structure. Design and undertake training. Develop payor strategy and contract terms. Do “ROI” 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 multi-disciplinary integration committee with HIT, 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 Payors** – 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 starting in January of 2014 as part of a broader strategy. (See Part Two 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 (“CQI”) loop. Collect and distribute the savings pool roughly in proportion to contributions to it.

VII. 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. It is the goal of this ACO Guide 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.

For more information on any aspect of this ACO Guide, please contact Julian (“Bo”) Bobbitt at either 919-821-6612 or bbobbitt@smithlaw.com. (www.smithlaw.com)

Part Two: Executing the Accountable Care Strategic Plan



North Carolina  **Medical Society**
Leadership in Medicine

 **THE
PHYSICIANS
FOUNDATION**
*Empowering Physicians
Improving Healthcare*

 **SMITH
ANDERSON**

Toward  **Accountable Care
Consortium**

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I. General Strategies for All Specialties

A. Strategy Number 1: How to Successfully Navigate the Medicare MSSP and Advance Payment Model Application Process

America's largest payor, Medicare, has committed to the ACO model, with a minimum of 50% sharing of savings to ACO 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 non-metropolitan areas, CMS will prefund them through the Advance Payment Model. This level of sustainable funding through ongoing shared savings distributions can "pay for" your ACO operations that can in turn be used for Medicaid, private payor, or other patient population engagements. **The applications are consistent with the principles and strategies of this Physicians' ACO Toolkit, and it is a useful reference to assist in responding to substantive portions of the applications.**

To review, CMS established the Medicare Shared Savings Program (the "MSSP") to facilitate coordination and cooperation among health care providers through ACOs to improve the quality of care for Medicare beneficiaries, while reducing unnecessary costs. In addition, the PPACA established a new Center for Medicare and Medicaid Innovations (the "Innovation Center") to test innovative care and service delivery models, including the "Advance Payment Model." This Chapter will assist ACOs in navigating the MSSP and Advance Payment Model application process.

1. 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 can be broken down into the following seven tasks: (a) identify timelines and deadlines; (b) creation and formation of the ACO; (c) file Notice of Intent to Apply; (d) obtain CMS User ID; (e) prepare and execute participation agreements; (f) prepare application; and (g) file application with CMS.

a. **Timelines and Deadlines** – Due to the sheer volume of information that must be submitted with the MSSP application, ACOs should begin the application process at least three months in advance. At the outset, ACOs interested in applying should review CMS's MSSP website, www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html, and identify all relevant deadlines. The ACO should then create a task checklist to ensure that all documents, forms, and applications are timely filed. The list of tasks set forth below may serve as a useful template in creating such a checklist.

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b. **Creation and Formation of the ACO** – ACOs applying to the MSSP must ensure that 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 will also need an Employer Identification Number from the IRS, which may be obtained online at <https://sa.www4.irs.gov/modiein/individual/index.jsp>.

The ACO must also 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% 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 that fail to comply with the policy.

Finally, the ACO must appoint officers with leadership and oversight responsibility for the ACO. At a minimum, such officers must include an executive officer, a medical director, and a compliance officer. The executive officer (such as a president, CEO, or executive director) must have leadership responsibility for the ACO, including 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 prior to applying for the MSSP.

c. **Notice of Intent to Apply** – Before applying to the MSSP and Advance Payment Model, ACOs must file a Notice of Intent to Apply (“NOI”) with CMS. ACOs should be aware that the filing deadline for the NOI will be approximately three months prior to the filing deadline for the MSSP application. While all ACOs that wish to apply to the MSSP must file the NOI, filing the NOI does not obligate the ACO to complete the application process. Thus, **ACOs that are even remotely interested in the MSSP should submit a Notice of Intent to Apply to preserve the opportunity to later submit the MSSP application.**

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d. **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. In order to use HPMS, the ACO must obtain a user ID and password using the CMS Form 20037 Application for Access to CMS Computer Systems, available at: www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/Downloads/EUAaccessform.pdf. After the ACO files the NOI, the ACO will receive an email from CMS with instructions for completing the Form 20037, along with the deadline for filing the Form 20037. The individual who will be preparing the MSSP application for the ACO should file the Form 20037.

e. **Participation Agreement** – ACOs applying to the MSSP must have participation agreements with their participating providers. At a minimum, the 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 non-compliance with the requirements of their agreements with the ACO. The ACO will need to submit its signed participation agreements with each 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.

f. **Preparing the Application** – As noted above, CMS now requires ACOs to file the MSSP application online using HPMS. Before completing the application online, however, ACOs should prepare all application materials in advance to ensure a smooth online application process. The ACO should first download and review the MSSP application template from the MSSP website. The ACO should 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 ACO participant. In order 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 (PECOS) for such participants. In addition, the ACO will need to prepare an organizational chart that includes the names of the ACO participants, governing board members, committees and committee members, and officers.

A significant portion of the MSSP application consists of certain narrative responses that must be completed by the ACO. 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

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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 that each element is discussed in detail; failure to address each required element may result in delay (or rejection) of the ACO's application. As mentioned, this Physicians' ACO Toolkit may be a useful aid in preparing this part of the application.

Assuming that 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 contact information for the ACO and complete certain attestations to ensure that the ACO 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). Prior to uploading this documentation, the ACO will need to review the MSSP application reference table for instructions regarding file names and other HPMS uploading requirements, which is available at: www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/sharedsavingsprogram/Downloads/MSSP-Reference-Table.pdf.

Finally, the ACO will need to complete the CMS Form 588 Electronic Funds Transfer Authorization Agreement. This agreement, along with a voided check, must be sent to CMS using tracked mail, such as certified mail, Federal Express, or United Parcel Service. The CMS Form 588 is available at: www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms588.pdf.

2. Advance Payment Model Application

In addition to the MSSP application, ACOs that wish to receive advance funding from the Innovation Center must also complete the Advance Payment Model application. The Advance Payment Model is open to only two types of ACOs: (a) ACOs that do not include any inpatient facilities and that have less than \$50 million in total annual revenue; and (b) ACOs in which the only inpatient facilities are critical access hospitals and/or Medicare low-volume rural hospitals and that have less than \$80 million in total annual revenue. ACOs that are co-owned with a health plan will be ineligible, regardless of whether they also fall into one of the above categories.

First, the ACO should review the Advance Payment Model application template, which is available at: <http://innovations.cms.gov/Files/x/Advance-Payment-Model-Application-Template-doc.pdf>. This document will assist the ACO in gathering the necessary information for the Advance Payment Model application.

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The Advance Payment Model consists of two primary sections: (a) the ACO's financial characteristics; and (b) the ACO's investment plan. With respect to the financial characteristics, the ACO will need to list the total annual revenue and total Medicaid revenue for each ACO participant during the preceding three years. The information submitted by the ACO will need to be based on either Federal tax returns or audited financial statements.

The second key section of the Advance Payment Model application is the ACO investment plan. The ACO must explain how it intends to use the advance payment funds awarded from CMS. Specifically, the investment plan must include: (a) a description of the types of staffing and infrastructure that the ACO will acquire and/or expand, using the funding available through the Advance Payment Model; (b) the timing of such acquisitions or expansions and the estimated unit costs; (c) a description of how such investments build on staff and infrastructure the ACO already has, or plans to acquire through its own upcoming investments; and (d) an explanation of how each investment will support the ACO in achieving the three-part aim of better health, better health care, and lower per-capita costs for Medicare beneficiaries.

Strategic Note: Here are some “unwritten rules” for application success gleaned through interactions with CMS. These sophisticated requirements are counterintuitive to the policy of seeking small, rural ACOs which need start-up help. Although the investment plan can be no longer than 20,000 characters, ACOs should be as detailed as possible, particularly addressing the ACO's own investments to operate under the collaborative care delivery model. The ACO should treat the investment plan similar to a grant application, keeping in mind that the Innovation Center will use the information contained in the investment plan to determine whether providing advance payments to the ACO is a worthwhile investment of government funds. Furthermore, the ACO should be aware that the MSSP and Advance Payment Model applications are evaluated separately; the ACO cannot assume that the Innovation Center will have access to or review the MSSP application in connection with the Advance Payment Model application. As a result, the ACO should include detailed information about the ACO's planned operations and activities, even if including this information in both the MSSP and Advance Payment Model applications seems redundant.

Once the ACO has compiled the necessary information for the Advance Payment Model application, the ACO must file the application with the Innovation Center. Like the MSSP application, the Advance Payment Model application must be completed online. In order to access the Innovation Center web portal (which is a different portal from HPMS), the ACO will need to obtain a user ID and password by emailing advpayaco@cms.hhs.gov. The subject of the email should read “LICENSE REQUEST: [ACO ID].” Instead of [ACO ID], the ACO should type the ACO ID number listed in the acknowledgement letter from CMS in response to the NOI. In the body of the email, the ACO should include its name as it appears on the ACO's application to the MSSP, the ACO ID number, and a phone number where the Advance Payment Model team can reach the person preparing the Advance Payment Model application.

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Following completion of the MSSP and Advance Payment Model applications, the ACO will receive email confirmations from CMS and the Innovation Center. ACOs should also be prepared to answer follow-up inquiries from CMS and the Innovation Center, often on very short notice.

ACOs with questions regarding the MSSP application may contact CMS by email at SSPACO.Applications@cms.hhs.gov or by telephone at (410) 786-8084. Questions regarding the Advance Payment Model application may be emailed to the Innovation Center at advpayaco@cms.hhs.gov. ACOs should also regularly check the CMS and Innovation Center websites for FAQs, application instructions, and other guidance documents.

3. Conclusion

With this Medicare ACO roadmap, you should not feel concerned about successfully applying for both these programs. The substance sought by the actual questions is remarkably close to the principles and strategies of this Physician's ACO Toolkit. Together, if you have done the spadework to bring together the 8 Essential Elements, success should be straightforward.

B. Strategy Number 2: [UNDER CONSTRUCTION.]

C. Strategy Number 3: [UNDER CONSTRUCTION.]

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II. Specific Strategies for Specific Specialties

A. Anesthesiologists. Previously, a separate copyrighted white paper and specialty-specific ACO strategic plan for anesthesiologists was developed by Smith Anderson and the North Carolina Society of Anesthesiologists (“NCSA”) ACO Task Force. It was underwritten by the NCSA, which holds distribution rights. If you are interested in obtaining a copy of these materials with permission, please contact the NCSA’s Executive Director, Karen Weishaar, at kweishaar@smithlaw.com.

B. Family Physicians. Previously, a separate copyrighted white paper and specialty-specific ACO strategic plan was developed for family physicians. It was underwritten by the North Carolina Academy of Family Physicians, the American Academy of Family Physicians, and several state chapters. A copy of the paper and strategic plan may be accessed at www.ncafp.com or by contacting Brent Hazelett, Deputy Executive Vice President, at bhazelett@ncafp.com.

C. Neurologists. [Accountable Care Guide for Neurologists is currently being developed by TACC personnel and the Accountable Care Workgroup of the North Carolina Neurological Society. (Fall 2013)]

D. Urologists. [Accountable Care Guide for Urologists is currently being developed by TACC personnel and the Accountable Care Workgroup of the North Carolina Urological Association. (Fall 2013)]

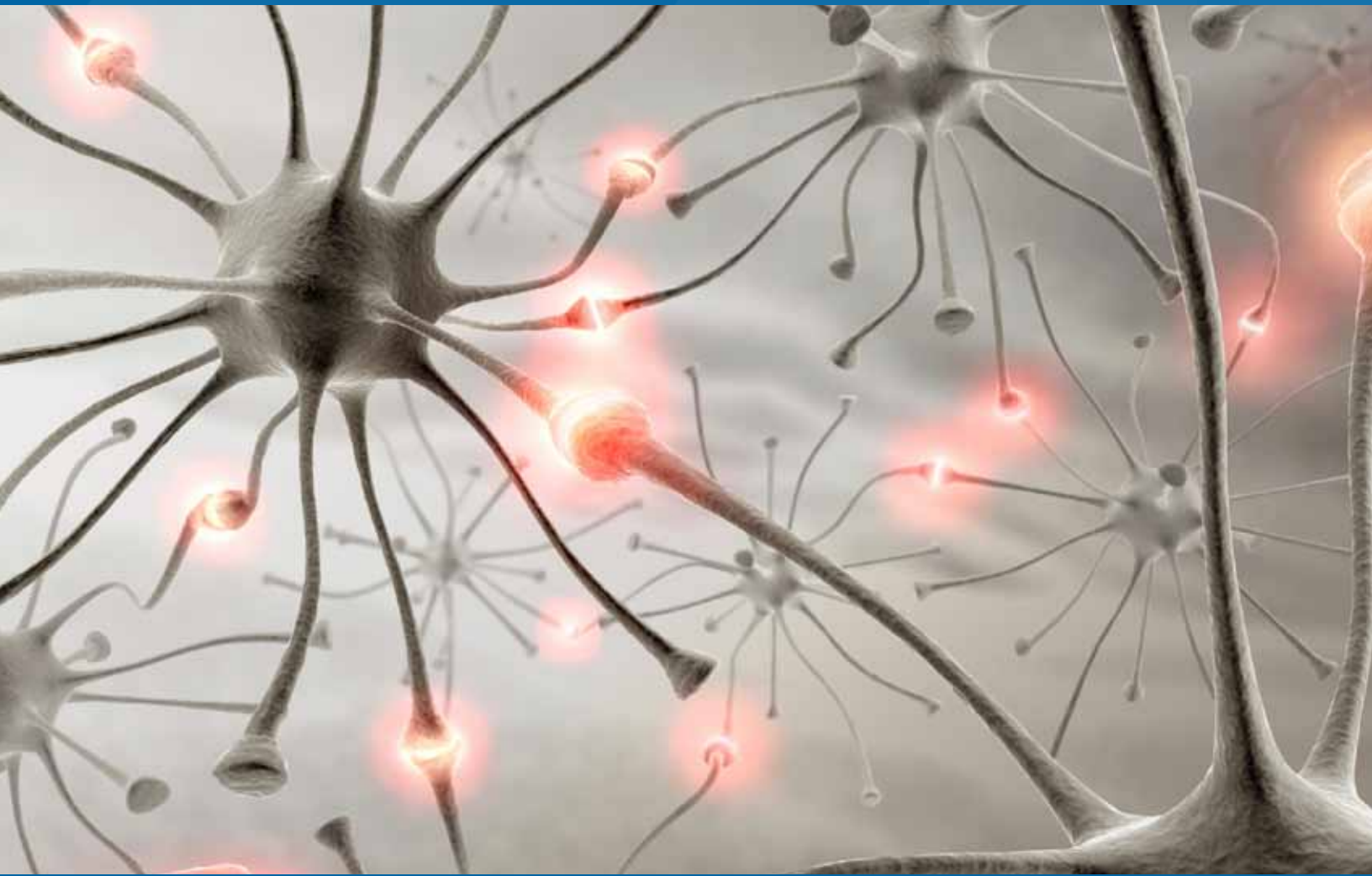
E. Radiologists. [Accountable Care Guide for Radiologists is currently being developed by TACC personnel and the Accountable Care Workgroup of the North Carolina Radiologic Society. (Fall 2013)]

F. Emergency Physicians. [Accountable Care Guide for Emergency Physicians is currently being developed by TACC personnel and the Accountable Care Workgroup of the North Carolina College of Emergency Physicians. (Fall 2013)]

G. Psychiatrists. [Accountable Care Guide for Psychiatrists is currently being developed by TACC personnel and the Accountable Care Workgroup of the North Carolina Psychiatric Association. (Fall 2013)]

III. Conclusion

Part Three: Accountable Care Guide for Neurologists



The Accountable Care Guide For Neurologists

I. Introduction

The companion *The Physician's Accountable Care Toolkit*® describes what it takes to create a successful ACO and the steps to get there. Since it is fundamental that an ACO be a win/win for all involved, it applies whether one is a primary care physician, specialist physician, or hospital executive. This *Accountable Care Guide for Neurologists*, on the other hand, spells out specific strategies for the neurologist, whether in a small rural practice, large multi-specialty independent practice, or employed by a health system.

II. Could Accountable Care Be A Good Thing For Neurologists?

In *The Physician's Accountable Care Toolkit*®, we learned what an ACO is, that it will not be going away, and how to know if one stands to be successful. But what, specifically, will this mean for the neurologist?

A. Pros

- Many neurologists find that the greatest positives of a well-organized ACO are the return of control of the physician/patient relationship to the physician and patient, and how system-wide care improvement vastly leverages their power to heal.
- Neurologists have a strong tradition of teaching and collaborating, skill sets generally in short supply in the accountable care era. Specifically, these skill sets are quite valuable in prevention and mitigation of the devastatingly expensive disease states of stroke, dementia, headache, and epilepsy. These skills are proving to be leadership assets in forming collaborative cultures adhering to the eight essential elements for successful ACOs identified in *The Physician's Accountable Care Toolkit*®.
- As with all physicians who have been battling a deeply fragmented system to provide cost-effective care, neurologists find that a model designed to truly gauge and value their contributions to health care shows respect for what they have been attempting to do and a validation of why they went to medical school and chose neurology.
- Once health care moves well into the value-based reimbursement transition, neurologists will view involvement in a successful ACO as important to provide professional and economic reward.
- The stakes are too high; the risks of doing nothing are much higher. Being unprepared is not an option.

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B. Cons

- Neurologists are working very hard and have run out of spare intellectual bandwidth to power these changes. You have seen this “next big thing” before and it didn’t work out as advertised. You have little experience and less spare capital to undertake something this complex.
- ACOs will reduce (avoidable or unnecessary) procedures, thus bringing down fee-for-service income, which may not be supplemented by other income sources.
- Some ACO models do not include neurology.
- It is hard to give up independence and be interdependent with other physicians and hospitals.
- Another risk is that if neurologists and other physicians will not step up to have a seat at the table, ACOs will not be properly constructed, the model will fail, and only dismal alternatives will remain.

III. The Recommended Approach For Developing Specialist Accountable Care Strategies

In the value-based reimbursement era, each specialty is rethinking its role. Some of the questions confronting specialists are: **What is our maximum value-adding contribution across an entire patient population? How can we generate quality and savings improvements for the ACO and thus maximize performance rewards for our specialty?** This rethinking is perhaps most dramatic regarding savings. The gain will not be from seeing a patient cheaper or quicker, but how to reduce costs for a patient population over a given period of time, often one to three years. For example, some physicians in highly specialized disciplines have found their greatest initial opportunities as multidisciplinary care team coaches or as educators across our currently fragmented system. Quality metrics exist to measure the quality of care rendered by that physician to that patient. But it is as fundamental as it is radically different that any accountable care strategic developments for any specialty focus on excising avoidable waste across the continuum of care for the entire patient population. New coaching, transition, education, and engagement metrics will need to be developed and properly weighted by peer clinicians. You do not want a bureaucrat making these decisions for you.

A hint of what a specialty should prioritize is given by this list of the top five high-yield targets for ACOs:

- Wellness/prevention
- Chronic care management
- Reduced hospitalizations
- Care transitions
- Multi-specialty coordination of complex patients

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From these, which ones are likely to have the quickest and biggest bang for the buck, proven metrics, and community champions? What is working elsewhere? This should reveal for the specialty its potential prioritized list of value-add ACO initiatives.

Once this list is in hand, the last step is to marry them in a particular locale through a gap analysis to the areas of avoidable waste in that region. The specialist can then make a compelling case that an area of the patient population's greatest need is matched with that specialty's greatest strengths.

The specialists also can benefit from ACO negotiation and marketing tips, knowledge of how to assure fair savings pool distribution, and what clinically valid metrics should be used to accurately measure their performance.

Ideally, this process should be led by a well-respected and diverse peer “accountable care workgroup” of a national or state professional society of that specialty.

IV. The Process Followed For Creation Of This Accountable Care Guide For Neurologists

Several neurologist leaders thought that neurologists should be prepared for the approaching accountable care era. They engaged their state specialty society, the North Carolina Neurological Society (“NCNS”) to work with the Toward Accountable Care Consortium (“TACC”). A Neurology Accountable Care Workgroup was formed. Following initial guidance from members of the Neurology Accountable Care Workgroup, staff and attorneys for the TACC conducted a national literature search, with emphasis on value-based care and benchmarking recommendations.

Strategic Note: Many, if not most, of the non-preventive care best practices may not be particularly useful without adaptation, as they tend to focus on specialist care in a fee-for-service setting of an individual patient. For example, it may not mention patient engagement, pushing knowledge “upstream” to the emergency department or primary care physician or transitioning across a “siloed,” fragmented system. Likewise, metrics abound measuring individual care, but are not yet common in areas such as transition coaching, care team education, or increased access through telemedicine.

Potential initiatives underwent further review by the Neurology Accountable Care Workgroup, with the TACC support team directed to perform more in-depth analysis of select possible target areas. These findings were further reviewed and revised by the Neurology Accountable Care Workgroup and

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presented to the NCNS and the TACC Physician Advisory Committee. Macro predictive cost savings estimates were made, but a refined financial predictive modeling analysis, though needed, is beyond the scope of this project. Likewise, while guidance on the nature and type of performance metric selection is provided, the actual full mapping of those metrics is beyond the scope of this project.

The researchers and physician peer reviewers are comfortable that this represents a useful start in this important and rapidly evolving field. This Guide is a beginning, not an end, to the process.

V. Recommended Accountable Care Initiatives For Neurologists

A. Awareness/Leadership/Urgency: Neurology's Role in Guiding Change

Neurology needs to know what an ACO is, how to recognize one with a likelihood of success, and the professional opportunities and risks involved (the purposes of this *Accountable Care Guide for Neurologists*). A number of leaders need to get up to speed and be catalysts for this transformative change. These champions need to act with confidence but also a sense of urgency. This is mentioned as a strategy in and of itself because the biggest risk of failure of the ACO movement and either collapse of Medicare and Medicaid (and consequent default to Draconian alternatives) is lack of informed physician leadership. If you do not become involved, there is a good chance that the roles of neurology will be missed and, like some early ACOs, you will not be involved at all in the shared savings pool distribution. Every successful ACO starts with a few champions. Why not have one be a neurologist? As Bert Coffey, M.D. said: "If you don't have a seat at the table, you are on the menu."

B. A Pattern of Coordinated Leadership

Our analysis has shown that movement in the accountable care era from fragmented care to coordinated care for patients with neurological issues presents significant opportunity to increase the quality of care and reduce the costs of care and suffering of these patients. As one neurologist stated, "With the intent of ACOs in improving 'health care' as opposed to 'sick care,' there should be an intense focus on working with primary care providers." Neurologists are natural educators and consultants. They are key resources to primary care physicians on their support team for patients with neurological issues.

Opportunities across disease states were found to exist in areas of coaching to improve primary care diagnosis and referral, teleconferencing, integration of treatment protocols with primary care, including urgent care centers, and increased availability to patients. Extending knowledge further "upstream," the neurologist, as educator, is going to be particularly helpful to patients through such things as group teleconferences, webinars, and web-based videos. Neurologists will add value through more engagement along the more active end of the continuum when patients are hospitalized, with active participation on the hospital's medical staff.

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These multidisciplinary teams can be virtual but also concrete in the form of “Stroke Clinics,” “Headache Clinics,” or like the Geisinger Clinic’s “Neurosciences Institute.”

Another manifestation of this extension of knowledge by neurologists is the strategic opportunity represented by allied provider care navigators and coordinators. These may be employees of the Patient-Centered Medical Home of the ACO, but work at the direction of neurologists, doing such things as supporting access to non-physician/institute resources for patients with dementia; epilepsy compliance to reduce Emergency Department visits or hospitalizations; patient self-management; and management of stroke-inducing hypertension and diabetes.

In summary, the neurologists’ skill sets of teaching and consulting when used across the care continuum and aided by technology, seem to present proverbial “low-hanging fruit” opportunities for neurologists in the accountable care era. Occurring in every strategic initiative, this represents the singular most promising accountable care theme for neurologists. Singularly important, this recurring core strategy is even more potent cumulatively.

C. Stroke

Prevention — Two Stages

1. Primary Prevention

Education and Training: An important component in a neurology strategy within the ACO is education and training of primary care providers, care coordinators, and ACO patients with one or more major risk factors for stroke. Such education and training can help proactively prevent the occurrence of a first stroke and could be coordinated through a stroke prevention and treatment clinic. The neurology group could provide training materials as well as a neurologist/teacher to lead the training. This training would have a double focus – both upstream – on primary care providers/care coordinators and on at-risk patients. Training materials and sessions would aim to: (1) sensitize primary care providers to recognize leading indicators or risk factors for potential stroke as well as to appropriate proactive follow-up measures once these indicators are identified; and (2) make the dangers of stroke concrete for at-risk patients as well as to equip them effectively to take charge of their own care. Additionally, the neurology group would coordinate with the patient care coordinators at the ACO to help develop

¹The risk factors for stroke are well-known, and include high blood pressure, high cholesterol, diabetes, atrial fibrillation, carotid artery disease, and diet/smoking/alcohol consumption. High blood pressure is the single most important modifiable risk factor for stroke. It is estimated that high blood pressure affects 65 million Americans, and that number appears to be growing. Despite the efficacy of antihypertensive therapy and the ease of diagnosis and monitoring, a large proportion of the population still has undiagnosed or inadequately treated hypertension. Blood pressure must be regularly monitored and high blood pressure must be aggressively treated, especially for those patients with additional stroke risk factors. For patients with diabetes, tight control of high blood pressure and high cholesterol are the most effective ways of preventing stroke. Atrial fibrillation is another significant risk factor. Patients over 65 years of age should be screened for atrial fibrillation. Patients with atrial fibrillation should be risk-stratified using predictive indices for stroke risk. Treatment is targeted to a given risk profile if a given atrial fibrillation patient, and ranges from aspirin for low risk patient to warfarin to high risk patients who can receive it safely. [Sources: Guidelines for the primary prevention of stroke; Secondary stroke prevention; A Review of the Use of Telemedicine Within Stroke Systems of Care; Prevention of Stroke: Canadian best practices.]

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protocols for the early identification of risk factors and combinations of risk factors, assessment of the level of risk, and appropriate, proactive follow-up measures. Consultation could be available on an ongoing basis.¹ These efforts are complementary to the ACO's initiatives regarding diabetes, hypertension, mental health, and obesity management. The relevant metrics here would be relatively straightforward, measuring the improvement in occurrences of primary stroke and in major stroke risk factors, say, over six-month intervals following above interventions.

2. Secondary Prevention/Ongoing Treatment

The single best predictor of stroke is a previous stroke. An estimated 30 percent of survivors of an initial ischemic stroke (which accounts for 87 percent of all strokes) will have a subsequent stroke within 5 years. Eighteen percent of these strokes will be fatal. Stroke also carries with it a serious risk of (1) cardiac involvement, with 5 percent of stroke survivors suffering a heart attack within a year, and (2) depression, with an estimated 40 percent of stroke patients experiencing depression within the year following the stroke.

Secondary stroke prevention is well suited to a model of care that aims at preventing long-term morbidity and mortality because (1) patients who suffer an initial stroke are easily identified; and (2) risk modification strategies can significantly decrease the likelihood of recurrence. With a stroke prevention and treatment team or clinic overseen by a neurologist, stroke patients would have a ready source for follow-up care, reducing both recurrence and hospital readmission. In conjunction with primary care providers, such a team or clinic also could provide services for other high-risk patients and/or offer guidance and consultation services to the primary care providers for these patients. For patients who have already suffered stroke, the follow-up would be more intensive and broad-ranging, encompassing aggressive follow-up for high blood pressure (e.g., with diuretics or ACE inhibitors), high cholesterol (e.g., with statins), and other risks factors; counseling on lifestyle changes such as diet, exercise, cessation of tobacco smoking, and moderation of alcohol consumption. For patients for whom more intensive care is deemed necessary, the team or clinic would employ nurses proactively to reach out to patients to engage them in their own recovery and to ensure prompt and regular follow-up. Neurologists would provide patient educational services and content, leveraging technology. Neurologists would play a leading role in the emerging demand for preventive stroke services by making risk factor modification a part of the neurological examination and by providing long-term follow-up and appropriate care in a stroke prevention clinic.² In addition to the measures outlined for the prevention of primary stroke, patients who have already suffered from stroke would be enrolled in a specialized program for stroke prevention led by physicians and nurses. Again, the relevant metrics here would be relatively straightforward, measuring the improvement in occurrences of secondary stroke and in major stroke risk factors, say, over six-month intervals following above specialized interventions.

²Guidelines for the primary prevention of stroke; Secondary stroke prevention, Mayo clinic

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D. Epilepsy

Epileptic seizures can be caused by almost anything that affects the brain, but are characteristically due to a spectrum of seizure syndromes and disorders that range in their severity and treatment outcomes. In March 2012, the Institute of Medicine released its landmark study, “Epilepsy Across the Spectrum: Promoting Health and Understanding,” the first authoritative independent appraisal of epilepsy in the United States. The study makes it clear that there are significant gaps in provision of high quality health care for many Americans burdened with epilepsy and its associated health problems. Optimal treatment is complex and must be tailored for each patient.

Epilepsy is the fourth most common neurological disorder in the United States — after migraine, stroke and Alzheimer’s disease. An estimated 2.2 million Americans have epilepsy, with 150,000 new U.S. cases diagnosed every year; about one in 26 people will develop epilepsy at some time in their lives. The estimated U.S. annual direct medical care cost of epilepsy is \$9.6 billion, according to the report.³ Virtual or concrete “Epilepsy Centers” improve care, lower costs, and are ideal for accountable care. Each center would be well integrated into the health system and locality of which it is a part as well as into the network of centers. Strong ties and partnerships with state health departments and other health care providers, particularly those focused on other neurological disorders, could expand the reach of coverage to people with epilepsy who are in rural and underserved areas through use of telemedicine, outreach clinics, and other relevant mechanisms. People with epilepsy and their families, as well as researchers and health care providers, also could benefit from the compilation and analysis of quality, outcomes, and health services data provided by all centers in the network.⁴

Even without the existence of a fully-functioning epilepsy center, ACO opportunities exist for neurologist leadership in: (1) patient education to dispel the stigma blocking people from coming forward; (2) educating primary and emergency care providers on the “mimickers of epilepsy” and standards of diagnosis, treatment, and referral, optimizing care in Emergency Departments and reducing stays in hospitals; (3) streamlining diagnosis to reduce hospitalization; (4) training of epilepsy nurses and EEG technologists; (5) teleneurology; and (6) expedition of mental health involvement to rein in avoidable hospitalization and diagnostic costs of pseudo-seizures.

Ideally, the expertise of ACOs’ multidisciplinary teams involved in managing complex epilepsy should include psychiatry, psychology, social work, occupational therapy, counseling, neuroradiology, clinical nurse specialists, neurophysiology, neurology, neurosurgery and neuroanaesthesia. Through technology, could this be made available to ACOs statewide from a central leveraging center? Teams should have MRI and video telemetry facilities available to them. The neurosurgeon in the multidisciplinary team should have specialist experience and/or training in epilepsy surgery and have

³<http://www.aan.com/elibrary/neurologytoday/?event=home.showArticle&id=ovid.com:/bib/ovftdb/00132985-201205030-00001>

⁴Institute of Medicine – Report on Epilepsy

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access to invasive EEG recording facilities. Information should be provided to children, young people and adults and families and/or caregivers as appropriate about the reasons for considering surgery. Metrics for this disease state could include measuring improvements in diagnosis and reduction in hospital stays for epileptic patients.

E. Alzheimer's Disease/Dementia

Alzheimer's disease is the most common type of dementia, accounting for 60-80 percent of dementia cases. Elderly people with Alzheimer's disease have as many as three times the hospitalizations as elderly people without Alzheimer's disease. There is demonstrated opportunity for improvement. A majority (11 of 18) of guideline-recommended dementia care processes have less than 40 percent adherence. The main reasons for hospitalization among Alzheimer's patients are falls (26 percent), ischemic heart disease (17 percent), and gastrointestinal disease (9 percent). These causes could be significantly reduced by better education of caregivers in terms of fall prevention, medication compliance, and diet. Patients with Alzheimer's disease use multiple medications, which raises the risk of adverse drug reactions and may increase hospital stays and costs. The engagement of a case manager and a pharmacist could reduce the adverse events associated with poly-pharmacy, including hospitalization for hip fracture and falls.

From an ACO patient population savings perspective, it is important to note that 47 percent of Alzheimer's patients are over 85 years of age. Appropriate use of pharmaceutical treatments delay onset and create significant savings in nursing home costs. The American Association of Neurology recommends that a care team, with the neurologist as team-lead, be utilized to reduce hospitalization costs. The neurologist makes decisions about dementia treatment, assessment, and monitoring. The primary care provider provides ongoing care, with ready consultative access to the neurologist and case manager. Home safety is important to reduce hospitalizations. Ideally, a neuropsychologist and geriatric psychiatrist are part of the care team as well. Care processes exist; the strategic initiative first will involve awareness, then widespread implementation of the care processes in a team setting. Neurologists have special expertise in early diagnosis of different types of dementia as well as effective medication management.

F. Migraine and Tension Headache

In 2011, the World Health Organization ("WHO") released a report, "Atlas of Headache Disorders and Resources in the World 2011." The report concluded that headache disorders are prevalent everywhere, across income levels, nationality, and gender. It is estimated, for instance, that nearly 30 million Americans suffer from migraine headaches. Headache, and especially migraine and tension headache (and, to a lesser extent, medication overuse headache), is high among the causes for consulting both primary care physicians and neurologists.

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Nine percent of the population suffers headaches, with 33 percent extremely severe and 45 percent severe. This leads to approximately \$1 billion in health care costs and \$13 billion in lost productivity costs. Headaches in the young is the number 1 reason for their lost productivity. As only 48 percent of headaches are properly diagnosed, an ACO strategy for neurologists to help improve quality and lower costs is to push their knowledge “upstream” to improve diagnoses for patients and primary care providers in the ACO.

There is unnecessary use of the local emergency department for migraines. Neurologists at one North Carolina ACO developed the following protocols, among others:

- Outpatient status migrainosis treatment options; and
- Outpatient same-day consults for patients with acute neurological problems.

The following example involving leadership of neurologists in a multi-specialty ACO shows that successful initiatives do not need to be complicated. The gap analysis showed unnecessary use of emergency room visits with unnecessary testing, yet delayed and fragmented treatment of patients diagnosed with migraine headaches. Neurologists created an algorithm based on evidence-based best practices to triage severe headaches. This was shared and discussed with the ACO’s primary care physicians. Neurologists made it clear that they were available for timely consults to facilitate diagnosis and treatment. Office-based interventions were made available. Multiple metrics to measure success suggested themselves, but the clearest one the ACO used was reduction in emergency room visits. The reduction was significant while patient health status improved.

Barriers to appropriate care include lack of knowledge of effective treatment among medical professionals who are inadequately trained to treat headache disorder, and there is a lack of appreciation among the public – including many of those who suffer from chronic headaches – of the serious nature of headache disorder, probably because they are episodic, do not cause death, and are not contagious. This lack of education coupled with this lack of awareness combines to lead to low consultation rates for serious headaches, leading, in part, to a serious lack of adequate treatment and a substantial and unnecessary economic burden as productivity is lost due to untreated or undertreated headaches. Because a substantial portion of the population self-medicates, broad education about effective headache treatment is critical; this is particularly important to avoid medication-overuse headache.⁵

As previously mentioned, the recurring strategies of increased availability to stem default emergency department use, increase teleconsulting, patient education through group website instruction, and

⁵Source: *Atlas of Headache Disorders and Resources in the World 2011y*

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a multidisciplinary approach to neurological care (i.e., “Headache Clinic”), again appear to be “low-hanging fruit” for an ACO and its neurologists.

Other headache strategies include:

- Early triggering of step care based on timely neurological exam; and
- Best practice protocols and algorithms to avoid unnecessary MRIs and other expensive technology.

G. Sleep Disorder Treatment

Though normally a logical candidate for an ACO initiative—common neurological problem with high avoidable costs and subject to mitigation through multidisciplinary adherence to standardized best practices—the Neurology Accountable Care Workgroup recommended deferral of strategic implementation. It is believed that the development of a common approach among the several medical disciplines currently providing care for this disorder will take time and resources that can be better used in the previously mentioned ACO strategies for neurologists. However, the Neurology Accountable Care Workgroup noted opportunity in earlier diagnosis of sleep disorders.

H. Back Pain

Other than visits for hypertension, pregnancy, or an upper respiratory tract infection, there may be no other complaints that patients seek care for more than back pain or neck pain. These patients will seek help from not only their primary care physicians, but a variety of consultants including neurologists, neurosurgeons, rheumatologists, physiatrists, orthopedists, psychiatrists, anesthesiologists, and other pain “specialists” such as chiropractors, acupuncturists and physical therapists. However, no specialist is better suited than a neurologist to guide the diagnostic and therapeutic path that these patients need to choose. In spite of the advances in imaging modalities, neurologists are best skilled to initially assess the impairments of the patient and devise an evaluation that is both medically and physically appropriate. Subsequent follow-up care can measure clinical progress and adjudicate the values of invasive or noninvasive therapies. While advances in molecular neurobiology and neuroimmunology have preoccupied the recent publications serving neurology, neurologists should not ignore this vast population of patients who need their continuing guidance. These patients represent diagnostic challenges and therapeutic conundrums that can be draining to a health care system if not properly managed. Neurologists should lead in guiding these patients through their care choices so that they may return as active participants in the work force or at least independent participants in their domestic lives.

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I. Inpatient Care

Although the majority of most neurologists' time is spent in ambulatory practice, they can provide inpatients with services that improve outcomes and create health care savings. While a broad range of disorders and maladies may need to be addressed by the consulting neurologist, particularly rewarding benefits may derive from the involvement with falls, spells, altered mental status, and hypoxemic brain injury. As of 2008, CMS designated in-hospital fall-related injury on a list of conditions for which reimbursements will not be provided. It will be incumbent on the hospital neurology consultant to recognize the potential for fall risks and address them even though the primary issue provoking the consult did not involve falls. Reaching 5-10 percent of all emergency department patients, those who have altered mental status suffer from a large number of etiologies. Neurology consultants can efficiently direct the evaluation following the elimination of more common diagnoses by the hospitalist and intensivists. Less serious, although not necessarily less difficult to evaluate, patients presenting with "spells" — changes in awareness, attention, or perception or abnormal movements—require careful questioning and examination followed by judicious diagnostic evaluations. Identification of the precise etiology should significantly limit subsequent hospitalizations. However, cost savings and improved outcome in the care of these conditions might be dwarfed by the potential savings lying within the population of hypoxic-ischemic brain injury patients. Staying involved in the intensive care management, including therapeutic hypothermia, should afford accurate response assessments to guide continuing therapy. In turn, communication with responsible family members of these patients should facilitate a timely and appropriate continuation or discontinuation of complex supportive measures. Frequent involvement with cerebrovascular diseases as primary or complicating issues will arise but are addressed in the section on stroke care. Most importantly the consulting neurologist will need to specifically address the transitional care of these various patients to smooth their reentry into the ambulatory care setting and limit readmissions.

J. Multiple Sclerosis

A chronic, lifelong illness with relatively young onset, multiple sclerosis ("MS") represents the most common non-traumatic cause of neurologic disability in patients less than 50 years old. MS presents in young adults, women being affected 2-3 times more often than men. To limit the accumulation of disability, these patients require the efforts of a health care team that includes nurses, physical therapists, speech therapists, neuropsychologists, and social workers as well as multiple physician specialists including ophthalmologists, radiologists, urologists, gynecologists, physiatrists, and psychiatrists. As the disease progresses, the neurologist acts as a primary care physician while carefully coordinating the variety of care providers. Patients with MS are at a higher risk for hospitalization, but often the reason for hospitalization is not always neurologic. These admissions will often involve infections, fall-

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related trauma, mental health management and transition to long-term care. Close follow-up of these patients and prophylactic management of these issues could cover the need for the costly care that complications would require.

Management by neurologists should help standardize the choice of medications that represent a substantial financial burden to any pay system. Close and experienced follow-up should verify that appropriate responses are being experienced by the patient. If not, early intervention with changes in therapy should help minimize the cost of disability down the road. Regular neurologic exams can lead to appropriate data collection that will offer patients and their families informed recommendations. Treatment of MS is constantly evolving as new medications come to market. With this particular disease process, having accurate and up-to-date exam and laboratory profiles will allow for optimal treatment matching. Outliers may be transferred to either virtual or actual comprehensive MS centers where ongoing trials can lend evidence-based support to therapy choices. All of the multiple ancillary care providers locally can continue to limit disability and lend practical support where needed.

Recently there have been controversial discussions regarding the necessity of continued drug therapy in MS patients with progressive disease. In spite of financial pressures to abandon the very expensive treatment of MS, it will be important for the neurologist to advocate for appropriate continuation of therapy while better long-term data is accrued in this patient population with progressive disease. This debate highlights the important role that the neurologist's experiential knowledge will play when precise clinical data is not available. Remember, success in value-based care is not based on the cheapest care but rather on evidence-based best care, standardized across the entire care team.

K. Parkinson's Disease

A chronic, progressive neurodegenerative disease of the motor system, Parkinson's disease primarily affects patients over 50 years old (only 10 percent suffering the disease before this age). These patients are driven into involvement with the medical system via myriad complications that primarily include fall-related trauma, urinary tract infections, respiratory difficulties, depression, and psychosis. As documented in one study, less than 50 percent of these patients had a neurologist involved in their care in the initial 48 months post diagnosis. However, evidence supports the idea that such care would lessen skilled nursing facility utilization and improve mortality over a six-year observation period.⁶ Another study identified that consistent neurologist care is associated with a reduced risk of hospitalization, specific to Parkinson's disease related complications.⁷ Whether it is the recognition of motor fluctuations signaling an early urinary tract infection or the adjustment of central nervous system

⁶Willis AW, Schootman M, Evanoff BA, Perlmutter JS, Racette BA. Neurologist care in Parkinson Disease: a utilization, outcomes, and survival study. *Neurology* 2011; 77: 851-857.

⁷Willis AW, Schootman M, Tran R, Kung N, Evanoff BA, Perlmutter JS, Racette BA. Neurologist-associated reduction in PD-related hospitalizations and healthcare expenditures. *Neurology* 2012; 79: 1774-1780.

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acting medications to avoid inpatient care for psychosis, neurologists may substantially contribute to the health care savings for these patients. In addition, avoidance of these complications will keep patients more independent and decrease their need for supervisory care settings. The slow, progressive nature of this disease and the depth of its various complications lead to frequent interactions with any health care system. Neurologists are uniquely qualified to preempt and minimize these interactions.

The conditions addressed in this section may move up to become priority initiatives if the ACO's gap analysis shows significant variation in quality and cost in one or more of these areas.

L. Avoidance of Expensive Drugs and Procedures with Marginal Value

Opportunities for improved care and cost also exist in pharmacy and procedure selection. Again, staying with the evidence base, think about the most cost-effective medications. This value based thinking will benefit the patients clinically and financially and benefit the shared saving. *Choosing Wisely*®, an initiative of the American Board of Internal Medicine (ABIM) Foundation, is a resource “to help physicians and patients engage in conversations to reduce overuse of tests and procedures, and support physician efforts to help patients make smart and effective care choices.” (<http://www.abimfoundation.org/Initiatives/Choosing-Wisely.aspx>) The recommendations of the American Academy of Neurology to the *Choosing Wisely*® initiative can be accessed at: <http://www.choosingwisely.org/doctor-patient-lists/american-academy-of-neurology/>.

VI. We've Got Some Great ACO Contributions - Now What?

As noted, there are some very clear strategies for improving care and reducing overall costs for commonly occurring disorders, which are ideal for accountable care's emphasis on collaboration and value-based reimbursement. But how does a neurologist find the right ACO partner, mesh these initiatives into programming, and be rewarded fairly?

A. Pick the Right ACO(s)

As detailed in the companion white paper, *The Physician's Accountable Care Toolkit*®, there are eight elements essential for every successful ACO. They are agnostic as to who or what owns or hosts the ACO, but they must all be present.

Culture will usually be the tell-tale indicator on whether any ACO has a chance for success.

- **Physician-Led** – Longstanding habits of individualism and competition among physician groups will have to transform to a culture of cooperation and collaboration. Physicians have not led complex change, are resistant to capital risk, and worry that fewer tests and procedures will lower incomes.

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- **Hospital-Led** – Hospitals need to change focus from the current business model of providing acute inpatient care and address head-on the operational impact of decreased admissions. Hospitals need to adopt a partnering culture with physicians and depart from a command-and-control approach encouraged by the fee-for-service system.

Even if a neurologist performs perfectly, he/she will still fail if the rest of the ACO is flawed.

The eight elements will determine the attractiveness of the ACO regardless of whether it is part of a hospital system, under the roof of a large multi-specialty clinic, or a network of small practices. However, each model has its nuances and present different strengths and weaknesses. Available ACO options will, of course, be different in metropolitan and rural settings. The presence or absence of large neurologist practices affects ACO partnering options.

B. You Have Picked a Winning ACO, Now Have the ACO Want to Pick You

1. **Build Relationships** – Neurologists should be engaged with all the medical specialties and the local health system. This is a first step to team-building and readiness to partner.
2. **Have a Compelling Story** – As noted, the skill sets of neurologists and some of the most obvious collaborative methods to improve patient care for strokes, headaches, dementia, etc. are ideally suited for ACOs. Employing them in an ACO is a “no-brainer.” We have heard of the “elevator pitch” for startups, whereby the entrepreneur can tell a convincing reason to invest in their company in the length of time it takes to ride an elevator. Neurologists have a great story and should reduce it to one or two pages. These initiatives are simple “plug and play” add-ons to the ACO’s existing activities, are synergistic, and will help the ACO meet quality and savings goals.

Strategic Note: Start simple. Start with your one best initiative, and then expand later.

Strategic Note: Another negotiating technique is to have something concrete. A Stroke Clinic or Neurosciences Institute resonates multi-disciplinary care and best practices. Again, this can be virtual, and more or less serve as an evocative label for your proposed initiative.

3. **Primary Care Is the Client** – In the new era, success will depend on the patient-centered medical home, or rather neighborhood, so that, at the end of the day, primary care is your focal point because of their ability to generate savings.

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C. Avoid Contract and Legal Pitfalls

1. **Avoid Legal Pitfalls** – The companion TACC ACO Legal Guide details legal issues of which you should be aware in engaging in ACO activities, and also provides negotiating tips for protecting your interests before signing a contract with an ACO.
2. **Muscle Up** – A neurologist in a small practice should collaborate with other colleagues to develop the necessary protocols, HIT, infrastructure and contract expertise for the future. This can be through joint venture contract or by joining a large practice, ACO network with a core of knowledgeable neurologists, or health systems. If you adopt high-value services and know how to market yourself, you can be the “go to” group regardless of size.

VII. What Are The Relevant Metrics?

You will need baseline data, of course, to create the comparison point on quality, efficiency, and patient satisfaction “before” the ACO took over so you can compare it to what happened “after.” Hopefully, some of this data also will be useful to determine local gaps in care to help you pinpoint initiatives to pursue. These need to match your initiatives that were selected. There is no “one-size-fits-all” set of metrics. They will need to cover quality, efficiency, and patient satisfaction. There will be some that are conclusory in nature and some over which you have minimal control. The National Quality Forum, National Committee for Quality Assurance, Agency for Healthcare Research and Quality, and the metrics required for the CMS MSSP are recommended sources for nationally validated metrics. The AMA-convened Physician Consortium for Performance Improvement® and your own specialty society are the other important sources of validated evidence-based measures.

VIII. How Do I Ensure That The Savings Pool Distribution Is Fair?

As mentioned in the *Toolkit*, some of the savings pool distributions should be used to maintain the ACO infrastructure, to “prime the pump” as it were. As much as possible should go to incentivize providers and facilities for the extra management time, practice pattern changes, and effort to create those savings. To create maximum motivation and trust, presumably the proportion of distributions should be in proportion to the relative contributions to the pool. The more incentive, the greater the odds of increasing the size of the savings pool going forward.

Strategic Note: Some ACOs may choose to use a portion of their shared savings to partially compensate hospitals and specialists who are seeing revenue reductions due to changes in practice patterns (which is not offset by increase in market share and overhead reductions). Some ACOs will distribute savings

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to capital investors. We caution that such tactics will slow the transformational changes needed, sap motivation, and ultimately challenge the competitive viability of the ACO altogether.

The TACC engaged a leading national health care valuation company, HORNE, LLP, to develop a merit-based shared savings pool distribution methodology for use with multi-specialty ACO initiatives. The resulting white paper: “Distribution Based on Contribution- A Merit-based Shared Savings Distribution Model” is available without charge at www.tac-consortium.org.

IX. Negotiation Tips

Negotiation tips may be found in the companion Accountable Care Legal Guide, available without charge through the Toward Accountable Care Consortium. These agreements have important and often novel terms, so engagement of skilled legal counsel is recommended before you negotiate ACO participation agreements.

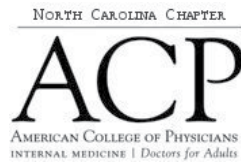
X. Conclusion

America's health care system will soon become unaffordable absent major change. The accountable care movement holds promise to address runaway costs and must thus be taken quite seriously. There are opportunities for professional and financial reward for the informed neurologist. Put another way, the risks of passivity are just too great. All the alternatives are unacceptable to a physician-led system of providing the highest quality at the lowest cost. Neurologists have skills and experience that position them to lead in the success of ACOs, but this is not widely recognized yet within the medical community. To make sure a fair and sustainable ACO model becomes reality, it is important for neurologists to step up with like-minded physicians to lead in this potentially career-changing transformation.

This guide is intended to illustrate the significant opportunities for neurologists in accountable care, to assist neurologists in avoiding the pitfalls, and for the development of accountable care strategies for neurologists in different settings. For further information, contact the TACC lead liaison, Melanie Phelps, at either mphelps@ncmedsoc.org or 919-833-3836.

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ACKNOWLEDGMENT



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