



ACCOUNTABLE CARE GUIDE FOR NEPHROLOGISTS

Preparing Nephrologists 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 and Initiative (“TAC”). This paper would not have been possible without the generous support of all TAC member organizations, including significant support from the North Carolina Medical Society, as well as a substantial grant from The Physicians Foundation. 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, to Christina Simpson, JD, for research and drafting, and to the following physicians for their expertise and input: James Godwin, MD, Capital Nephrology Associates; Michael Holland, MD, Boice-Willis Clinic; and Ike Nwubu, MD, Cornerstone Health Care. This guide would not have be 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

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Specialty Societies

Carolinas Chapter, American Association of Clinical Endocrinology
North Carolina Academy of Family Physicians
North Carolina Chapter of American College of Cardiology
North Carolina Chapter of the American College of Physicians
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
North Carolina Psychiatric Association
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North Carolina Society of Eye Physicians and Surgeons
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State Societies / Organizations

Community Care of North Carolina
Carolinas Center for Hospice and End of Life Care
North Carolina Academy of Physician Assistants
North Carolina Association of Local Health Directors
North Carolina Community Health Center Association
North Carolina Foundation for Advanced Health Programs
North Carolina Healthcare Quality Alliance
North Carolina Medical Group Managers
North Carolina Medical Society

INTRODUCTION

This strategic guide involved input through participation by many thought leaders who have come together to form the Toward Accountable Care Consortium and Initiative (“TAC”). 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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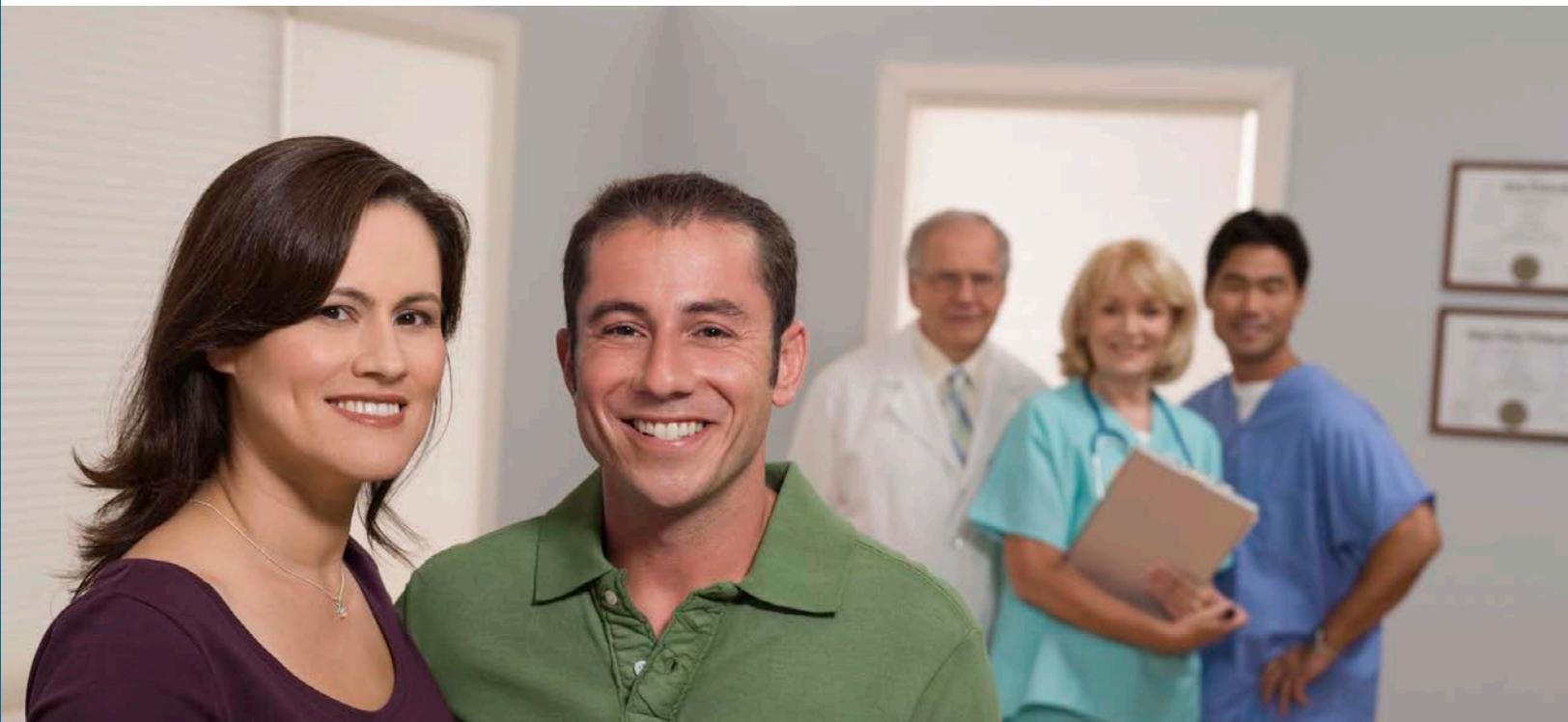
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The Physician's Accountable Care Toolkit

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



North Carolina  **Medical Society**
Leadership in Medicine

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Empowering Physicians
Improving Healthcare

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The Accountable Care Guide For Nephrologists

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?

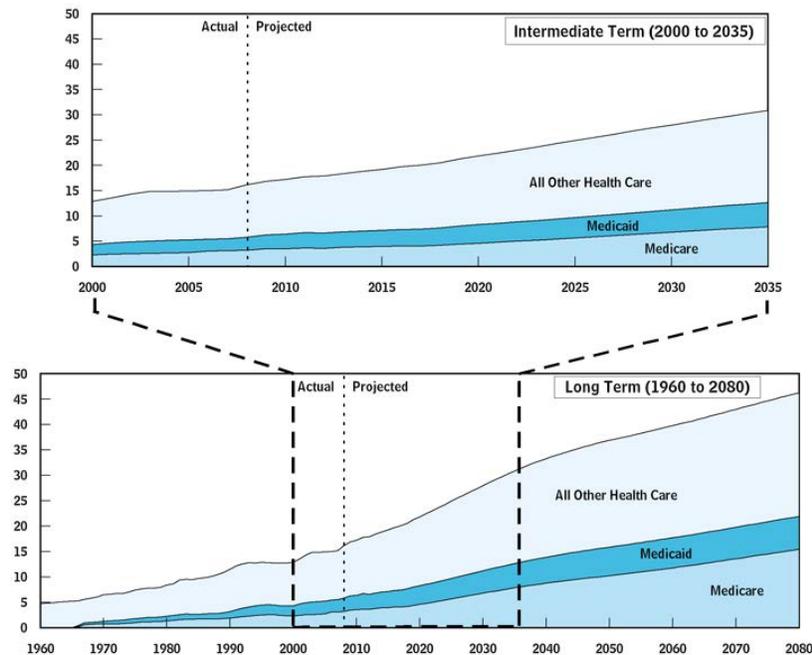
The Patient-Centered Medical Home (“Medical Home”) emphasizes strengthening and empowering primary care to coordinate care for patients across the continuum of care. It is complimentary to the ACO and can become the core of an ACO, but it is different in two main respects: (1) Financial Incentives - 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



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.

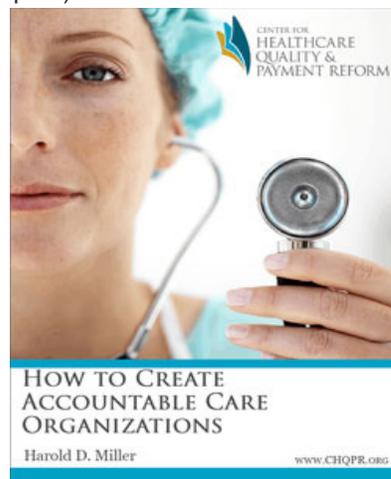
¹⁹ *Toward Accountable Care*, The Advisory Board Company (2010).

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.

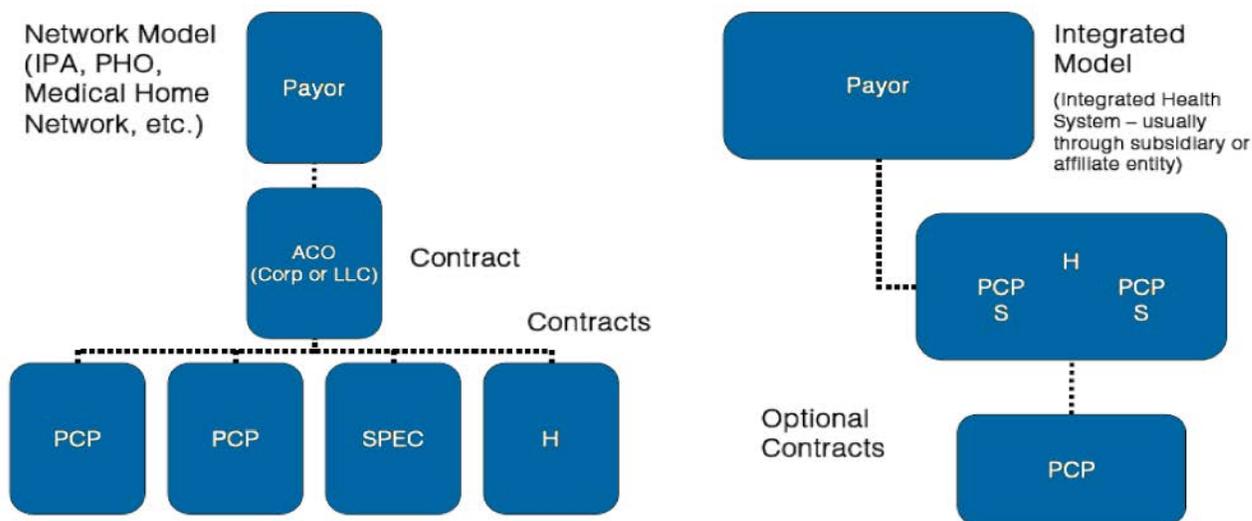
²⁵ Doug Hastings, Accountable Care News (December 2010), p. 6.

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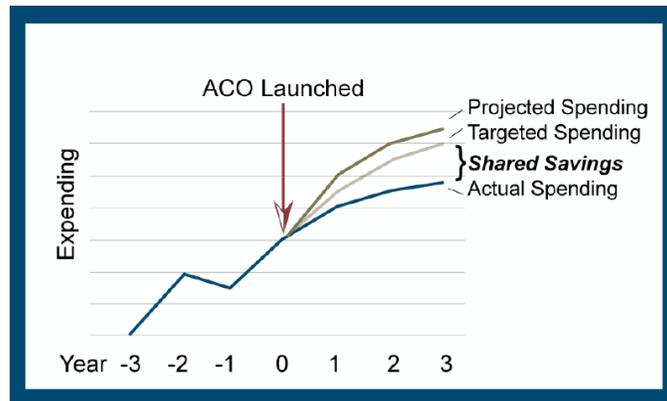
a. **Shared Savings** – If quality and patient satisfaction are enhanced or maintained and there are savings relative to the predicted costs for the assigned patient population, then a portion (commonly 50% according to some surveys and the MSSP Final Rule) of those savings is shared with the ACO. This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

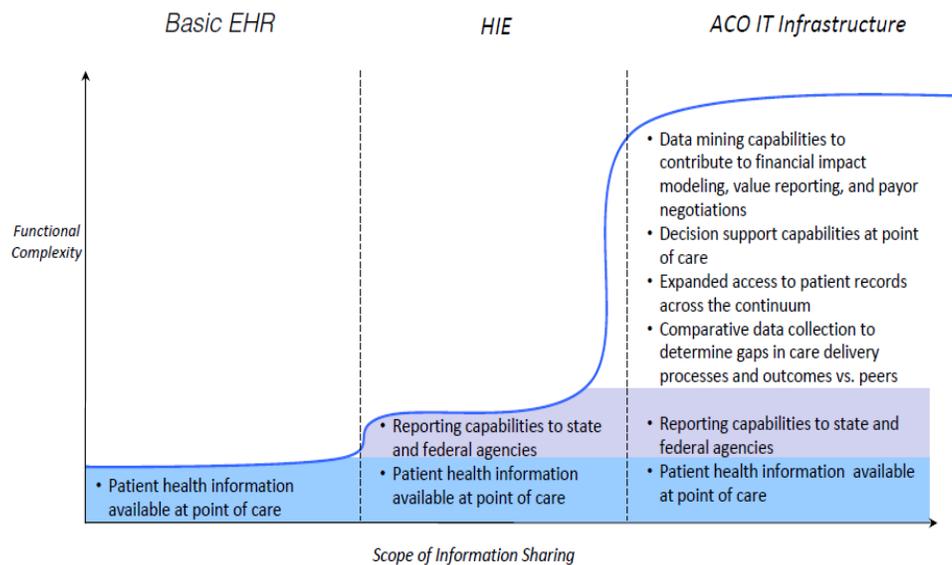
4. **“Meaningful Use” Regulations Incentives.** We include the “Meaningful Use” payments as an ACO financial incentive because the basic Health Information Exchange within your ACO will likely qualify the ACO’s providers for the Phase Two and Phase Three “Meaningful Use” incentives.²⁸ If your ACO can 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.

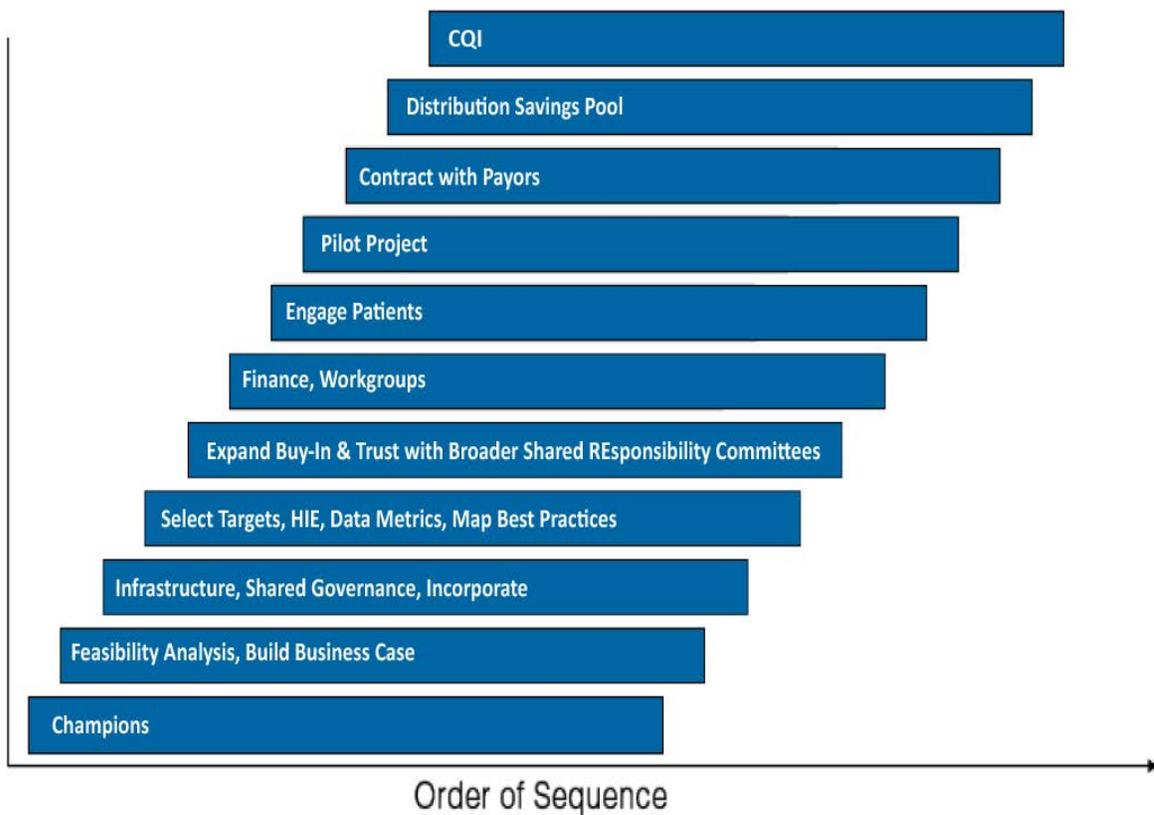
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VI. Successful Implementation – A Step-By-Step Guide

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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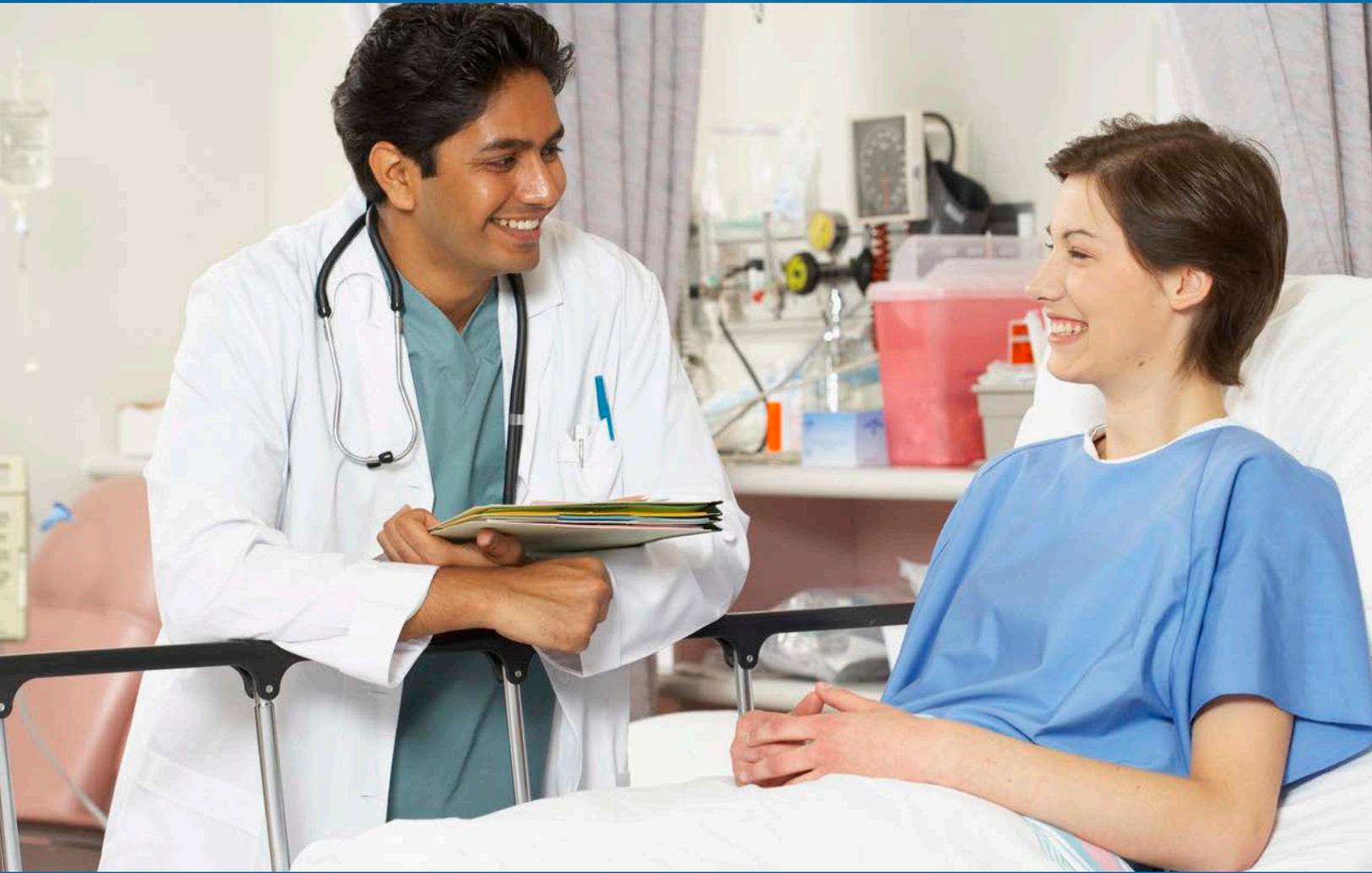
5. **Structural Foundation** – Choose the legal entity approach and formal governance structure most appropriate to your culture and business plan. It must be driven by the form most likely for the success of the ACO, not controlled by success for any particular stakeholder. Establish membership criteria 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: The Accountable Care Guide for Nephrologists

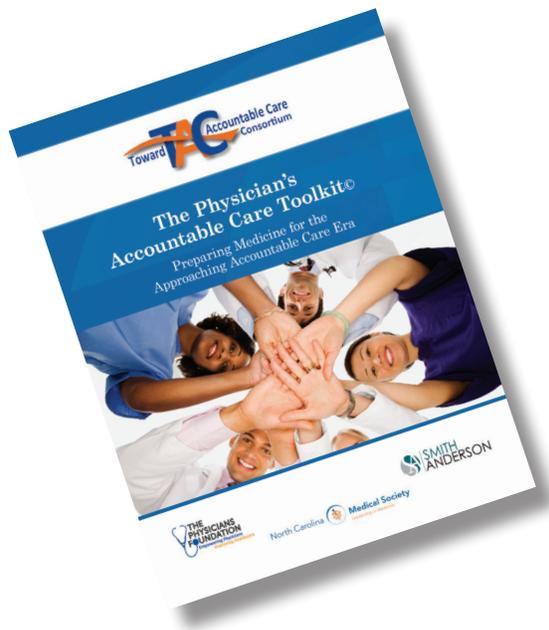


The Accountable Care Guide For Nephrologists

I. Introduction

A. Purpose of this Guide

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 an ACO be a win/win for all involved, it applies whether one is a nephrologist, hospital administrator, caregiver or other physician specialist. This *Accountable Care Guide for Nephrologists* on the other hand, spells out specific strategies for nephrologists, whether in a small rural office, a large independent practice, or employed by a health system.



B. Recap of *The Physician's Accountable Care Toolkit*®

1. **What Is an ACO?** – 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.”¹ 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

¹ 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.

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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 also will need the administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance, and organize providers around shared goals.”²

2. **This is Big, Different and Inevitable** – If we stay on the current spending glide path, by 2035, health care costs in this country will be more than the total of all tax and other revenues collected in our country, and by 2080, taxpayer funded health care will equal all of our governmental revenues, meaning that everything else—defense, roads, education—must be funded by borrowing. The other options are simply unthinkable: tax increases, rationing care or drastic reimbursement cuts. As a country, our health care costs are more than 50 percent more than in any other country, but we are now ranked 32nd in what we get for our investment. The Congressional Budget Office laid the groundwork for accountable care’s “pay-for-value” when it reported much of the blame for our runaway health care costs should be placed on our fee-for-service payment system where “providers have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists.”

Besides fragmentation, duplication and “more is better” excess, there are significant unjustified variations in quality and costs of care for similar patient populations. Yet, when motivated providers collaborate to drive the highest quality outcomes and the lowest costs, they do. Wonderful things happen—the patient is happier, employers finally see a slackening of spiraling health care costs, physicians regain control of the physician-patient relationship and there is “found money” in savings from squeezing out waste to reward them for their efforts.

Yes, reversing the way health care is paid for is big, and it will require significant change. But, physician-led accountable care is the best way to fix health care and provide physicians financial and professional reward.

² National Committee for Quality Assurance, [Accountable Care Organization \(ACO\) Draft 2011 Criteria](#), p. 3.

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C. 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. **As early ACO success and failure reports confirm, by far, the most important element for ACO success is the creation of an interdependent culture of mutual accountability committed to higher quality at the lowest cost.**

1. **Culture** – Full collaboration and true partnering among hospitals, physicians and other providers will drive success. This must be coupled with a buy-in to change habits to work in teams to drive value with a “win/win” population management philosophy. This is way, way out of physicians’ and hospital administrators’ comfort zones. Physicians love independence, autonomy and often just want to see patients. Administrators have heretofore succeeded through strong leadership direction and infrastructure control. **“The most significant challenge of becoming accountable is not forming an organization, it is in forging one.”**³ Culture keys are: champions, governance and advance planning for merit-incentives.

2. **Primary Care Physicians** – When reviewing Element 6 below, the core role of primary care becomes clear. Prevention, wellness, care transition and patient coordination management are the “low-hanging fruit” for ACO improvements and savings and are all in primary care’s sweet spot. Primary care is the only subspecialty required in Medicare’s ACO program. Sophisticated ACOs will thrive with hospitals, specialists and community health partners, but primary care, at least one-third of the total membership, will always be at the core. This is not to diminish the role of specialists; far from it. Indeed,

³ Phillip L. Rowing, *Becoming Accountable*, HFMP Compendium Contemplating the ACO Opportunity, Appendix, p. 40 (Nov. 2010).

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ACOs cannot reach full potential without multiple specialties interacting with primary care physicians. Some analysts have noted the second wave of ACOs, which is emerging now, and which they call ACO 2.0, will include value-adding specialists and post-acute care. ⁴

3. **Adequate Administrative Capabilities** – ACO structural, operational and legal considerations are essential, but are relatively straightforward. Developing the interdependent culture and commitment to clinical transformation across the full continuum of care is more elusive and should receive most of the ACO leadership's attention. Ironically, because they are objective, readily measurable and more familiar, structural, operational, legal and HIT issues often consume the bulk of planning time, leaving the subjective and "invisible" culture and care transformation issues behind.

4. **Adequate Financial Incentives** – "[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."⁵ One rule of thumb may be found in antitrust law, where the behavior changing tipping point in health care is considered to be roughly 20 percent of total compensation. Fifty percent savings for ACOs not taking downside financial risk is a fairly common measure and viewed by most as adequate.

5. **Health Information Technology and Data** – Every successful ACO will run on a sound technology platform with meaningful, actionable data at the point of care, transferable across the continuum, and available in aggregate form to prioritize ACO initiatives, measure performance, and report to payers and health care regulators. In contrast to fee-for-service with its demands of physician time and lack of incentives to log and study data, ACO physicians clamor for such information. These HIT and data capabilities need not be prohibitively expensive nor mandate linking EMRs. Sometimes a "Chevy" will get you where you need to go just about as well as a "Cadillac."

6. **Best Practices Across the Continuum of Care** – The five identified high-impact target areas for ACO initiatives are:

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

⁴ Navigant Issue Brief, *The Future of Accountable Care Organizations*, Summer 2014.

⁵ Ann Robinow, *Accountable Care News*, *The Top 30 Obstacles to ACO Implementation*, (Dec. 2010).

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“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.”⁶

7. **Patient Engagement** – How can your compensation be based on outcomes when the patient is not “in the game?” Patient engagement and patient-centeredness are essential to ACO success for this reason. The patient who was not self-referred to your office may be more important to population health management than the one who was. Two simple strategies often seen in successful ACOs are longer face-to-face initial visits with patients/families employing true communication skills and nurse coordinators who follow up with patients after they leave the facility or office. Technology is extending the virtual reach of these physicians and coordinators and is proving their “ROI,” or return on investment, in the value-based payment era.

8. **Scale-Sufficient Patient Population** – There are certain front-end investments and ongoing fixed costs requiring a minimum scale of patient population to succeed. Medicare’s ACO minimum threshold of 5,000 beneficiaries is a useful benchmark.

D. These Apply to Everyone

Because a successful ACO must be “win/win,” with every stakeholder motivated to achieve their optimum value-added contribution to the enterprise, these principles transcend medical specialty, employment status, payer relationship or facility type. They are not mysterious; they are doable; culture dominates. It is the goal of *The Physician’s Accountable Care Toolkit*® to serve as a roadmap for every reader to be able to unlock ACO success for their patients, themselves, and their ACO.

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

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 nephrologists?

We recognize there are various models and levels of integration for nephrologists. As a result, the recommendations that follow may not be applicable to all, but serve as a starting point and reflect strategies that may be modified and adapted based on variables such as geographic location, provider team make-up, access to facilities and equipment such as dialysis centers, breadth of service offerings and patient population (high risk, rising risk and low risk).

⁶ *Toward Accountable Care*, The Advisory Board Company (2010).

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A. Cons

- Nephrologists are working very hard and have run out of spare intellectual bandwidth to take on yet another nonclinical project that many doubt.
- Many an internist says “I just want to see my patients.”
- You have seen this “next big thing” before and it didn’t work out as advertised.
- Physicians rarely have a “war chest” to cover ACO start-up costs.
- Patients with end-stage-renal disease, a significant portion of the nephrologist’s population base – are typically health care ‘super-users’ for whom the focus on preventative service may not apply.
- It is more difficult to generate savings for patients with end-stage-renal disease, a population that constitutes a significant portion of the nephrologist’s practice base.
- Many ACOs have not qualified for shared savings.
- Collaborative care raises concerns of malpractice and HIPAA privacy liability.
- Few ACOs currently involve nephrologists.
- Many nephrologists agree with the sentiment, “I just want to see patients.”

B. Pros

- Because end-stage renal disease (“ESRD”) is the highest cost patient population in the Medicare program, it also may be its greatest ACO opportunity. This should be quarterbacked by nephrologists. Realizing this, ACOs have begun recruiting nephrologists. One ACO expert stated that a nephrologist-led ESRD medical home “could be a game changer” in Medicare Advantage.⁷
- The current *status quo* is not an option. The “default future” for nephrology and medicine in general is more fee cuts, less control of the physician/patient relationship and degraded patient care as the system further fragments. The specialty has the opportunity to participate in redesigning health care delivery, regaining empowerment over the process, and being compensated for their leadership.
- As with all physicians who have been heroically battling a deeply fragmented system to provide cost-effective care, nephrologists will find rewarding a model designed to truly gauge and value their

⁷ Grace Terrell, M.D., grace.terrell@cornerstonehealthcare.com; email to Melanie Phelps, *et al.*, (Feb. 23, 2015).

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contributions to health care, show respect for what they have been attempting to do and validate why they chose health care as a profession.

- System-wide care delivery improvements will vastly leverage the care expertise of nephrologists and may remove much of the frustration they experience with the current limitations presented by the health care system. For example, under the fee-for-service model, a nephrologist's interaction with patients and direct impact was limited to preventing further damage to an already severely compromised organ. With an ACO, nephrologists are better able to influence patient care and risk identification to avoid the crisis-events – and be compensated for this vital contribution.
- There is a compelling value-add case for nephrologists in the ACO model. With their excellent diagnostic skills, experience balancing multiple clinical concerns and competing co-morbid conditions and leading interdisciplinary teams nephrologists bring vital skill sets essential for successful ACO population management.

III. The Recommended Approach For Developing Specialty 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. Quality metrics exist to measure the quality of care rendered by one physician to one patient. But it is as fundamental as it is radically different, that accountable care strategic developments for any specialty focus on excising avoidable waste across the continuum of care for the entire patient population. New coordination transition, education and engagement metrics will need to be developed and properly weighted by peer clinicians.

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

- Wellness/prevention
- Mental health management
- Reduced hospitalizations
- Care coordination and transitions
- Multi-specialty coordination of complex patients

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From these potential initiatives, prioritize the ones which are likely to have the quickest and biggest results, proven metrics and community health care leaders willing to champion the effort. 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 ensure 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 category of providers.

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

A number of nephrologist leaders realized nephrologists must be prepared for the approaching accountable care era. They partnered with the Toward Accountable Care Consortium and Initiative ("TAC"). Following initial guidance from members of this TAC Nephrology Accountable Care Workgroup, staff and attorneys for the TAC Consortium and Initiative conducted a national literature search, with emphasis on value-based care and benchmarking recommendations. The findings were further reviewed and revised by the Nephrology Accountable Care Workgroup and presented to the TAC Consortium 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 impact of these metrics is beyond the scope of this project.

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

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V. Recommended Accountable Care Initiatives For Nephrologists

A. Early Identification of and Intervention for At-Risk Patient

Delaying dialysis, through (1) earlier identification of at-risk patients, and (2) use of interventions that slow further degeneration of kidney function, is the biggest ‘bang for the buck’ a nephrologist can make in the quality and cost of care for individual patients. Treatment of a patient for as little as six months to a year prior to dialysis dramatically decreases mortality and cost.⁸ One of the physicians on the TAC Physician Advisory Committee opined because of the “absolute evidence that **early referral to nephrology is associated with marked improvement in outcomes,**” it is “**one of the best examples we have for clinical outcomes impact from a specialty.**”⁹

The success of an ACO venture relies upon its ability to identify and refer such at-risk patients prior to a crisis-event. As one of the physician members of the Workgroup noted, “earlier referral is key.” One member of the Workgroup drew an analogy between patients with kidney damage and ante-natal care: in both instances we (1) can identify a definite approaching medical event, and (2) know the outcome of that medical event is frequently determined by the advance care received. Nephrologists have the capacity to slow, stop or even reverse the progression of kidney disease, provided they have the opportunity to intervene in advance.¹⁰

Whereas, under the siloed fee-for-service model, nephrologists were very careful to avoid any impression of ‘poaching’ patients from referring physicians, within an ACO, incentives are aligned for greater coordination between specialists and the primary care physician. The first, fundamental step is for primary care physicians and providers to be educated and have access to simplified guidelines to direct when a referral should be made.¹¹

The systemic use of urinalysis screening to identify and refer such patients is one way to accomplish this. Nephrologists also have an important role in educating primary care physicians on best practices to avoid further kidney damage, most specifically through the avoidance of non-steroid anti-inflammatory drugs.¹² The importance of this educative and collaborative role and its capacity to transform health outcomes is forcefully demonstrated by the five Choosing Wisely® campaign recommendations associated with nephrology.¹³ Choosing Wisely, a partnership between the American Board of Internal

⁸ See e.g. Kinchen KS, Sadler J, Fink N. et al., The timing of a specialist evaluation in chronic kidney disease and mortality. *Ann Intern Med* 2002; 137: 479-486; Junger P, Massy ZA, Nguyen-Khoa T. et al. Longer duration of predialysis nephrological care is associated with improved long-term survival of dialysis patients. *Nephrol Dial Transplant*, 2001; 16: 2357-2364; Stack AG. Impact of timing of nephrology referral and pre-ESRD care on mortality risk among new ESRD patients in the United States. *Am. J. Kidney Dis.* 2003; 41: 310-318.

⁹ Grace Terrell, M.D., grace.terrell@cornerstonehealthcare.com; email to Melanie Phelps, et al., (Feb. 23, 2015).

¹⁰ Rettig, RA, Norris K, Nissenson AR: Chronic Kidney Disease in the United State: A Public Policy Imperative, *Clin J Am Soc Nephrol* 3, 1902 – 1910, 2008.

¹¹ *Id.*

¹² Epstein M. Non-steroidal anti-inflammatory drugs and the continuum of renal dysfunction. *J Hypertens* 2002; 20 [Suppl 6].

¹³ Williams AW, Dwyer A, Eddy A et al: Critical and Honest Conversations: The Evidence Behind the “Choosing Wisely” Campaign Recommendations by the American Society of Nephrology, *Clin J Am Soc Nephrol* 7: 1664-1672, 2012.

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Medicine Foundation, *Consumer Reports* and nine subspecialty organizations, including the American Society of Nephrology, identifies practices across specialties “most open to improvement.”¹⁴ Each of the nine participating subspecialties evaluated best practices within their field and identified the five most misused or overused tests, procedures or intervention associations. Of the five “Don’t Do” recommendations promulgated by the American Society of Nephrology, three deal with interventions typically performed by non-nephrologists.¹⁵ These interventions reflect what nephrologists wish other practitioners would adopt when treating patients at risk of (further) kidney damage.¹⁶ The ACO structure lends itself to the integration of such best practices across providers, providing, in this instance, a concrete opportunity for nephrologists to directly influence the nature and quality of patient care before a crisis-event. Your savings are higher for the health problems you avoid—in other words, for the patients you do not see—than for the problems you treat.

Examples:

Consolidate clinical guidelines for dissemination and referral by primary care physicians during routine check-ups.

Lunch and Learn segments focusing on early CKD recognition and intervention.¹⁷

Regular “Case Study” emails to primary care physicians, outlining examples of cases of when to make a referral and what information to include in that referral.

B. Nephrologist-Led Primary Care Teams for Complex Patients

As noted in the introductory materials, the level of coordination and transition management of complex, high-risk patients is both one of the greatest failings of the fee-for-service system and one of the greatest opportunities under accountable care.¹⁸ These patients commonly comprise around 10 percent to 20 percent of the patient population, yet consume 50 percent to 70 percent of the total costs. Because this management yields significant overall contributions to the Triple Aim, they are considered “low-hanging fruit” by ACOs. The ACO model provides the opportunity to formalize and reward nephrologists’ existing leadership in treating complex patients and coordinating care across multiple specialties.¹⁹

¹⁴ *Id.*

¹⁵ These interventions include: (1) elimination or reduction of routine cancer screenings for patients on dialysis; (2) avoidance of non-steroidal anti-inflammatory drugs; and (3) not placing peripherally inserted central catheters in patients with Stage 3 and up of kidney damage. *Id.*

¹⁶ The American Society of Nephrology’s Choosing Wisely recommendations reflect the goal of improving care for patients with kidney disease by distributing a “consistent message to health care providers and patients about common but not always necessary tests, procedures and therapies” or interventions that may otherwise harm or conflict with subsequent interventions by a nephrologist. *Id.* at 1672.

¹⁷ Retting RA, Norris K, Nissenson, AR, Chronic Kidney Disease in the United States: A Public Policy Imperative, *Clin J Am Soc Nephrol* 3: 1902-1920 (2008).

¹⁸ As one example, a member of the Work Group identified the impact reliable transportation can have on improving care and reducing hospitalizations. This correlation between (1) access to a dialysis center through such reliable transportation and (2) reduction of hospitalizations was demonstrated forcefully by the anecdotal observation of an annual increase in admissions around the Christmas holidays of around 10%, reportedly attributable to the change in scheduling and the interruption in a patient’s support network of family and friends.

¹⁹ *Accountable Care Organizations and ESRD: The time has come* Am. J. Kidney Dis. 2012; 59(5); 724-733.

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Nephrologists are ideally suited to serve leadership roles in such efforts:

The nephrologist – a central provider for patients with CKD, ESRD, or kidney transplants – assumes a critical position in addressing the primary care needs of these patients, who tend to require frequency of contact. A care coordination role has emerged for the nephrology health care team due to the extensive co-morbidities of these patients as well as to the interdisciplinary models in dialysis and transplantation involved in their care.²⁰

A patient's care team needs to coordinate, know their roles, practice to the top of their licenses and be supervised by a nephrologist. "Supervision" is a carefully chosen role, and one with which nephrologists have ample experiences.

The October 2014 Commonwealth Fund study of common attributes of high-performing ACOs found the following:

"Care management of patients with costly, complex needs. All study sites have invested resources in deploying care managers, outreach workers or virtual care teams to engage with and help improve outcomes for patients with complex needs or at risk of incurring high costs. All stress an individualized approach to identify and address unmet needs through in-person or telephone visits. For example, care teams may include social workers as well as pharmacists and case managers have been deployed by urban safety-net clinics affiliated with Health Share and by Hill Physicians Medical Group to help address the psychosocial and clinical factors that play a role in improving patients' health and treatment adherence. Marshfield Clinic embedded nurse care coordinators in all its primary care clinics to help patients avoid unnecessary hospital use, with the expectation that shared savings would help fund this infrastructure. It subsequently discontinued the program because it was partially duplicating a service offered by its health plan and because the program's cost was not sustainable without support from other payers. The clinic retains a care management program serving heart failure patients, and is reconfiguring primary care teams to take over the care coordination responsibilities."²¹

Other complex patient "best practices" of the high-performing ACOs revealed by the study included: (1) virtual care teams of pharmacists, social workers and case managers help primary care physicians manage the clinical and psychosocial needs of this population; (2) physicians are embedded in skilled nursing facilities to prevent avoidable hospital and emergency department admissions; (3) care coordination nurses navigate care and provide individualized care management; and (4) nurses receive electronic alerts when patients visit an emergency department or are discharged.

²⁰ The Future Nephrology Workforce: Will there be one? CJASN, 2011 available at <http://cjasn.asnjournals.org/content/6/6/1501.full>

²¹ McCarthy D, Klein S, Cohen A, *Case Studies of Accountable Care Systems*, The Commonwealth Fund, October 2014, Pub. 1778 Vol. 21, 3.

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One of our Internal Medicine Accountable Care Workgroup members added that, “This is a much more enjoyable way to practice.” Having navigators, nutritionists, mental health and access to specialist input brings the right resources to the patient (and treating nephrologist) at the right time and at the right place. Early and accurate intervention is enhanced and offsite physical referral needs are diminished. Discharge planning and post-acute care coordination for these complex patients pay dividends.

With a nephrologist as the primary care first point of contact, nephrologists may have the freedom to organize treatment at shorter intervals between visits; allowing closer monitoring of patients and the opportunity for ‘micro-changes’ to treatment, thus avoiding crisis events and more expensive interventions.²² As mentioned, because of their extraordinarily high costs, a nephrologist-led ESRD medical home stands to be a “game changer” in Medicare Advantage-type ACOs.

As this is already the way nephrologists practice themselves, the ACO provides the opportunity to remove some of the frustrations many nephrologists expressed in terms of the ‘too many hand-offs’ of a patient, leading to duplicative processes and missed opportunities.

- **I Get It—We Need to Step Up To The Coaching Box, But How?** Assembling the team for systematized care of a complex patient population presents structural and logistical difficulties; however, nephrologists can rely on their existing expertise in coordination of complex care, and build on established principles of collaborative care and early ACO initiatives to fashion the structure most appropriate to your patient population, payer contract, access to skilled providers in your region and cultural readiness.

[N]ephrologists regularly work with varied members of the care team (e.g., dieticians, social workers, nurses and patient care technicians) and other physicians (e.g., vascular surgeons, endocrinologists, cardiologists and general practitioners) to coordinate the care of dialysis patients. Functioning as de facto principal care physicians, collaborating with other subspecialties, balancing multiple clinical opinions and competing co-morbid conditions, directing care teams that have weekly direct contact with patients, leading interdisciplinary teams and directing quality management efforts are key roles of the ACO primary care physician nephrologists already perform.

C. Site of Service

What is the least expensive site of treatment consistent with best practices? This applies for both acute and sub-acute. Many benefits in value-based care are hard to measure—like the infection that did not

²² Observation by Dr. Godwin.

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happen. But an equally effective treatment in a lower cost setting is readily measurable. Some things you may wish to consider include: (1) outpatient access to the ACO's same day clinic in lieu of referral to the emergency department; (2) where appropriate, increased utilization of home-based dialysis treatment plans; and (3) utilization of support services provided by dietitians, social workers and even psychiatric nurses in other settings to manage care.

- **Develop Guidelines for Palliative Dialysis**

*The field of nephrology is shifting from an exclusive focus on increasing survival to one that provides greater attention to quality of life. There is an opportunity to integrate the advances of palliative medicine into the comprehensive treatment of those patients.*²³

A discussion on the site and nature of service is particularly important when considered in the context of patient-centered care for palliative dialysis. As Dr. Lewis Cohen, Director of the Renal Palliative Care Initiative, noted, "The tradition in nephrology – as in medicine in general – has been to view death as an enemy to be overcome by any means. A generational shift has taken place, with some balance now being provided by interest in quality of life."²⁴ This increasing appreciation for quality of life and the importance of advance planning by an informed patient supplied with the necessary support system to implement those decisions has engendered support for the development of clinical guidelines for **palliative dialysis**.²⁵

There are many patients who simply need some dialysis to avoid uremic symptoms and avoid fluid overload and heart failure. And, as one of our Workgroup members noted, this objective – when considered in the context of the patient's choice – should be kept in mind. Currently, dialysis treatment plans, reflecting the structure and expectations of the Quality Incentive Program, are typically treated in an "all or nothing" approach. The protocol is to "chase phosphorus, albumin and adequacy in patients" where such ideal numbers will not improve life expectancy or quality to any appreciable degree.²⁶ Instead, nephrologists could further refine existing protocols for this subset of patients, offering an easier, more comfortable treatment, shorter times, less rigorous dietary restriction, and even fewer than the standard three treatments a week.

²³ Cohen LM, Moss AH, Weisbord SD, Germain MJ, *Renal Palliative Care*, J Palliat. Med., 2006 Aug; 9(4): 977-92.

²⁴ *Nephrologists Expand the Use of Palliative Care in ESRD*, Renal & Urology News, April 1, 2010.

²⁵ The Renal Palliative Care Institute (RPCI) based out of the Baystate Medical Center in Massachusetts is one example of such an initiative. Founded in part through a 2003 grant from the Robert Wood Johnson Foundation, and recipient of the 2003 Circle of Life Award, honoring innovations in palliative and end-of-life care, RPCI fosters collaboration between families, physicians, nurses and social workers in developing and implementing protocols in end-of-life care. See www.promotingexcellence.org/baystate.

²⁶ *Id.* (Quoting Dr. Moss, Professor of Medicine and Director of the Center for Health Ethics & Law at West Virginia University, "One major catalyst in the decision to rework the dialysis-withholding/withdrawal guideline is the fact that more than half a dozen studies demonstrate that select patients may live just as long with medical management alone as with dialysis.") See also, Michael Germain, *Supportive Care for the Renal Patient* (Oxford University Press, 2010).

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Barriers continue to exist, however, to the institution of such a more tailored approach. The most notable obstacle being the current metrics under which dialysis facilities are graded and compensated. These metrics “punish” facilities for the withdrawal or reduction of dialysis, despite evidence such a one-dimensional assessment may not accurately reflect clinical best practices or the best interests of patients.²⁷ The question of how to quantify the quality of care for ESRD continues to be a difficult one; however, the realignment and restructuring introduced with an ACO presents an important opportunity as it equips nephrologists – as advocates for their patients – with new resources and alliances to address this problem.

D. Compressing Unjustified Variability

More clinically credible, evidence-based best practices are emerging in kidney care. Standardized observance of those practices would produce meaningful savings. Members of the Nephrology Accountable Care Workgroup felt, and research supports, reduction in variation regarding guidelines for renal care would be particularly effective. Such standardization would allow closer monitoring of a patient’s vital indicators – regardless of whatever other entities and care providers are involved. Standardization will translate to fewer errors and greater efficiency.

E. Patient and Family Education and Communication

The quality and integrity of long term care for chronic illnesses, such as end-stage-renal disease, depends upon a patient’s informed participation and the ability to articulate priorities and decisions in advance of crisis-events. Allowing patients to be part of the care plan development helps ensure their ongoing engagement and investment in their health care needs.²⁸ In addition, patient adherence to a care plan and self-management help drive down health care costs.

Patient-centered care also emphasizes patient and family education as a means of achieving patient-centered goals of care and preventing unnecessary or unwanted care. The ACO model provides opportunities for nephrologists to receive greater institutional support and recognition for their contribution in helping patients to articulate their health goals and priorities. Providers can initiate and/or facilitate these sometimes challenging, time consuming and yet vital discussions around goals of care.

This is particularly important for nephrologists, who treat some of the most complex cases in a hospital. Dialysis specifically is an invasive and disruptive procedure. Members of the Workgroup, noted decisions of patients with terminal disease to go on dialysis are frequently driven by fear and a

²⁷ See e.g. “What’s wrong with the 5-star rating system for the renal community,” M Krishnan, Nephrology News & Issues, July 16, 2014; See also, www.promotingexcellence.org/baystate .

²⁸ See Williams AW, Dwyer A, Eddy A *et al*: Critical and Honest Conversations: The Evidence Behind the “Choosing Wisely” Campaign Recommendations by the American Society of Nephrology, *Clin J Am Soc Nephrol* 7: 1664-1672, 2012 (positing that “the decision to initiate long-term dialysis is often shaped more by provider and system-level factors than by patient preferences” and advocating for informed, shared decision making relationship between the providers and the patient in decisions to initiate long-term dialysis.)

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family's natural desire to defer difficult decisions. One member noted he believed patients, if armed with information in advance, would choose not to go on dialysis.

F. Leverage Impact Through Technology

The above recommendations can be optimally implemented through the use of a reliable electronic health record system that “talks” to the system of the referring physician. While fee-for-service “punished” use of available techniques and tools to allow collaboration – creating silos of information and duplication of care – value-base payment introduces a significant “return on investment”. Nephrologists need to have a patient’s complete information available to them at the time of treatment, and to be confident his/her treatment notes and directives go with the patient.

G. Awareness/Leadership/Urgency: Nephrologists’ Role in Guiding Change

Nephrologists need 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 Nephrologists*). 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 with a sense of urgency. This is mentioned as a strategy in and of itself because the biggest risk of failure of the accountable care movement and either collapse of Medicare and Medicaid or default to Draconian alternatives is lack of informed provider leadership. If you do not become involved, there is a good chance the roles of nephrologists 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 nephrologist? As Bert Coffey, M.D., said: “If you don’t have a seat at the table, you are on the menu.”

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 nephrologist 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.

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- **Physician-Led** – Longstanding habits of individualism and competition among individual 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 procedure will lower incomes.
- **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 bureaucratic fee-for-service system.

Remember, even if an internist 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 and will vary based on the patient population. The presence or absence of nephrologists affects ACO partnering options.

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

1. **Build Relationships** – Nephrologists should be engaged with all the medical specialties and the local health care delivery system. This is a first step to team-building and readiness to partner.
2. **Have a Compelling Story** – As noted, the skill sets of nephrologists, including expertise managing complex cases across multiple disciplines, are ideally suited for ACOs. Nephrologists have the benefit of already operating in a manner compatible with an ACO setting and objectives. Nephrologists are ideally suited, not only to adapt to an ACO, but to serve as a leader. Utilizing 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 the time it takes to ride an elevator. Nephrologists 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 initiatives, and then expand later.

3. **Primary Care Is the Client** – In the new era, success will depend on the patient-family centered medical home and neighborhood. Though primary care in some cases has lost its decision-making

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authority to health systems, payers and large clinics, at the end of the day, primary care must be at the core of a successful ACO and will thus be a key partner. As discussed, the evolution of ACOs to “ACO 2.0” and beyond will allocate ACO incentives and control among all specialties that can demonstrate value, thus perhaps lessening the priority role of primary care, but they will always be important.

VII. What Are The Relevant Metrics?

A. The Basic Categories and Sources

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. Broadly, the measures chosen will need to cover quality, efficiency and patient satisfaction. An ACO may choose to match clinical initiatives and metrics (e.g., prevention of emergency dialysis and reduction of rapid vascular access interventions) but early metrics could be more general. The National Quality Forum, National Committee for Quality Assurance and the metrics required for the CMS Medicare Shared Savings Program are recommended sources for nationally validated metrics. The AMA-convened Physician Consortium for Performance Improvement® and the American Society of Nephrology and Performance Excellence and Accountability in Kidney Care (PEAK), convened by Kidney Care Partners, are especially important for integration measures. Thinking of ACO common interests will be helpful in decisions about metrics for your specialty. For example, in addition to metrics specific to nephrologists, think about those also important to the ACO (e.g., the MSSP quality measures, utilization or cost saving indicators), your hospital partner (Joint Commission measures) and payers. Since many of the benefits/savings of the ACO initiatives are societal and frequently intersect with end-of-life decisions, the Nephrology Accountable Care Workgroup suggests consideration of such things as quality of life metrics, with examples of same included.

B. Examples of Measures That Measure Nephrologist Performance

- Preventive services measures including early detection and screening, namely routine use of urinalysis screening in adult patients.
- Implementation of ACO integrated care protocols.
- Open line of communication between primary care and nephrologist care team.
- Establishment of baseline renal care plans and assessment of patient performance against the plans.

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C. Examples of changes in Quality of Life Metrics to Measure Patient Performance:

- Physical being (health, hygiene, nutrition, exercise, appearance).
- Psychological being (health and adjustment, cognitions, feelings, self-esteem, self-concept, self-control).
- Spiritual being (personal values, standards of conduct, spiritual beliefs).
- Physical belonging (home, school, community).
- Social belonging (family, friends).
- Community belonging (school, educational and recreational programs).
- Practical becoming (school and volunteer activities, meeting health and social needs).
- Leisure becoming (promote rest and relaxation).
- Growth becoming (promote maintenance and improvement of knowledge and skills, adaptation to change).²⁹

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

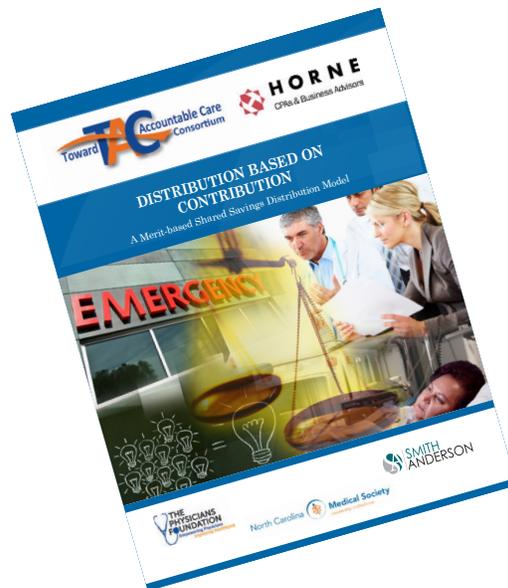
As mentioned in the *Toolkit*, some of the savings pool distributions should be used to maintain the ACO infrastructure, to “prime the pump” as it were. As much as possible should go to incentivize providers and facilities for the extra management time, practice pattern changes and effort to create those 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 to capital investors. We caution such tactics will slow the transformational changes needed, sap motivation and ultimately challenge the competitive viability of the ACO altogether.

²⁹ “Quality of Life Model and Conceptual Framework”, Quality of Life Research Unit, University of Toronto.

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The TAC Consortium and Initiative has overseen the development of a merit-based shared savings pool distribution methodology for use with multi-specialty ACO initiatives. The guide can be found here: http://www.tac-consortium.org/wp-content/uploads/2013/09/Shared-Savings-Guide_091013_revised_reduced-file.pdf.



IX. Protect your interests: Negotiation Tips

A. Negotiating with ACOs

Physicians may be asked to sign ACO participation agreements with an ACO. While every provider who follows this guide will bring much to the table and is in position to negotiate a reasonable contract, these are very specialized arrangements and it is recommended you retain legal counsel knowledgeable in negotiating these types of agreements. Physicians should be particularly mindful of the following areas:

- **Investment** – Any ACO upfront cost obligations?
- **Ongoing Risk** – What happens if the ACO takes on medical cost risk and does not meet targets? Are you proportionately responsible? What additional risk assumed based on the patient population (i.e. low, rising, high risk)?

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- **Distribution of Savings** – It should be distributed in proportion to contribution to savings, after expenses, but will savings go to investors, owners, to cover lost hospital or providers' revenues relative to fee-for-service? Are the expectations when the distribution of savings is met mutually understood by all negotiating parties?
- **Data** – Who collects it? Is the severity adjusted? Are the metrics clinically valid for your specialty?
- **Corrective Action** – Your continued participation is tied to performance. ACO contracts will have “teeth.” Review the fairness and peer review aspects of the contract.
- **Exclusivity** – Are you contractually bound to just one ACO? (Distinguish from extra-contractual restrictions of a payer, including CMS.)
- **Support** – ACOs are team-based systems that should provide you every reasonable tool and human support to help you optimize your performance and patient care. These should be spelled out. *The Physician's Accountable Care Toolkit*® is specific about what types of support you should seek from your ACO.

B. Negotiating with Private Payers

The bulk of this *Guide* promotes your reimbursement optimization by: (1) designing high-value initiatives; (2) earning participation in a well-designed ACO by making the value case; and (3) protecting your interests by negotiating a merit-based shared savings distribution.

However, in order to maximize revenues, both the ACO in its negotiations with commercial payers and you directly during this transition period, need to know what commercial payers are looking for regarding nephrology care.

- **Value-based Payment.** Commercial payers are moving to shared savings and risk contracts, usually with clinically integrated multi-disciplinary organizations. As we have seen, a “siloe” nephrology-care only arrangement cannot leverage the main savings opportunities you have. So, the value proposition outlined in this guide also holds true for the strategy to maximize reimbursement from commercial payers in these types of arrangements.
- **Hybrid/Transition Models.** The transition model for the integrated primary care home for nephrologists should address the costs associated with patient care coordination, regardless if the patient is present, and tele-care for patient health care discussions. The current health care system does not support these coordinated nephrology patient mental health care discussions.

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- **Fee-for-Service.** Of course, use of savings data, and seeking expanded coverage, also are useful in fee-for-service negotiations.

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 thus must be taken seriously. There are opportunities for professional and financial reward for the informed nephrologist. Put another way, the risks of passivity are just too great. All the alternatives are unacceptable to a provider-led system of providing the highest quality at the lowest cost. Nephrologists have skills and experience that position them to lead in the success of ACOs, but this is not yet widely utilized in the first wave of ACOs. To make sure a fair and sustainable ACO model becomes reality, it is important for nephrologists to step up with like-minded providers to lead in this potentially career-changing transformation.

This *Guide* is intended to illustrate the significant opportunities for nephrologists in accountable care, to assist them in avoiding the pitfalls and to help them develop accountable care strategies for nephrologists in different settings. For further information, contact the Toward Accountable Care (TAC) Consortium and Initiative lead liaison, Melanie Phelps, at either mphelps@ncmedsoc.org or 919-833-3836.

Part Three: Executing the Accountable Care Strategic Plan



North Carolina  **Medical Society**
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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

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organization; (b) how the ACO plans to use shared savings payments; (c) how the ACO will use and protect Medicare data; (d) how the ACO will require its participants to comply with and implement its quality assurance and improvement program; (e) how the ACO defines, establishes, implements, evaluates, and periodically updates its process to promote evidence-based medicine; (f) how the ACO defines, establishes, implements, evaluates, and periodically updates its process to promote patient engagement; (g) how the ACO defines, establishes, implements, evaluates, and periodically updates its process and infrastructure to support internal reporting on quality and cost metrics; and (h) how the ACO defines, establishes, implements, evaluates, and periodically updates its care coordination processes. The ACO will need to carefully review the required elements of each narrative listed in the MSSP application and ensure 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. 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

Accountable Care Guides for the following specialties can be accessed on the website for the Toward Accountable Care (TAC) Consortium and Initiative at <http://www.tac-consortium.org/resources/>.

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.
http://www.tac-consortium.org/wp-content/uploads/2013/04/Anesthesiologist_ACO_Toolkit.pdf

B. Cardiologists. Accountable Care Guide for Cardiologists was developed by the Accountable Care Workgroup of the North Carolina chapter of American College of Cardiology and TAC personnel.

C. Child Psychiatrists. Accountable Care Guide for Child Psychiatrists was developed by the Accountable Care Workgroup of the North Carolina Council on Child and Adolescent Psychiatry and TAC personnel.

D. Community Health Partners. Accountable Care Guide for Community Health Partners was developed by the Accountable Care Workgroup of the North Carolina Foundation for Advanced Health Programs and TAC personnel.

E. Emergency Medicine Physicians. Accountable Care Guide for Emergency Medicine Physicians was developed by the Accountable Care Workgroup of the North Carolina College of Emergency Physicians and TAC personnel.

F. 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.
http://www.ncafp.com/files/ACOGuide-CME_1.pdf

G. Gynecologists. Accountable Care Guide for Gynecologists was developed by the Accountable Care Workgroup of the North Carolina Obstetrical and Gynecological Society and TAC personnel.

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H. Hospice and Palliative Care. Accountable Care Guide for Hospice and Palliative Care was developed by the Accountable Care Workgroup of the Carolinas Center for Hospice and End of Life Care and TAC personnel.

I. Hospitalists. Accountable Care Guide for Hospitalists was developed by the Accountable Care Workgroup of the North Carolina Medical Society and TAC personnel.

J. Internal Medicine. Accountable Care Guide for Internists was developed by the Accountable Care Workgroup of the North Carolina Chapter of the American College of Physicians and TAC personnel.

K. Nephrologists. Accountable Care Guide for Nephrologists was developed by the Accountable Care Workgroup of the North Carolina Medical Society and TAC personnel.

L. Neurologists. Accountable Care Guide for Neurologists was developed by the Accountable Care Workgroup of North Carolina Neurological Society and TAC personnel.

M. Obstetricians. Accountable Care Guide for Obstetricians was developed by the Accountable Care Workgroup of the North Carolina Obstetrical and Gynecological Society and TAC personnel.

N. Oncologists. Accountable Care Guide for Oncologists was developed by the Accountable Care Workgroup of the North Carolina Oncology Association and TAC personnel.

O. Orthopedics. Accountable Care Guide for Orthopedics was developed by the Accountable Care Workgroup of the North Carolina Medical Society and TAC personnel.

P. Pediatricians. Accountable Care Guide for Pediatricians was developed by the Accountable Care Workgroup of the North Carolina Pediatric Society and TAC personnel.

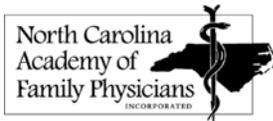
Q. Psychiatrists. Accountable Care Guide for Psychiatrists was developed by the Accountable Care Workgroup of the North Carolina Psychiatric Association and TAC personnel.

R. Radiologists. Accountable Care Guide for Radiologists was developed by the Accountable Care Workgroup of the North Carolina Radiologic Society and TAC personnel.

S. Urologists. Accountable Care Guide for Urologists was developed by the Accountable Care Workgroup of the North Carolina Urological Association and TAC personnel.

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