Toward Accountable Care Consortium

ACCOUNTABLE CARE GUIDE FOR RHEUMATOLOGISTS

Preparing Rheumatologists for the Approaching Accountable Care Era

THE PHYSICIANS FOUNDATION
Empowering Physicians Improving Healthcare

SMITH ANDERSON

North Carolina Medical Society
Leadership in Medicine

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. and Shawn Parker of the Smith Anderson law firm, for compiling the information in this non-technical "blueprint" format, and to the following individuals for their expertise and input: Ron George, MD, Wilmington Health Rheumatology; W. Hayes Wilson MD, Piedmont Rheumatology Consultants; Aldona Ziolkowska, MD, Cornerstone Health Care; Peter Anthony Saway, MD, Rheumatology Associates, P.C.; Mark Finnicum, Abbvie; and Ann Marslett, Rheumatology Associates of Baltimore, LLC. 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

continued next page

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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
North Carolina Radiologic Society
North Carolina Society of Anesthesiologists
North Carolina Society of Asthma, Allergy & Clinical Immunology
North Carolina Society of Eye Physicians and Surgeons
North Carolina Society of Gastroenterology
North Carolina Society of Otolaryngology – Head and Neck Surgery
North Carolina Oncology Association
North Carolina Society of Pathologists
North Carolina Society of Plastic Surgeons
North Carolina Spine Society
North Carolina Urological Association

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

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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 TAC member organizations, including significant support from the North Carolina Medical Society, as well as a substantial grant from The Physicians Foundation. We are grateful to Julian D. ("Bo") Bobbitt, Jr. of the Smith Anderson law firm, who has many years of experience providing strategic counsel regarding integrated care, for compiling 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.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

TABLE OF CONTENTS

Part One: The Physician's Accountable Care Toolkit

How to Identify and Build the Essential Elements of Any Successful ACO

I. Purpose of the ACO Guide

II. What is an ACO?

III. Why Should I Care?

IV. Are ACOs Really Coming?

V. What Are the Essential Elements of a Successful ACO?

- A. Culture of Teamwork – Integration
- B. Primary Care Physicians
- C. Adequate Administrative Capabilities
- D. Financial Incentives
- E. Health Information Technology and Data
- F. Best Practices Across the Continuum of Care
- G. Patient Engagement
- H. Scale-Sufficient Patient Population

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

VII. Conclusion

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

Part Two: The Acountable Care Guide For Rheumatologists

I. Introduction

II. Could Accountable Care Be a Good Thing for Rheumatologists?

III. The Recommended Approach for Developing Specialist Accountable Care Strategies

IV. The Process Followed for Creation of this Accountable Care Guide for Rheumatologists?

V. Recommended Accountable Care Initiatives for ACOs with Rheumatologists?

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

VII. What Are the Relevant Metrics?

VIII. How Do I Ensure That the Savings Pool Distribution is Fair?

IX. Negotiation Tips

X. Conclusion

Part Three: Executing The Accountable Care Strategic Plan

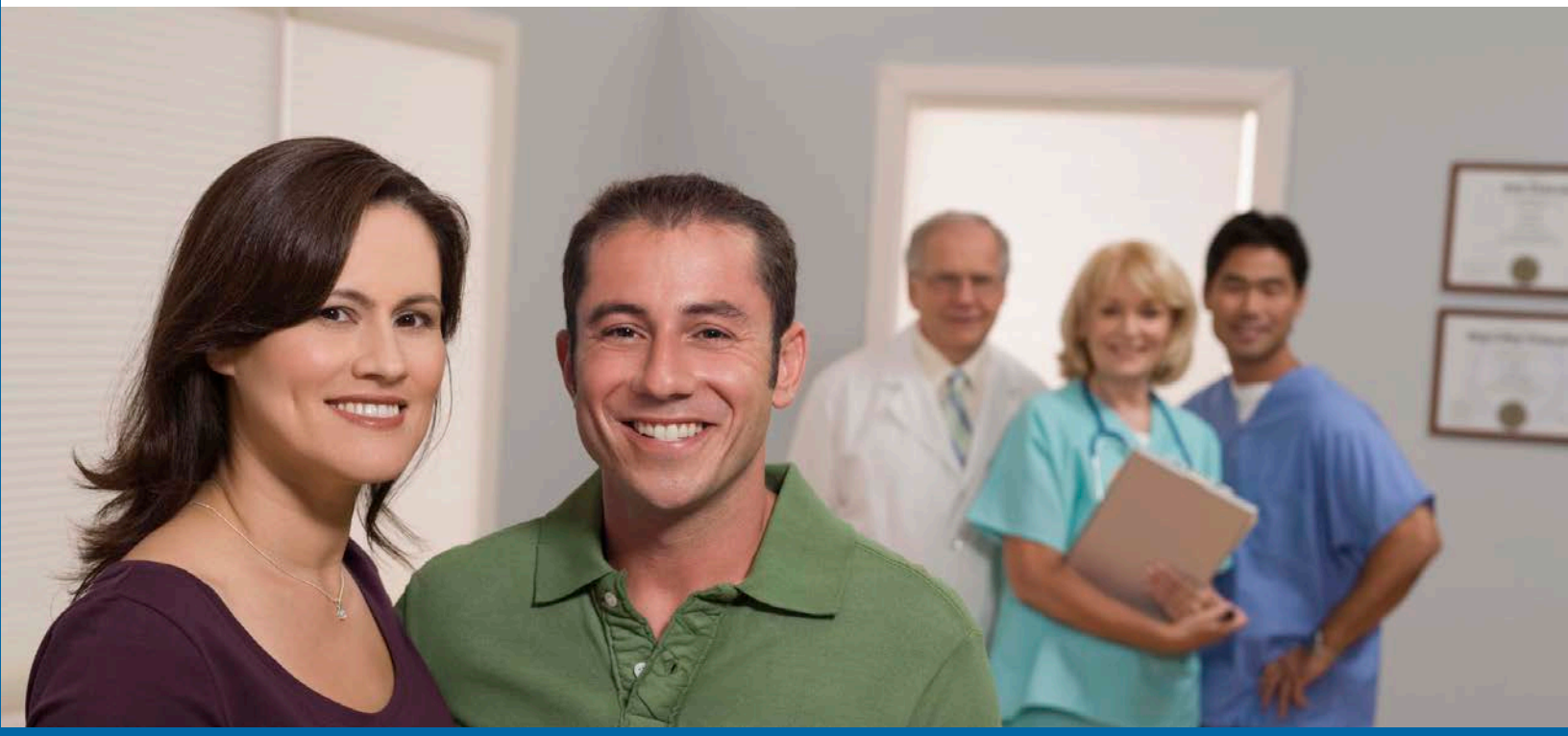
I. General Strategies for all Specialties

II. Specific Strategies for Specific Specialties

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

The Physician's Accountable Care Toolkit

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



North Carolina Medical Society
Leadership in Medicine

THE PHYSICIANS FOUNDATION
Empowering Physicians Improving Healthcare

SMITH ANDERSON

Toward Accountable Care Consortium

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").

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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 auhorized 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 2010[6] 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.*)).

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

C. How Is It Different From a Medical Home?

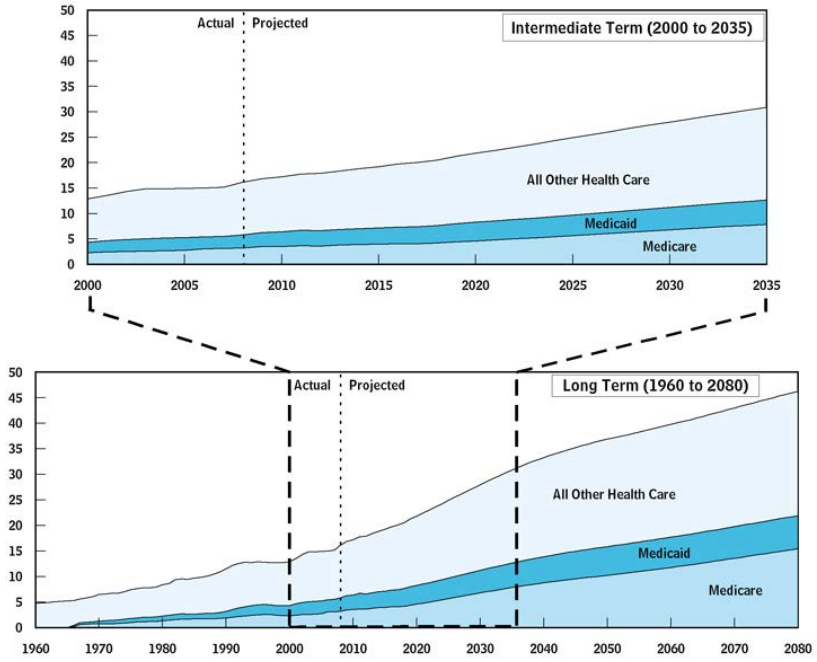
The Patient-Centered Medical Home ("Medical Home") emphasizes strengthening and empowering primary care to coordinate care for patients across the continuum of care. It is complimentary to the ACO and can become the core of an ACO, but it is different in two main respects: (1) Financial Incentives -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

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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)

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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).

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.*

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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).

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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).

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

- "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.

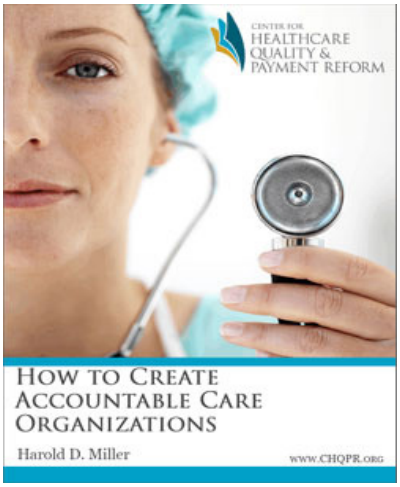
Harold Miller of the Center for Healthcare Quality and Payment Reform concluded, "it seems clear that, in order to be accountable for the health and healthcare of a broad population of patients, an Accountable Care Organization must have one or more primary care practices playing a central role."[20] 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).

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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/CEOReports/PCMH-and-ACO.cfm, (2010).

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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

---

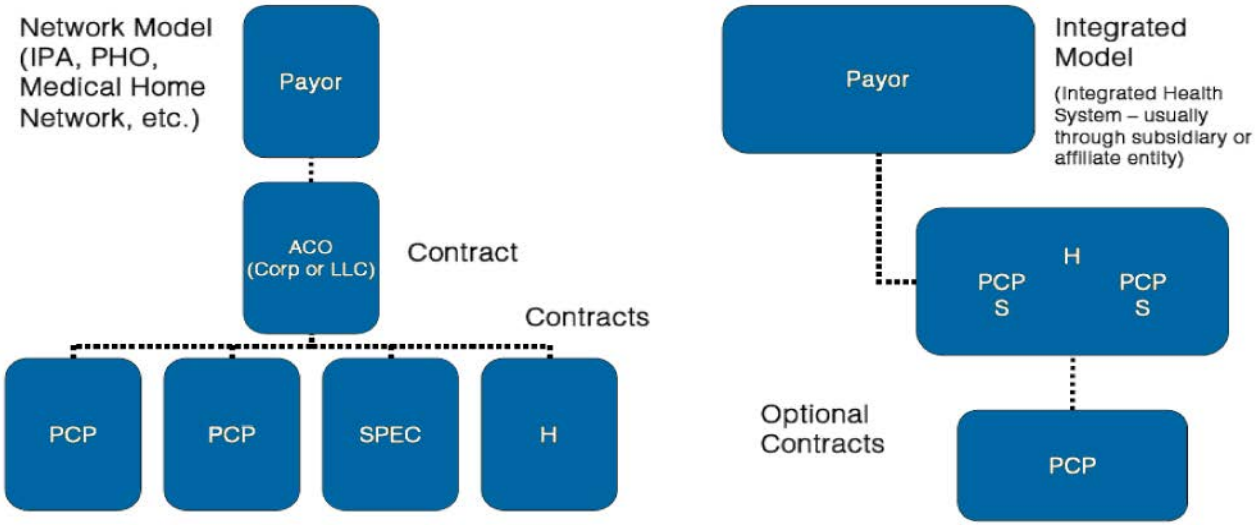
[23] NCQA, pp. 7-8.
[24] 76 Fed. Reg. 67975.
[25] Doug Hastings, Accountable Care News (December 2010), p. 6.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

- 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

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

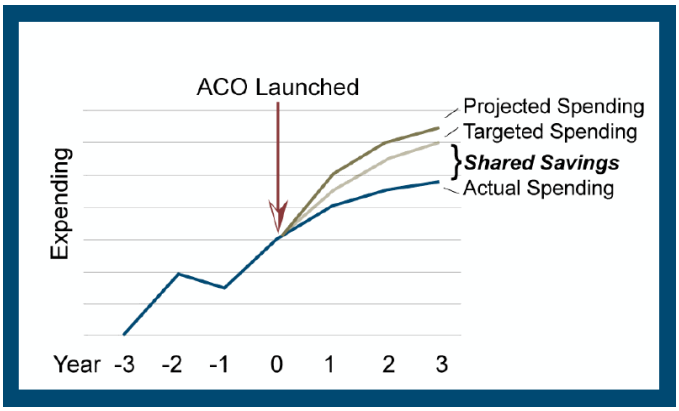
a. Shared Savings – If quality and patient satisfaction are enhanced or maintained and there are savings relative to the predicted costs for the assigned patient population, then a portion (commonly 50% according to some surveys and the MSSP Final Rule) of those savings is shared with the ACO. This is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

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.

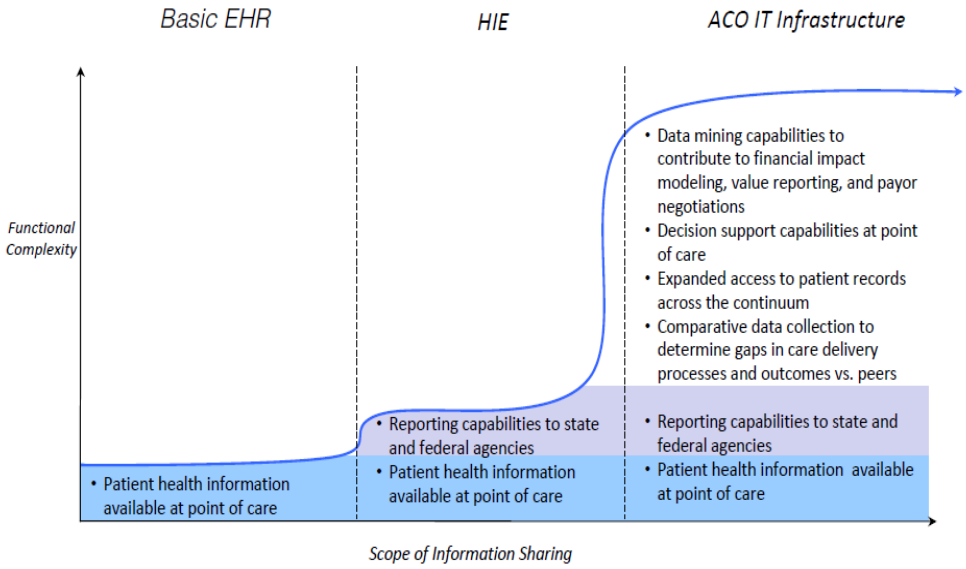
3. Is This the Same as Bundled Payment or Episode of Care Payment? ACO incentives can be aligned with these and other payment experiments under consideration. An "episode of care" is a single amount to cover all the services provided to a patient during a single episode of care. When that episode payment 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).

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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 preform 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.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.

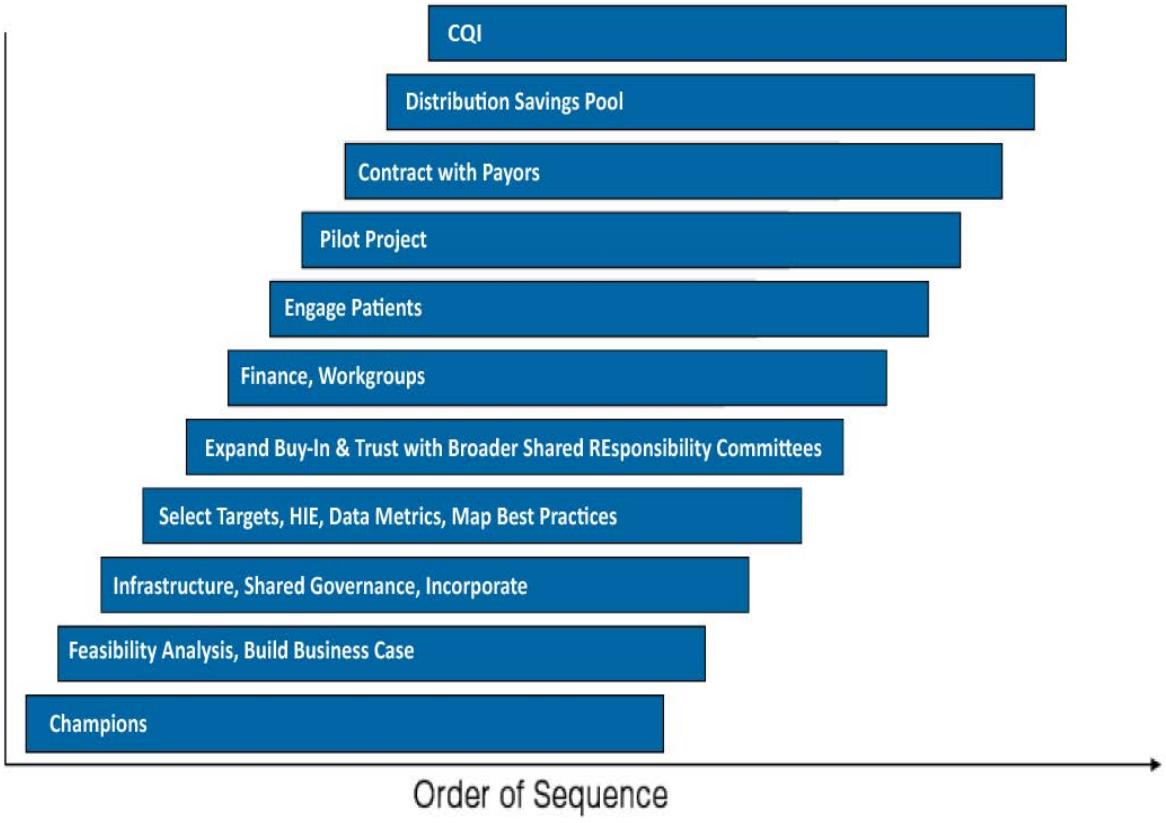
©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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)

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

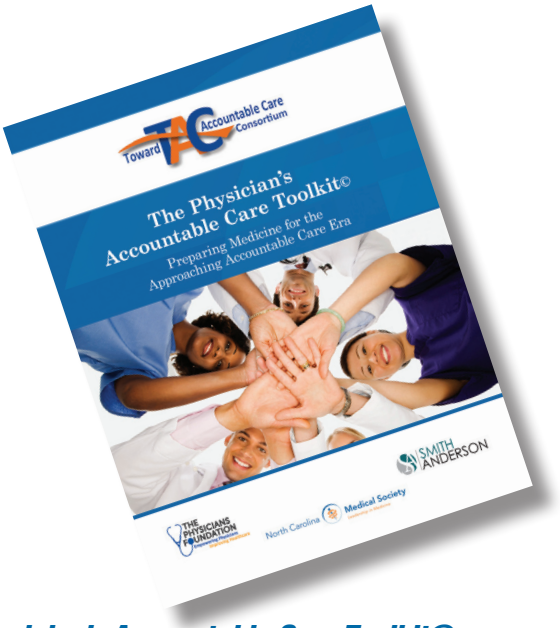
Part Two:
The Accountable Care Guide for Rheumatologists

Toward Accountable Care Consortium

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. Because it is fundamental that an ACO be a win/win for all involved, it applies whether one is a primary care physician or specialist physician. This *Accountable Care Guide for Rheumatologist*, on the other hand, spells out specific strategies for rheumatologists, whether in a small rural setting, a large independent practice or employed in 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.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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 greater 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" underpinning when it reported that 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."

On April 16, 2015, Congress enacted the Medicare Access and Chip Reauthorization Act ("MACRA"), which will transform the way providers are paid for providing services to Medicare patients. This law was enacted to replace the Sustainable Growth Rate ("SGR") formula. MACRA replaces the SGR with incentives for physicians to participate in Alternative Payment Models ("APMs") such as ACOs. For example, physicians participating in a qualifying Medicare ACO will automatically receive compensation increases. These APMs aim to move physician payment from a fee-for-service model, which is employed currently, to a payment mechanism that more appropriately pays for value as opposed to rewarding only volume. Starting in 2019, those who do not participate in APMs will be subject to value payment adjustments under a new Merit-Based Incentive Payment System ("MIPS"). So even if you do nothing, you will be moved to a value payment model, but if you participate in a qualifying ACO, you receive compensation increases.

Although Medicare is only one payer, previous trends have proven that ultimately, when the Centers for Medicare and Medicaid Services (CMS) make changes to payment policies, often many other private payers and Medicaid agencies also follow suit. The result of the passage of MACRA will accelerate changes to physician payment and care delivery currently underway.

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

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.

The Interplay of Quality, Risk, Outcomes and Value – While the term quality and value are often used together to describe the outcome of a successful ACO, as noted by the TAC workgroup they should not be seen as interchangeable and truly innovative care requires considerations of both quality and value. For example, high quality care is achieved when we squeeze out the unjustified variability against evidence-based best practice care and provide team-based coordinated care of particularly complex patients, including involving and educating the family and the patient to have a mastery understanding, or at least accept responsibility for their own care. Additionally, those actions are going to deliver value, i.e. highest quality at the lowest cost. What undermines value is redundancy of testing, errors, readmissions and inappropriate referrals of patients, who become mismanaged and drop through the cracks.

3. The heart and soul of ACOs is providing the highest quality of care with attention to value, one can throw a CAT scan or an MRI at everythingor, in the case of rheumatoid arthritis, use high-cost biologics instead of considering triple therapy that would likely ensure high quality, maybe ultimate high quality. That would not be value, however, and no health care system could be sustained by that behavior. An overarching goal for providers, as well as every other stakeholder, must be improving value for patients, where value is defined as the health outcomes that matter to patients are achieved relative to the cost of achieving those outcomes. Improving value requires either improving one or more outcomes without raising costs or lowering costs without compromising outcomes or both.[3]

A measure of outcomes that has been quietly emerging since the passage of the Patient Protection and Affordable Care Act ("ACA") is the risk adjustment model known as the Hierarchical Condition Categories ("HCC"). The HCC model, which has been the basis for reimbursement for Medicare Advantage plans since 2004, uses data to prospectively estimate predicted costs for enrolled members during the next year of coverage. The model is now being used, in part, for reimbursement for ACOs. In ACOs, providers are assuming risk by virtue of recording health status for their patients. Providers

[3] Porter, Michael E., and Thomas H. Lee, M.D. "The Strategy That Will Fix Health Care." *Harvard Business Review* (October 2013). Web. 23 May 2016. <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care#article-top>.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

and ACOs participating in risk adjusted markets need to be aware of the impact of appropriate documentation and coding to determining the impact of their productivity and effectiveness in creating reimbursable value.[4] The HCC model is just one example of practicing medicine in the new risk adjustment environment. Understanding and being prepared to provide a multi-faceted approach is necessary to ensure success.

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, besides the obvious "deal killer" of no or inadequate financial incentives, 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 so far 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."**[5] Culture keys are: champions, governance and merit-incentives.

---

[4] http://www.icd10monitor.com/enews/item/1072-what-you-need-to-know-about-hierarchical-condition-categories-and-icd-10

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

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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 sub-specialty 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.

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 are 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" [6] The incentive must not only be proportional to the effort, it must be substantial enough to warrant the additional effort. 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. Early learnings from value-based care models reveal it is not enough to focus solely on provider incentives to drive appropriate utilization. Plan design changes on the patient and payer side also must align members with the desired quality and value objectives.

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

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.

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 essentials to ACO success for this reason. The patient who has not self-referred to your office but should is more important to population health management than the one who has. 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. In lieu of a face-to-face visit, sufficient patient contact, feedback, or collection of health status information might be more efficiently obtained through such things as telephone calls, emails or telehealth technologies.

8. Scale-Sufficient Patient Population – There are certain frontend investments and ongoing fixed costs requiring a minimum scale of patient population to succeed. Medicare' 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 all stakeholders motivated to achieve their optimum value-added contributions to the enterprise, these principles transcend medical specialty, employment status, payer relationship or facility type. They apply to you whether you are a primary care physician, hospital CEO, community nonprofit or specialist physician. 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 ACOs.

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

In *The Physician's Accountable Care Toolkit*©, we learned what an ACO is, that it will not be going

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

away, and how to know if one stands to be successful. But what, specifically, will this mean for rheumatologists?

We recognize that there are various models for rheumatology practices. As a result, the recommendations that follow may not be applicable to all organizations. The recommendations are merely a starting point and reflect strategies that may be modified and adapted based on variables such as geographic location, provider team make-up and breadth of service offerings.

A. Cons

- Rheumatologists are working very hard and have run out of spare intellectual bandwidth to take on these changes.

- Busy practicing rheumatologists do not want additional demands on their time.

- In an ACO, financial risk may be transferred from health plans and payers to providers who are fiscally responsible for the entire continuum of care for their patients.

- It will be difficult for physicians to give up independence and be interdependent with other physicians and hospitals.

- There is a real fear among rheumatologists and other cognitive specialists, who primarily provide evaluation and management services, that they'll be left on the side of the road.[7]

- It costs money to create an ACO; rheumatologists don't have "war chests;" the only payment, shared savings, takes 18 months; and many ACOs don't get any payment.

- Inability of an ACO to validate, through shared savings methodologies, appropriate remuneration for rheumatologist participation.

B. Pros

- Rheumatologists are well-positioned to drive significant outcome improvements and reduce population costs in accountable care.

- Rheumatologists are experienced in managing complex disorders that cost the system a lot of money.

[7] http://www.the-rheumatologist.org/article/what-you-need-to-know-about-acos/

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

- Now is the time to make sure rheumatologists are playing a significant role, because ACOs are on the verge of becoming mainstream.

- Opportunity to qualify for incentive payments under the Advanced Alternative Payment Model, and access to the tools needed to perform successfully within the Merit Incentive Payment System implemented under MACRA.

- Venue for increased communication with primary care providers to develop care pathways and referral protocols that can ensure patients are seen in the appropriate setting.

- The ability to access and utilize an ACO's electronic data registry places rheumatologists in position to be an ACO's early warning system and care coordinators, especially for patients with rheumatoid arthritis.

- Opportunity for increased referrals from a competitively selective network of participating primary care physician members who know of and have witnessed your commitment to quality and value.

- Opportunity to continue to improve care for each individual patient while benefiting the patient population as a whole. In an ACO, the biggest impact you may have is on a patient you never personally see.

- Many rheumatologists will find the greatest positives of a well-organized ACO, such as improved communication and coordination of care among physicians on behalf of and with patients, are already components of rheumatic care and treatment models.

- As with all physicians who have been heroically battling a deeply fragmented system to provide cost-effective care, rheumatologists will find rewarding a model designed to truly gauge and value their contributions to health care, show respect for what they have been attempting to do and validate why they chose health care as a profession.

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

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

costs for a patient population over a given period of time, often one to three years. 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
- Chronic care management
- Reduced hospitalizations
- Care and transitions
- Multi-specialty coordination of complex patients

From these potential initiatives, prioritize the ones which are likely to have the quickest and biggest results, proven metrics and leaders within the specialty willing to champion the effort. What is working elsewhere? This should reveal for the specialty its potential prioritized list of value-add ACO initiatives.

Interventions work…but it may take time.

	Activity	Expected Impact	Time to Impact
Effects Within Months	Transitions of care management	Reduce readmissions	3 months
	Case management for high-risk patients with targeted conditions: diabetes, heart failure, COPD	Reduce primary admissions and ED	3-6 months
	Case management for other high-risk patients	Reduce primary admissions and ED	6-12 months
	Pharmacy management	Increase generic use	6-12 months
Effects Within 1-2 Years	Nursing home management	Reduce readmissions/primary admissions	12-18 months
	More efficient specialists and ancillary providers	Decrease cost per episode of care	12-18 months
	High-end imaging	Reduce unnecessary testing	12-18 months
Effects Within 3-5+ Years	Interventions for low-risk chronic disease patients: disease registries, chronic disease care optimization	Improved control; avoid complications	2-5 years
	Preventive care; screening; lifestyle change; wellness	Earlier identification and treatment; decrease incidence of chronic diseases	2-5+ years

Source: Geisinger

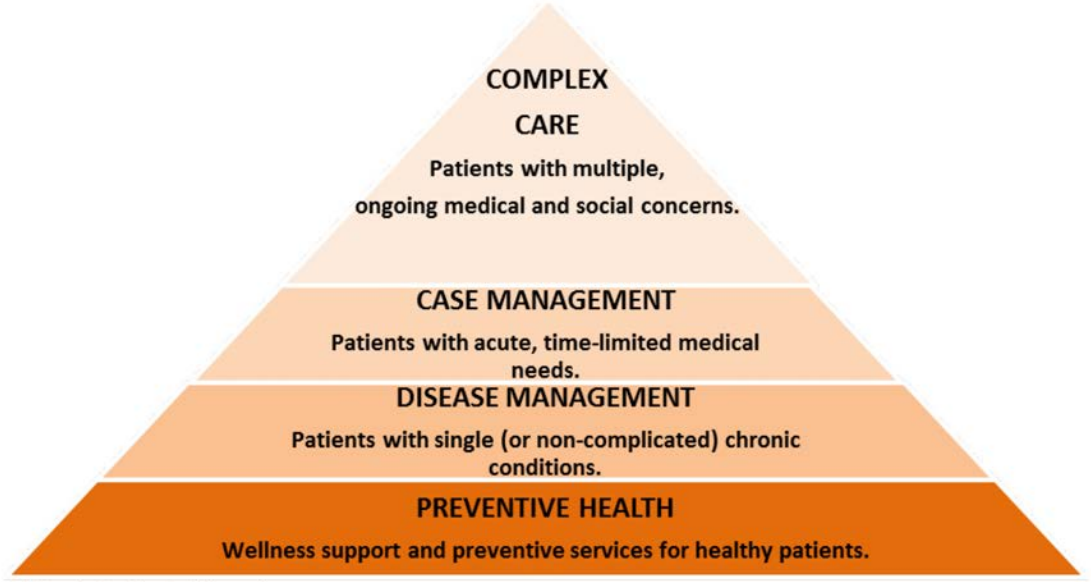
©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.

Unlike in fee-for-service, where the patient of your concern was the one who made an appointment, your concerns now are all the patients attributed to you in your ACO's defined patient population(s). That population should be evaluated and stratified according to diagnosis and severity. As the graphic below illustrates, separate ACO strategies unfold for each category of patient.



California Quality Collaborative

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

A group of rheumatology leaders saw the need to prepare a practical ACO Guide specifically designed for use by the practicing rheumatologist. They associated with the Toward Accountable Care Consortium (TAC) and Initiative and convened an introductory meeting to overview goals and development steps, and to review the preliminary value-add strategies raised for consideration based on research by the

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

TAC support team. Potential initiatives underwent further review by the Accountable Care Workgroup, with the TAC support team directed to perform more in-depth analysis of select possible target areas. These findings were further reviewed and revised by the Rheumatology Accountable Care Workgroup, and presented to the TAC Physician Advisory Committee. Macro predictive cost savings estimates were made, but a refined financial predictive modeling analysis, though needed, is beyond the scope of this project. Likewise, while guidance on the nature and type of performance metric selection is provided, the actual full mapping of those metrics is beyond the scope of this project. The researchers and physician peer reviewers are comfortable that this represents a useful start in this important and rapidly evolving field. This *Guide* is a beginning, not an end, to the process.

V. Recommended Accountable Care Initiatives For Rheumatologists

With guidance from the Rheumatology Accountable Care Workgroup, the TAC staff engaged in national-level research and investigation of activities to determine the highest value-adding initiatives involving rheumatology. The prioritization methodology in Section III was followed.

A. Mutual Benefit of Collaborative

Primary care providers (PCPs) play a pivotal role in the management of rheumatoid arthritis (RA). Active PCP involvement through early diagnosis of RA and ongoing monitoring of RA patients is crucial to achieving successful outcomes. If treatment is not initiated in the early stages of the disease, many RA patients develop disabilities that compromise their ability to perform activities related to daily living. Appropriate application of disease-modifying therapy, provided by rheumatologists, can reduce that potential for disability by more than 60 percent.[8]

Early diagnosis and initiation of therapy with disease-modifying antirheumatic drugs ("DMARDs") are essential to achieving optimal clinical outcomes, a fact that gives primary care providers ("PCPs") a critical role to play in minimizing the impact of RA. Because they are likely to see patients at the first stages of symptom development, PCPs are in the best position to recognize RA in its earliest stages and refer patients to a rheumatologist for confirmation of the diagnosis and initiation of DMARD therapy. Patients who receive early treatment experience significant improvement in quality of life, a reduction in work disability, and a slowing in the progression of joint damage. One study found many PCPs are uncomfortable managing RA with DMARDs.[9] Lack of accessibility to rheumatologists and discomfort in prescribing DMARDs for patients with RA are potential barriers to optimal treatment. The role of a rheumatologist in value-based care is critical and essential. Once a patient has been diagnosed with RA

[8] Kosinski M, Kujawski SC, Martin R, et al. Health-related quality of life in early rheumatoid arthritis: impact of disease and treatment response. *Am J Manag Care.* 2002; 8:231-240.

[9] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3334638/.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

and placed on a treatment regimen, it is important that all health care providers involved in the patient's care schedule regular follow-up visits to monitor disease progression, adverse events and changes in the patient's general health. The role of the PCP in monitoring a patient with RA includes obtaining regular laboratory tests, monitoring for infections and conducting routine screening for malignancies.

RA is a complex disease that requires cooperation between the PCP and rheumatologist to minimize the effect of the disease on a patient's quality of life and overall health status. The best practices for the management of RA include:

- Early provisional diagnosis of RA by PCPs
- Early rheumatology referral to enhance the early and accurate diagnosis of RA and early initiation of DMARD therapy
- Collaboration and co-management of RA patients by PCPs and rheumatologists
- Improved monitoring of RA to screen for cardiovascular disease, malignancy and infection
- Appropriate vaccination of RA patients to reduce the risk of infection.[10]

Primary care physicians will be the gatekeepers, so establishing relationships with them is important. Given the type of medicine rheumatologists practice, not everyone knows when and how to best use these specialists, ACO decision makers need an education on the value they can provide.[11] Purposeful collaboration for the management of complex rheumatology patient care can and should extend beyond the relationship with the primary care physician. For example, as noted by a member of the TAC Physician Advisory Committee, the aspects of caring for a patient with chronic rheumatoid arthritis, include consideration of integrated behavioral health strategies, an understanding of community resources available for services such as transportation, and a consideration of integrated clinical pharmacy for patients on a large number of expensive medicines, noting the impact of high deductible health plans on the use and access to high-cost biological drugs

B. Rheumatologists Bring Built-In Efficiency

Dr. James Dwyer, who has been co-chair of the National Committee for Quality Health Care (NCQHC) Performance Measurement Tools Task Force since 2004, says that "rheumatologists are very efficient in the way that they care for patients with complex rheumatic disease. To the extent that efficiency is an important part of an ACO, then partnerships between primary care physicians and rheumatologists is beneficial to both specialties. There are many opportunities for rheumatologists to be involved in the care of their patients and to partner with primary care physicians to improve efficiency and coordination

[10] Primary Care Management of Rheumatoid Arthritis: Making the Diagnosis and Optimizing Outcomes. Weinblatt, M. and Collins, L. *Primary Care Management of Rheumatoid Arthritis: Making the Diagnosis and Optimizing Outcomes* [PDF document]. Retrieved from http://jeffline.jefferson.edu/jeffcme/rapid/pdfs/Rapid_Monograph.pdf

[11] www.the-rheumatologist.org/article/what-you-need-to-know-about-acos/ .

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

of care." One study, for example, revealed that pre-appointment screening by a rheumatologist of patients referred to a rheumatology clinic found that only 60 percent of patients actually needed to see the specialist, highlighting another way that care by rheumatologists can be cost effective and efficient.

In a 2000 study that included nearly 5,000 person-years of follow-up in patients with rheumatoid arthritis, care that included specialists was associated with higher quality. Several studies have revealed that primary care physicians over-utilize imaging studies, such as MRIs, in patients with acute back pain, and that rheumatologists are more efficient with these modalities. In one study, care delivered to rheumatoid arthritis patients by rheumatologists was not more expensive than care provided by primary care specialists largely because more lab testing was performed in primary care. [12]

C. Bundled payments

ACOs may want to bundle payments around musculoskeletal conditions that rheumatologists manage, including back pain and knee or hip replacement. These are particularly important conditions for study in the ACO debate, because they hit both the commercial insurance populations and Medicare populations at high rates, and "they're one of the biggest spends," according to Dr. Rodney Hochman. "How are you going to leverage your expertise in these conditions? Rheumatologists are uniquely positioned to be the manager of how that bundled health care dollar should be split," Dr. Hochman says. He adds that physicians working in health care systems like the Cleveland Clinic, for example, may have an advantage because their organizations already understand the value provided by their rheumatologists when it comes to care for patients with back pain and joint replacement. [13]

D. Use of Best Practices

While there are multiple resources that provide clinically developed and proven best practice guidelines, one example of a useful source of core best practices may be found in the recommendations of the American College of Rheumatology to the Choosing Wisely® program sponsored by the ABIM Foundation and is included below:

1. "Don't test ANA subserologies without a positive ANA and clinical suspicion of immune-mediated disease. Tests for anti-nuclear antibody (ANA) sub-serologies (including antibodies to double-stranded DNA, Smith, RNP, SSA, SSB, Scl-70, centromere) are usually negative if the ANA is negative. Exceptions include anti-Jo1, which can be positive in some forms of myositis, or occasionally, anti-SSA, in the setting of lupus or Sjögren's syndrome. Broad testing of autoantibodies should be avoided; instead the choice of autoantibodies should be guided by the specific disease under consideration.

[12] *Id.*

[13] *Id.*

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

2. Don't test for Lyme disease as a cause of musculoskeletal symptoms without an exposure history and appropriate exam findings. The musculoskeletal manifestations of Lyme disease include brief attacks of arthralgia or intermittent or persistent episodes of arthritis in one or a few large joints at a time, especially the knee. Lyme testing in the absence of these features increases the likelihood of false positive results and may lead to unnecessary follow-up and therapy. Diffuse arthralgias, myalgias or fibromyalgia alone are not criteria for musculoskeletal Lyme disease.

3. Don't perform MRI of the peripheral joints to routinely monitor inflammatory arthritis. Data evaluating MRI for the diagnosis and prognosis of rheumatoid arthritis are currently inadequate to justify widespread use of this technology for these purposes in clinical practice. Although bone edema assessed by MRI on a single occasion may be predictive of progression in certain RA populations, using MRI routinely is not cost-effective compared with the current standard of care, which includes clinical disease activity assessments and plain film radiography.

4. Don't prescribe biologics for rheumatoid arthritis before a trial of methotrexate (or other conventional non-biologic DMARDs). High quality evidence suggests that methotrexate and other conventional non-biologic disease modifying antirheumatic drugs (DMARD) are effective in many patients with rheumatoid arthritis (RA). Initial therapy for RA should be a conventional non-biologic DMARDs unless these are contraindicated. If a patient has had an inadequate response to methotrexate with or without other non-biologic DMARDs during an initial 3-month trial, then biologic therapy can be considered. Exceptions include patients with high disease activity and poor prognostic features (functional limitations, disease outside the joints, seropositivity or bony damage), where biologic therapy may be appropriate first-line treatment.

5. Don't routinely repeat DXA scans more often than once every two years. Initial screening for osteoporosis should be performed according to National Osteoporosis Foundation recommendations. The optimal interval for repeating Dual-energy X-ray Absorptiometry (DXA) scans is uncertain, but because changes in bone density over short intervals are often smaller than the measurement error of most DXA scanners, frequent testing (e.g., <2 years) is unnecessary in most patients. Even in high-risk patients receiving drug therapy for osteoporosis, DXA changes do not always correlate with probability of fracture. Therefore, DXAs should only be repeated if the result will influence clinical management or if rapid changes in bone density are expected. Recent evidence also suggests that healthy women age 67 and older with normal bone mass may not need additional DXA testing for up to ten years provided osteoporosis risk factors do not significantly change."[14]

[14] http://www.choosingwisely.org/societies/american-college-of-rheumatology/.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

E. Optimize Site-of-Service

Providers are encouraged to seek to move procedures to lower-cost facilities or outpatient sites when consistent with best practices. Particular opportunity exists for providing alternatives to the Emergency Department, which has a pronounced patient engagement aspect, discussed below. For example, when a patient presents at an Emergency Department with pain associated with Rheumatoid Arthritis, the patient will likely need to undergo a series of expensive tests to rule out a variety of causes. However, if seen in the rheumatologist's office, the specialized expertise of the clinician can rule out certain conditions and thereby reduce the number of tests that may need to be completed. One way this can be accomplished is by offering after-hours access for patients to avoid potentially unnecessary Emergency Department use. Additionally, rheumatologists should focus on avoidance of expensive in-hospital procedures when the same procedure can be done in a less expensive setting with the same or better quality outcomes, such as a physician's office or Ambulatory Surgical Center. Practice based infusion therapy is typically less expensive than when performed in a hospital outpatient facility.

F. Participation in National Clinical Data Registry

Rheumatologists may find value in participating in their national Clinical Data Registry, RISE[15]. The Rheumatology Informatics System for Effectiveness (RISE) registry provides enhanced quality improvement capabilities by directly extracting data from the rheumatologist's EHR; providers without an EHR also may participate in the Rheumatology Clinical Registry. These registries support practice improvement, local population management and participation in national quality programs. Additionally the registries provide access to performance improvement tools, benchmarking, statistical analysis and evidenced-based medicine support, and help rheumatologists identify gaps in care to improve on and also includes longitudinal data analysis.

G. Drug Management

Use of best practices and effectiveness evidence in determining the best drug for treatment may lead to cost reductions. Biologics are expensive but vitally important therapeutic options for patients with rheumatic diseases. Given their effectiveness and potential to reduce long-term disability, patients should have affordable access to biologic therapy without undue delay[16]. Unfortunately, there is a lack of pricing transparency in the eyes of the patients, providers and the public. Pricing differences between companies or plans are not based on clinical decision making or standards of practice and are subject to change with tremendous frequency. A major component of value-based care requires the physician to have knowledge of the actual cost to pursue a cost-effective result that does not undermine the important clinical considerations and decisions made by patients and their doctors when choosing a biologic.

[15] http://www.rheumatology.org/I-Am-A/Rheumatologist/Registries/RISE.

[16] American College Rheumatology Position Statement on Patient Access to Biologics found at www.rheumatology.org/Portals/0/Files/Patient Access to Biologics aka Model Biologics.pdf.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

H. Use of Telehealth

With the onset of a multitude of telehealth technology options entering the market, rheumatologists may find the use of telehealth technology increases access to care and improves the patient experience. Clinical lives are already complex and demanding, and technology is often seen as an intrusion. Additionally, the ability to integrate telemedicine into a specialty largely dependent on touch is a central question. [17] [18]

What started out as a way to bring specialty medicine to rural areas around 40 years ago has evolved from sharing imaging and laboratory results to seeing and interacting with patients remotely. Telemedicine is beginning to evolve from its traditional urban–rural linkage, and rheumatologists are following along.[19] Telemedicine can be utilized in multiple areas of rheumatologic care such as following up with patients who have rheumatoid arthritis, discussing diagnostic challenges with multiple joint involvement, facilitating discussion involving orthopaedists, nurse practitioners, and other rheumatologists with respect to difficult-to-manage cases.[20]

Most telemedicine projects work around this concern by having a "presenter" with the patient. Usually a specially trained RN, LPN or medical assistant, the presenter gets the person checked in, obtains vital signs and asks about any concerns or complaints. They also help with assessing such things as range of motion, tenderness or warmth of joints, locating rashes, evaluating muscle strength, etc. According to one study, even the most clinical exam–dependent subspecialties can do this if they do it with the right infrastructure. It is a good example of how broad the reach of telemedicine can be. It is very empowering for patients, many of whom are challenged physically, economically, or because of time and distance by getting to major medical centers—.[21] A big problem in rheumatology is access. One of the best uses for telemedicine can be opening up opportunities for specialist treatment for patients who have not had it before. Telemedicine helps reduce, and, to some extent, eliminate the number of patients who are lost to follow-up. "At our center, about 40 percent of patients at remote sites with no specialists available would forego treatment if they [had to travel] more than two hours," says Dr. Rohit Aggarwal. "Patients are not getting top-quality care. We can expand the reach of the rheumatologist using telemedicine."[22] Telemedicine dramatically increases the ability to care for more patients.

---

[17] *Telemedicine in Rheumatology*, Steven Edworthy, MD. The Journal of the Canadian Rheumatology Association, Winter 2003/06; accessed at https://search.yahoo.com/yhs/search?p=Telemedicine+in+Rheumatology.+Steven+Edworthy%2C+MD.+The+Journal+of+the+Canadian+Rheumatology+Association.&ei=UTF-8&hspart=mozilla&hsimp=yhs-001.

[18] *Does Telemedicine Work in "Hands-on" Specialties?* Bret S. Stetka, MD; Daniel L. Albert, MD, December 03, 2014; accessed at http://www.medscape.com/viewarticles/835667.

[19] *Rheumatologists Expand Reach Through Telemedicine*, Kurt Ullman. May 15, 2015; accessed at http://www.the-rheumatologist.org/article/rheumatologists-expand-reach-through-telemedicine/.

[20] *Telemedicine in Rheumatology*, Steven Edworthy, MD. The Journal of the Canadian Rheumatology Association, Winter 2003/06; accessed at https://search.yahoo.com/yhs/search?p=Telemedicine+in+Rheumatology.+Steven+Edworthy%2C+MD.+The+Journal+of+the+Canadian+Rheumatology+Association.&ei=UTF-8&hspart=mozilla&hsimp=yhs-001.

[21] *Does Telemedicine Work in "Hands-on' Specialties?* Bret S. Stetka, MD; Daniel L. Albert, MD. December 03, 2014 accessed at http://www.medscape.com/viewarticles/835667.

[22] Rheumatologists Expand Reach Through Telemedicine. Kurt Ullman. May 15, 2015 accessed at http://www.the-rheumatologist.org/article/rheumatologists-expand-reach-through-telemedicine/.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

I. Prevention

Rheumatologists can be a critical part of the care team working on patient education and prevention such as urging patients to quit smoking. Smoking is the best-studied environmental factor involved in the development of RA. One early study found that among patients positive for rheumatoid factor (RF), those who smoked were at a greater risk of developing RA if they had HLA-DR shared epitope genes.[23]

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 rheumatologist find the right ACO partner, mesh these initiatives into programming, and be rewarded fairly?

A. Pick the Right ACO(s)

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

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

- Physician-Led – Longstanding habits of individualism and competition among 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 procedures will lower incomes.

- Hospital-Led – Hospitals need to shift 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.

Twelve questions to ask before signing up with an ACO:

a. Is it selective in picking and keeping only high-performing members; or are they signing up everybody to get "old school" referrals?

b. What is its specific value-add strategic plan?

[23] Padyulov L, Silva C, Stolt P, et al. A gene=environment interaction between smoking and shared epitope genesin HLA-DR provides a high risk of seropositive rheumatoid arthritis. *Arthritis Rheum*. 2004;50:3085-3092.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

c. What are the opportunities identified in its needs assessment?

d. Do they include my skillsets?

e. How will it distribute savings?

f. Is it on a merit basis—savings distribution in proportion to contribution?

g. Is the ACO exclusive—can I join another ACO?

h. Are there fees?

i. Am I personally at risk?

j. Have you spent millions on IT—may I see its budget? Will there be anything left of savings distributions after feeding the overhead??

k. Does it have knowledgeable and empowered providers on the clinical, IT and finance committees?

l. What is its community health partnering strategy?

Remember, even if a rheumatologist 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 presents different strengths and weaknesses. Available ACO options will, of course, be different in metropolitan and rural settings. The presence or absence of rheumatologists affects ACO partnering options.

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

1. Build Relationships – Rheumatologists 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 rheumatologists are ideally suited for ACOs. 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 her company in the length of the time it takes to ride an elevator. Rheumatologists 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. Good calling cards to open an

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

ACO discussion are: Your ability to drive so many of the MSSP's metrics and the fact that MSSP ACO patients are attributed only to patients of designated primary care subspecialties, of which internal medicine is one.

3. Primary Care Is the Client – In the new era, success will depend on the patient-centered medical home and neighborhood. Though primary care in some cases has lost its decision-making authority to health systems, payers and large clinics, at the end of the day, primary care is 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.

Strategic Note: You might approach the ACO with the two top initiatives from Section V. Show how they would match an ACO's identified gaps in care, that you have good metrics, and that you have done a financial projection showing savings that would occur for the ACO's patient population. Show you have enlisted champions and have worked out the mechanics and processes. It's a simple "plug and play" for the ACO, with higher quality, provider engagement and added net dollars to the savings pool after the merit-based distribution to you.

VII. What Are The Relevant Metrics?

A. The Basic Categories and Sources

You will need baseline data, of course, to create comparison points 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.*, decreasing Emergency Department utilization by measuring this for each physician and specialty), 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 your own specialty society are other important sources of validated evidence based measures. Thinking of ACO common interests will be helpful in decisions about metrics for your specialty. For example, in addition to metrics specific to rheumatologists, think about those that are also important to the ACO (*e.g.*, the MSSP quality measures, utilization or cost saving indicators) your hospital partner (Joint Commission measures) and payers.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

B. Examples of Possible Rheumatology Performance Measures

Rheumatologists can consult the 23 measures for rheumatology that can be captured from your electronic health record (EHR) through the RISE Registry. All 23 have been peer group benchmarks, some have CMS benchmarks and all are regular PQRS/CQM measures:

- RISE 01 - Disease Activity Measurement for patients with RA
- RISE 02 – Functional status assessment for patients with RA
- RISE 03 – DMARD therapy for active RA
- RISE 04 – TB testing prior to first course biologic therapy
- RISE 05 – Screening or therapy for osteoporosis for women aged 65 and older
- RISE 06 - Glucocorticosteroids and other secondary causes
- RISE 07 – Pharmacologic therapy for men and women aged 50 and older (dx of osteoporosis)
- RISE 08 – Management following fracture of hip, spine or distal radius for men and women aged 50 and older (looks for DXA or Rx)
- RISE 09 – Communication with the physician managing ongoing care post fracture of hip, spine or distal radius for men and women aged 50 and older
- RISE 10 – Use of imaging studies for low back pain (measurement for NO imaging within 28 days of diagnosis of low back pain)
- RISE 11 – Preventive care and screening: Tobacco use screening and cessation counseling
- RISE 12 - Documentation of current medications in the medical record
- RISE 13 – Use of high risk medications in the elderly (Rx one high risk med)
- RISE 13B – Use of high risk medications in the elderly (Rx at least 2 high risk meds)
- RISE 14 - Controlling high blood pressure
- RISE 15 – Preventive care and screening: BMI screening and follow up plan
- RISE 16 – Pain assessment and follow up
- RISE 17 – Preventive care and screening: Influenza immunization
- RISE 18 – Pneumonia vaccine status for older adults
- RISE 19 – Functional deficit: Change in risk adjusted functional status for patients with elbow, wrist or hand impairment

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

- RISE 20 – Gout: Serum urate monitoring
- RISE 21 – Gout: Serum Urate Target
- RISE 22 – Gout: ULT therapy
- RISE 23 – Functional deficit: Change in risk-adjusted functional status for patients with hip impairment.

C. Examples of Changes in Quality of Life Metrics to Measure Patient Satisfaction:

- How many days patients are out of work
- How soon can they return
- Patient satisfaction in pain management

VIII. I SEE THAT THE ROLE OF GOOD DATA IS HUGE, BUT HOW DO I GET IT?

You have got to have meaningful, actionable data. Let's be careful about the scope of data needed. Health status is primarily influenced by nonmedical factors such as stress at home, education, jobs (or lack thereof) and other social determinants. The *Brookings Guide* provides the following overview of data sources to consider:

SOURCE	ADVANTAGES	DISADVANTAGES
Claims Data	• Important starting point since ACO is measured on costs/patient at end of year. • Information includes diagnoses, admissions, visits to the ED and outpatient providers, diagnostic tests, and procedures.	• 30-60-day lag time between a clinical encounter and receipt of the claims report. • Only as accurate as the claims that are submitted by providers; depends on appropriate coding.
Clinical Data	• Medical records contain valuable data such as provider notes, lab results, vital signs, and medication lists that can help to risk-stratify patients.	• Data must be tagged into discrete fields to allow for sorting and analysis. • Analysis can be difficult for ACOs that do not have a single, comprehensive EHR.
Providers	• Clinicians with longstanding relationships with patients can provide intangible information that can help identify those at high risk.	• Lack of literature on physicians' ability to identify patients at high risk of future health care utilization.
Patient-Reported Data	• Research shows that patient reported outcomes and patient engagement metrics correlate with utilization and cost. • Many metrics freely available, including those for specific diseases.	• Can be time-consuming to collect and measure these metrics from patients. • Patients may lack confidence/trust to accurately respond to survey questions.

[24]

[24] *Id.*

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

Where are your patients generating costs? How does this compare by provider and Zip Code? Clinical intuition is a powerful tool. For example, one of the best ways to find out which patients will be high-risk is asking the internist or other primary care physician which patients are at highest risk of being admitted to the ED or hospital in the next six months.

The most recent MSSP proposed regulations emphasize the use of health information technology to collect, sort, analyze, and stratify relevant data. No one method will perfectly identify the disease status of patients, but many different approaches work reasonably well.

IX. 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 that such tactics will slow the transformational changes needed, sap motivation and ultimately challenge the competitive viability of the ACO altogether.

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.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

X. Protect your interests: Negotiation Tips

A. Negotiating with ACOs

Physicians may be asked to sign ACO participation agreements with an ACO. Although 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 that 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?

- 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?

- 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

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

interests by negotiating a merit-based shared savings distribution. However, both the ACO in its negotiations with commercial payers, and you, as its member depending on the results, need to know the agreement's hotspots.

- Prepare Before You Negotiate – A well-negotiated shared savings agreement merely creates the framework for providers to succeed. There must be a team committed to the shared savings principles who share a common culture of trust and willingness to be flexible and welcome changes. It is also important to know who are your accountable care partners. Your facility or practice group could be doing a great job, but the endeavor will fail if others do not provide the necessary quality and efficiency. You must match the strengths of your accountable care organization with any gaps in care for your target patient population and determine whether the predicted return on infrastructure investment will be positive. [25]

- Know Your Patient Population – The arrangement could start with one population and eventually expand. Since the premise of determining savings depends on comparing actual costs with the anticipated unmanaged costs of a defined population, it is crucial to know exactly who is in the patient pool to determine baseline historical spending.

- Understand How Patients Are Assigned to Physicians – The predominant shared savings model, the Medicare Shared Savings Program (MSSP), "attributes" patients to an ACO's primary care physicians based on where they receive a plurality of primary care services. Medicare patients have freedom of choice, so in some areas, there is problematic patient leakage that makes care management and financial forecasting difficult. While this may become the default assignment standard, it is preferable in agreements with private payers to have the patient assigned to the network and reflect this on a patient's enrollment card. It is important to determine how long patients must be enrolled before their performance measurements should occur.

- Identify Any Service Carve-Outs – Most arrangements cover the full range of services, which makes savings calculations much easier. However, sometimes pharmacy, mental health, organ transplants, dental, pediatric, out-of-area, emergency, catastrophic or untrackable services are carved out. It is possible that a specialty or type of service not provided within a network may be excluded.

- Strive to Achieve More Than Cost Savings – The goals and performance metrics are to uphold CMS' "Triple Aim" Vision—improved population health, enhanced patient satisfaction and decreased cost. Only if the hurdles of the first two are met are you eligible for shared savings.

[25] Portions reprinted with permission from The Advisory Board Company©.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

- Think Beyond Performance Metrics – Performing well on payers' list of metrics is the way to maximize reimbursement; however, it is not sufficient just to "teach the test". In order to succeed, an ACO needs to have the right infrastructure investments in place to deliver better quality and lower cost care for populations of patients. This includes investments in care management for engaging patients inside and outside of the health system, and information technology for tracking gaps in care and clinical outcomes over time. Metric selection should align with hospital initiatives to successfully redesign the delivery of care for patients and families. It is also prudent to standardize metrics across payers to the extent possible.

- Pin Down How Savings Are Determined – Although the concept is simple—the ACO gets a share of savings if it is able to do a good job at managing costs of the attributed population; carefully reviewing how savings will be determined is essential. For example, shared savings contracts may include downside risk to the provider if cost targets are not met, and it's important to consider your organization's appetite for financial risk before entering into such an agreement. It also is recommended not to focus solely on year-over-year performance. Accountable care is a marathon, not a sprint, and requires a dedicated commitment from leadership to transform into an effective population manager.

- Obtain Payer Support – Increasingly, payers are providing resources and support to fledgling ACOs to help achieve the goal of higher value care. Consider negotiating for such things as the following:

    - Data – Seek supplementary claims and other health and financial data. Payers sometimes offer database access, reporting tools and utilization, cost and other reports. ACOs cannot effectively assess where the waste is or how they are doing without access to this type of information.

    - Help with Patient-Centered Medical Homes ("PCMHs") – Payers often assist providers in establishing accredited PCMHs and provide enhanced fee-for-service or performance payments to support practice transformation.

    - Payer-supplied care coordination training.

    - Participation rights to roundtables and forums.

- Other Contract Considerations – A shared savings negotiation checklist also should include consideration of the following:

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

- Flexibility for the ACO to localize the most appropriate value-adding programs;
- Description of duties of payer and providers;
- Description of the association of shared savings with fee-for-service payments;
- Benefit design and co-pays to facilitate achieving your care management goals; and
- Marketing and steerage—will your organization be in a "narrow network?"

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 quite seriously. There are opportunities for professional and financial reward for the informed rheumatologist. 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. Rheumatologists have skills and experience that position them to lead in the success of ACOs, but this is not yet widely recognized within the medical community. To make sure a fair and sustainable ACO model becomes reality, it is important for rheumatologists 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 rheumatologists in accountable care, to assist them in avoiding the pitfalls, and to help them develop accountable care strategies for rheumatologists in different settings. For further information, contact the TAC Consortium and Initiative lead liaison, Melanie Phelps, at either mphelps@ncmedsoc.org or 919-833-3836, or its lead researcher and drafter, Bo Bobbitt, at either bbobbitt@smithlaw.com or 919-821-6612.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

Part Three: Executing the Accountable Care Strategic Plan

North Carolina Medical Society
Leadership in Medicine

THE PHYSICIANS FOUNDATION
Empowering Physicians Improving Healthcare

SMITH ANDERSON

Toward Accountable Care Consortium

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.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.**

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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.]

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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

F. 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.

G. 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

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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

I. 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.

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

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

L. 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.

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

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

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

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

Q. Ophthalmologists. Accountable Care Guide for Ophthalmolgists was developed by the Accountable Care Workgroup of the North Carolina Medical Society and TAC personnel.

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

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

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

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

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

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

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

X. Rural Health. Accountable Care Guide for Rural Health was developed by the Accountable Care Workgroup of the North Carolina Medical Society and TAC personnel.

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

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

ACKNOWLEDGMENT

continued next page

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.

©2016 Smith, Anderson, Blount, Dorsett, Mitchell & Jernigan, L.L.P.