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North Carolina Pediatric Society  
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# ACCOUNTABLE CARE GUIDE FOR PEDIATRIC CARE

Preparing Pediatric Care for the  
Approaching Accountable Care Era





## ACKNOWLEDGMENT

This strategic guide involved input through participation by many thought leaders of the following sponsoring organizations who have come together to form the Toward Accountable Care Consortium and Initiative (“TAC”). This paper would not have been possible without the generous support of all TAC member organizations, including significant support from the North Carolina Medical Society, as well as a substantial grant from The Physicians Foundation. Special thanks to the North Carolina Academy of Family Physicians and North Carolina Society of Anesthesiologists, whose seminal ACO white papers are the underpinning of this Toolkit. We are grateful to Julian D. (“Bo”) Bobbitt, Jr. of the Smith Anderson law firm, for compiling the information in this non-technical “blueprint” format, and to Sheri Bangura, legal intern and to the following physician members of the North Carolina Pediatric Society for their time and expertise: Margarete (Gretchen) Hoyle, MD, Novant Health Twin City Pediatrics; John Meier IV, MD, Wake Internal Medicine Consultants; John Rusher, MD, Raleigh Pediatric Associates; William (Pascal) Stewart, MD, Cornerstone Health Care; Alan Stiles, MD, UNC Health Care; Calvin Tomkins, MD, Asheville Pediatric Associates; Steve Wegner, MD, AccessCare; Steve Shore, North Carolina Pediatric Society; Docia Hickey, MD, Charlotte, NC, and Michael Cotten, MD, Duke University Health Systems. This guide would not have been possible without the efforts of these individuals.

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North Carolina Community Health Center Association  
North Carolina Foundation for Advanced Health Programs  
North Carolina Healthcare Quality Alliance  
North Carolina Medical Group Managers  
North Carolina Medical Society

## INTRODUCTION

This strategic guide involved input through participation by many thought leaders who have come together to form the Toward Accountable Care Consortium and Initiative (“TACC”). This paper would not have been possible without the generous support of all TACC member organizations, including significant support from the North Carolina Medical Society, as well as a substantial grant from The Physicians Foundation. We are grateful to Julian D. (“Bo”) Bobbitt, Jr. of the Smith Anderson law firm, who has many years of experience providing strategic counsel regarding integrated care, for compiling the information in this non-technical “blueprint” format.

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

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

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





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# The Physician's Accountable Care Toolkit

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



North Carolina  **Medical Society**  
*Leadership in Medicine*

 **THE PHYSICIANS FOUNDATION**  
Empowering Physicians  
Improving Healthcare

 **SMITH ANDERSON**

Toward  **Accountable Care Consortium**

# The Accountable Care Guide For Pediatric Care

## 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.<sup>1</sup>

## 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.”<sup>2</sup> 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.”<sup>3</sup> (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.

<sup>1</sup> 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.

<sup>2</sup> 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.

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

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Without grasping this shift, an understanding of ACOs will remain elusive. It also is important to note what is not in the definition. No definitions specify any particular type of legal entity (i.e., IPA, PHO, employed). There is no mandatory organizational form for an ACO.

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

## **B. PPACA Requirements**

ACOs eligible for the Medicaid Shared Savings Program under the Patient Protection and Affordable Care Act of 2010<sup>6</sup> 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.

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<sup>4</sup> 76 Fed. Reg. 67802 (Nov. 2, 2011)

<sup>5</sup> 76 Fed. Reg. 67974

<sup>6</sup> Section 3022 of the Patient Protection and Affordable Care Act of 2010 (amends Title XVIII of the Social Security Act (42 USC 1395 *et seq.*)).

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## C. How Is It Different From a Medical Home?

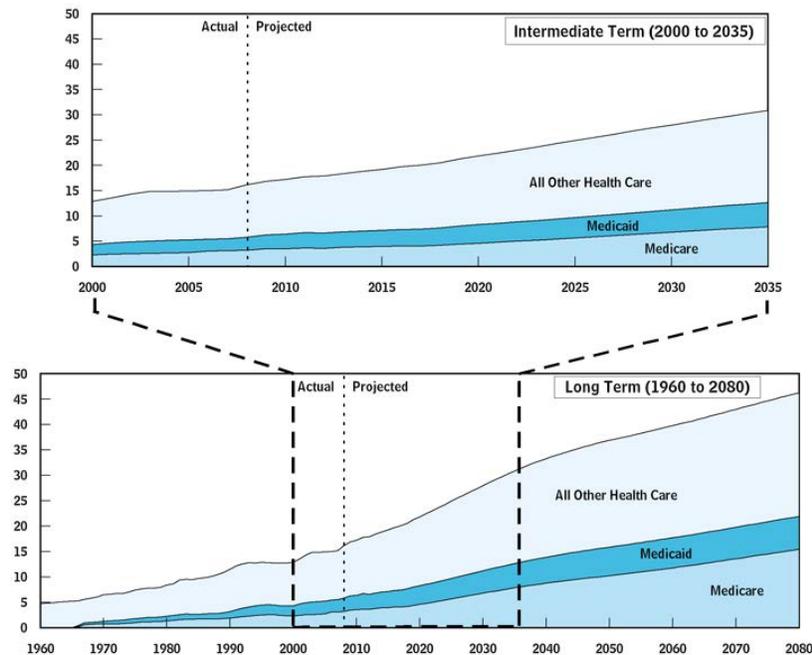
The Patient-Centered Medical Home (“Medical Home”) emphasizes strengthening and empowering primary care to coordinate care for patients across the continuum of care. It is complimentary to the ACO and can become the core of an ACO, but it is different in two main respects: (1) Financial Incentives -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

## III. Why Should I Care?

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

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



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



Article By Influential Writer Sparks Strong Debate

The Congressional Budget Office Report on the ACO’s predecessor, the Bonus-Eligible Organization, includes this rationale: “[P]roviders have a financial incentive to provide higher-intensity care in greater volume, which contributes to the fragmented delivery of care that currently exists.”

<sup>7</sup> Atul Gawande, *The Cost Conundrum*, *The New Yorker* (June 1, 2009)

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

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."<sup>9</sup> 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."<sup>10</sup>

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.

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<sup>8</sup> World Health Organization, *World Health Statistics* 2009.

<sup>9</sup> President Barack Obama, interview excerpt, July 23, 2009.

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

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In the shared savings only models, there is no downside risk. Second, vital administrative capabilities, data measurement capability, identified common metrics, severity adjustment, and electronic health information exchange sophistication were not present in the capitation era.

**Strategic Note:** Though many experts propose that newly-formed ACOs assume financial risk through financial penalties, or partial or whole capitation, the 15 years clinical integration experience of this author strongly suggests that ACOs TRY NOT TO ACCEPT DOWNSIDE RISK UNTIL THEY HAVE THREE CONSECUTIVE YEARS OF MEETING BUDGET ESTIMATES.<sup>11</sup> 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.”<sup>12</sup> 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.”<sup>13</sup>

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<sup>11</sup> 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.

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

<sup>13</sup> *Id.*

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## The Eight Essential Elements of a Successful ACO



### A. Essential Element No. 1: Culture of Teamwork – Integration



The most important element, yet the one most difficult to attain, is a team-oriented culture with a deeply-held shared commitment to reorganize care to achieve higher quality at lower cost. A fully-functional ACO will catalyze the transformation of health delivery. “While strong hospital-physician alignment has always been a cornerstone of success, the necessary degree of future collaboration, partnership, and risk-sharing will dwarf what has come before it. Hospitals and physicians will have to recognize, embrace, and leverage their growing interdependence to create organizational structures and incentive models that are strategically aligned and mutually rewarding.”<sup>14</sup>

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.

<sup>14</sup> *Toward Accountable Care*, The Advisory Board Company (2010).

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

**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.”<sup>16</sup>**

**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.”<sup>17</sup>
- **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.”<sup>18</sup> 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.

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<sup>15</sup> Phillip L. Roning, *Becoming Accountable*, HFMA Compendium—Contemplating the ACO Opportunity, Appendix (November 2010), p. 40.  
<sup>16</sup> *Id.*

<sup>17</sup> 76 Fed. Reg. 67974.

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

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- **“Spiral of Success.”** The following strategy could help meld team culture: An early pilot project for your ACO should be consistent with the new vision, led by champions and cut across specialty and department lines. A multi-disciplinary team decides how to collect and share data in new ways to facilitate this care initiative. The data, in paper or electronic format, is available at the point of care. Quality goes up and there is a savings pool. New team habits begin to emerge. Small scale is OK, but it must succeed, so the “spiral of success” can start. Trust goes up and buy-in for the next collaboration will occur more quickly.
- **Employment Not a Panacea.** Isn't the most obvious path to integration through hospital employment? This is a feasible approach if the parties have worked together in the past and there is a pre-existing level of trust and respect. This will not work if there are not shared goals and the control and financial incentive issues are not resolved. “Current trends in physician employment represent neither a necessary nor sufficient condition for true integration; value-added integration does not necessarily require large-scale physician employment and simply signing contracts does not ensure progress toward more effective care coordination.”<sup>19</sup>

## 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.”<sup>20</sup> 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.

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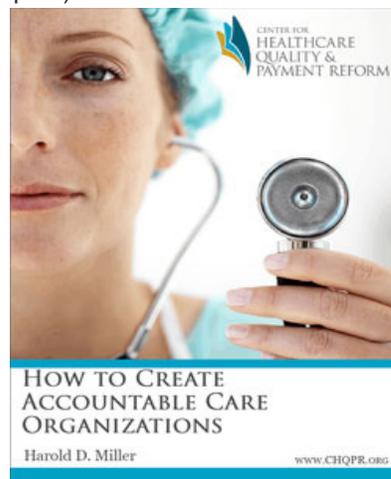
<sup>19</sup> *Toward Accountable Care*, The Advisory Board Company (2010).

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

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2. **What Are the Roles of Specialists In ACOs?** It is becoming clear that specialists are going to serve important roles in ACOs. Given the opportunities for ACOs listed in Section V.B.1. above, specialists should see roles in Medical Home coordination on diagnosis and treatment, transitions across settings, reducing avoidable hospitalizations, and in multi-specialty complex patient management. Inpatient specialists can tackle hospital through-put, minimizing avoidable adverse events and readmissions, and quality improvements. Specialists intent on preserving volume at the expense of best practices have no role in an ACO.

3. **What Are the Roles of Hospitals In ACOs?** Hospitals are logical ACO partners for several reasons: Patients will need hospitalization, hospitals have extensive administrative and HIT infrastructure, ACOs are consistent with their missions, and hospitals are often a medical community's natural organizational hub. But the typical ACOs tend to reduce hospitalizations. As Mr. Miller observes, "the interests of primary care physicians and hospitals in many communities will not only be unaligned, but will be in opposition to one another."<sup>21</sup> 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."<sup>22</sup>

<sup>21</sup> *Id.*, p. 15.

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

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## C. Essential Element No. 3: Adequate Administrative Capabilities



What Kind of Organization Can Be an ACO? The very label “accountable care organization” tends to convey an impression that an ACO must be a particular type of organization. In retrospect, it probably should have been called “Accountable Care System.” **It is about function, not form.** The NCQA’s ACO criteria look to core competencies and infrastructure to implement them, but are “agnostic to organizational structure (i.e., whether or not it is led by a multi-specialty group, hospital, or independent practice association).”<sup>23</sup> Similarly, a wide array of organizations may become eligible for CMS Shared Savings Program under PPACA and the Final Rule:<sup>24</sup> 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.”**<sup>25</sup>

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

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<sup>23</sup> NCQA, pp. 7-8.

<sup>24</sup> 76 Fed. Reg. 67975.

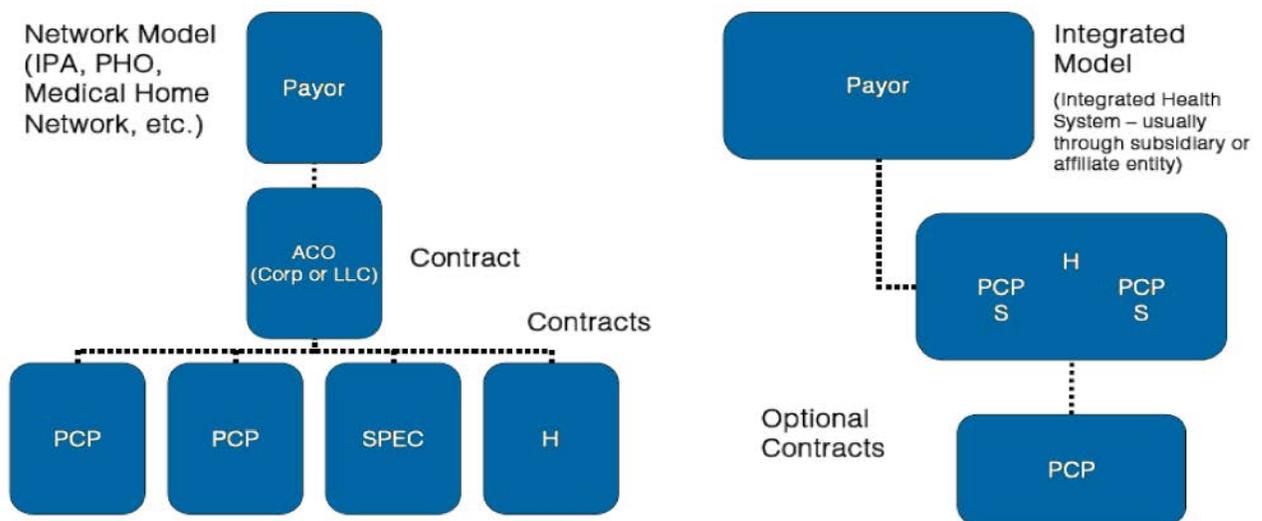
<sup>25</sup> Doug Hastings, Accountable Care News (December 2010), p. 6.

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

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

## Possible Organizational Forms



### 1. Network Model

a. **Independent Practice Associations (“IPAs”)** – An IPA is basically an umbrella legal entity, usually an LLC, for-profit corporation or nonprofit organization, with physician participation contracts with hospital-employed and independent physician practices. Payors contract with the IPA. These structures became familiar in the fee-for-service and capitation eras, and the form is still suitable for the accountable care era. However, the IPA now needs to have ACO-level infrastructure as described in this Guide. It is particularly dependent on robust health information exchange, as the continuum of care is more “virtual” because the providers are independent. The

# The Accountable Care Guide For Pediatric Care

participation agreements are different, too. The provider agrees to undertake the responsibilities agreed upon by the ACO and accept some type of performance-based incentive, like shared savings, in addition to fee-for-service. It can have any combination of specialists, primary care, hospital, and tertiary care participating contracts. An IPA is owned by physicians. Legal issues of note in IPAs involve antitrust, self-referral, insurance regulation, HIPAA, malpractice, and the Stark law.

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

c. **Medical Home-Centric Model** – Under this variation, an umbrella entity is owned by Medical Home practice members or networks. It contracts with payors, initially for the medical-home-related primary care services, but includes accountable care financial arrangements and performance measurement capabilities. It broadens the scope of initiatives and patient populations by adding select specialists and hospitals through contractual arrangements. These may be sub-ACO arrangements whereby the contract is with a PHO or hospital ACO. The same requirements and caveats of the other Network Model forms apply. Community Care of North Carolina is an example of a statewide confederation of 14 Medical Home-Centric Networks.

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

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



1. **Isn’t This the Same As Insurance?** No. An insurance company assumes the financial risk of whether a person gets ill or has an accident requiring medical care. Accountable care risk is accountability for higher performance treatment of patients once they become ill. This gets fuzzy when one remembers that the ACO will be responsible for an entire patient population, especially as it assumes more risk, as in full capitation. However, this distinction is why the ACO performance expectations need to be severity-adjusted.

2. **What Are the Types of Financial Incentive Models for ACOs?** There are three tiers: upside-bonus-only shared savings; a hybrid of limited-upside and limited-downside shared savings and penalty; and full-upside and full-downside capitation.

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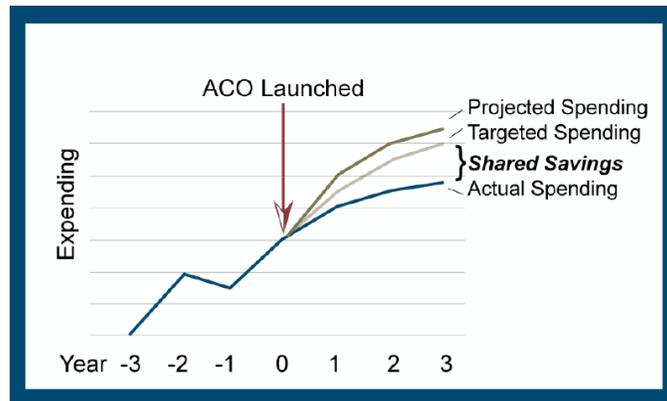
a. **Shared Savings** – If quality and patient satisfaction are enhanced or maintained and there are savings relative to the predicted costs for the assigned patient population, then a portion (commonly 50% according to some surveys and the MSSP Final Rule) of those savings is shared with the ACO. This is stacked on top of the provider’s fee-for-service payments. To maximize incentivization, the savings pool should be divided in proportion to the level of contribution of each ACO participant. This aligns incentives of all ACO participants to keep patients as well as possible, and if ill, to receive optimum care in a team environment across the care continuum. If primary care has especially high medical home management responsibility, this may be accompanied by the addition of a flat per member/per month payment.

Some of the savings pool distributions should be used to maintain the ACO infrastructure, but as much as possible should go to reward providers and facilities for the extra time and attention devoted to patient management and technology investments. As mentioned, it should not go to pay affected physicians or hospitals for reduced revenues under fee-for-service for reductions in volume.

A strength of this model is that it is easy to understand and transition to, since it builds upon the familiar fee-for-service system. That is also its weakness, since fee-for-service still rewards volume, not value. This shared savings model has been criticized as being “asymmetric” or “one-sided,” with no consequence if there are higher costs or no care improvement. Another problem is that there is by necessity a lag time to measure the “delta,” or the difference between the actual costs and the expected costs, so the ACO is uncertain whether there will be revenues. The delay saps the incentivization to adhere to the ACO’s best practices and coordination.

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## The Shared Savings Model



\*Courtesy of the Brookings Institution

**Strategic Note 1:** How to Calculate Shared Savings. Although the concept is simple – the ACO gets 50% of the difference between what the costs for the population turned out to be versus what the costs would have been if the ACO were not in place – DO NOT try to do this by comparing your population costs year-to-year. It might work the first year, but will be inappropriate after that. Having to beat your performance from the prior year, every year, is like calling an Olympic medalist a failure if she does not break her world record the next time out. In some CMS demonstration projects, relatively unmanaged counties in other parts of the country were picked as the control populations. Another way that works is to use an actuary that can predict the medical costs for your region or comparable community and use that actuarially valid projected amount as your unmanaged “comparable.” A variation of this latter approach has been chosen by CMS for calculation of the MSSP savings.<sup>26</sup>

**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.

<sup>26</sup> 76 Fed. Reg. 67985-67988.

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b. **Savings Bonus Plus Penalty** – As with the shared savings model, providers receive shared savings for managing costs and hitting quality and satisfaction benchmarks, but also will be liable for expenses that exceed spending targets. This model is called “symmetric” or “two-sided” and the bonus potential is increased to balance the accountability for exceeding pre-set goals. Fee-for-service is retained. This resembles the “two-sided” model mentioned in the Final Rule.<sup>27</sup>

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.<sup>28</sup> 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.

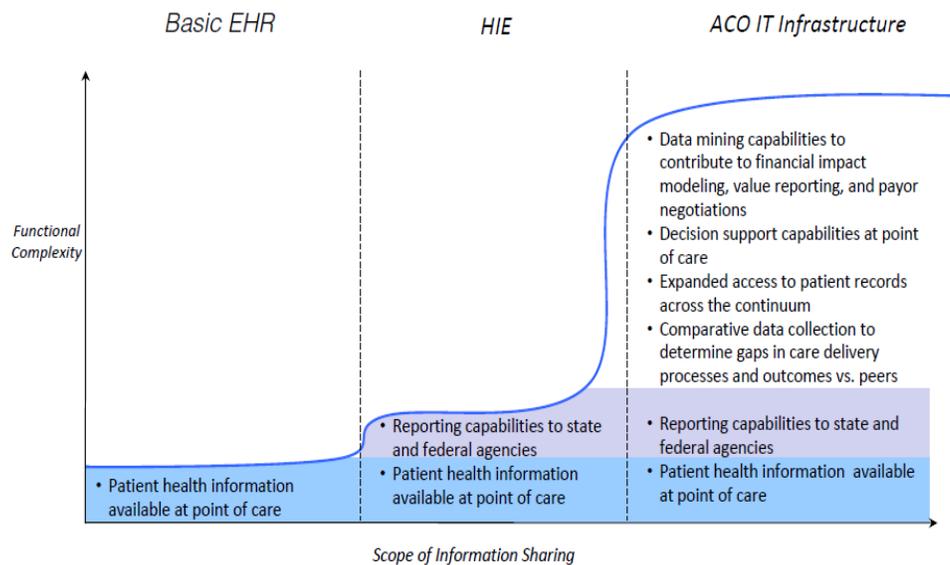
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<sup>27</sup> 76 Fed. Reg. 67986-67987.

<sup>28</sup> 75 Fed. Reg. 44314 (July 28, 2010).

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



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

a. **Baseline Data** – This is often overlooked. To compare anything, there needs to be a beginning reference point. Can you collect costs and quality data? Who owns it now? Who collects it? Do you trust them to be accurate and objective? Use it to perform a “gap analysis”: Where are your local quality and cost numbers outliers to the ideal? This tells you where your “low-hanging” fruit may be. Match those outlier opportunity areas with the particular strengths of the provider array of your ACO and you have your prioritized initiatives or targets.

b. **Performance Data** – In the value-based reimbursement era, it will not be enough to provide exceptional cost-effective care; you must prove it. A practical way to determine your ACO’s needed performance data is to start by selecting the ACO’s targeted initiative as mentioned above. Then select from emerging nationally recognized quality and efficiency metrics, if they apply. Even if they do apply, convene a multi-specialty committee of clinicians to vet their clinical validity. This committee will recommend performance benchmarks from scratch if national standards are not yet available for all of the care pathways of your initiative. They should address quality, patient satisfaction, and efficiency. They need to be severity-adjusted. Obviously, if and when a third-party payor, including CMS, sets the performance benchmarks, they should be part of the performance array. Many payors want to allow local flexibility and clinical leadership in metric-setting.

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

c. **Data As a Clinical Tool** – Once the ACO targeted care initiatives are selected, the best practices across the care continuum will be determined. The appropriate ACO committee will then usually “blow up” each pathway into each component and assign clinical leadership, decision support, data prompts, and embed relevant clinical data into each step at the point-of-care. ACOs are discussing virtual workstations and data dashboards. Coordination with downstream providers will be optimized with the real-time sharing of upstream care results and scheduling.

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

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

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

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



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

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

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

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

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.<sup>30</sup>

<sup>29</sup> *Toward Accountable Care*, The Advisory Board Company (2010)

<sup>30</sup> Section 3022 of the Patient Protection and Affordable Care Act of 2010 (42 U.S.C. §§ 1395, et seq.). See also 76 Fed. Reg. 67976.

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## What Can an ACO Do to Engage Patients?

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

- **The Patient Compact** – Some ACOs, such as the Geisinger Clinic, engage the patient through a compact, or agreement. It may involve a written commitment by the patient to be responsible for his or her own wellness or chronic care management, coupled with rewards for so doing, education, tools, self-care modules, and shared decision-making empowerment. The providers will need to embrace the importance of patient involvement and hold up their end of the engagement bargain.
- **Benefit Differentials for Lifestyle Choices** – The financial impact of many volitional patient lifestyle choices is actuarially measurable. A logical consequence of the patient choice could be a benefit or financial differential reflecting at least partially these avoidable health care costs.

## H. Essential Element No. 8: Scale-Sufficient Patient Population



It is OK, even desirable, to start small; to “walk before you run,” so to speak. However, it is often overlooked that there needs to be a minimal critical mass of patients to justify the time and infrastructure investment for the ACO. PPACA’s Shared Savings Program requires that the ACO have a minimum of 5,000 beneficiaries assigned to it.

**Strategic Note:** Some ACOs commence activities through a single pilot, or demonstration project, without a sustainable patient population scale. It can de-bug the initiative and test-run the ACO early enough to fix problems before ramping up. This must succeed, however. If it does, it will be much easier for the ACO champions to gain buy-in from others.



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

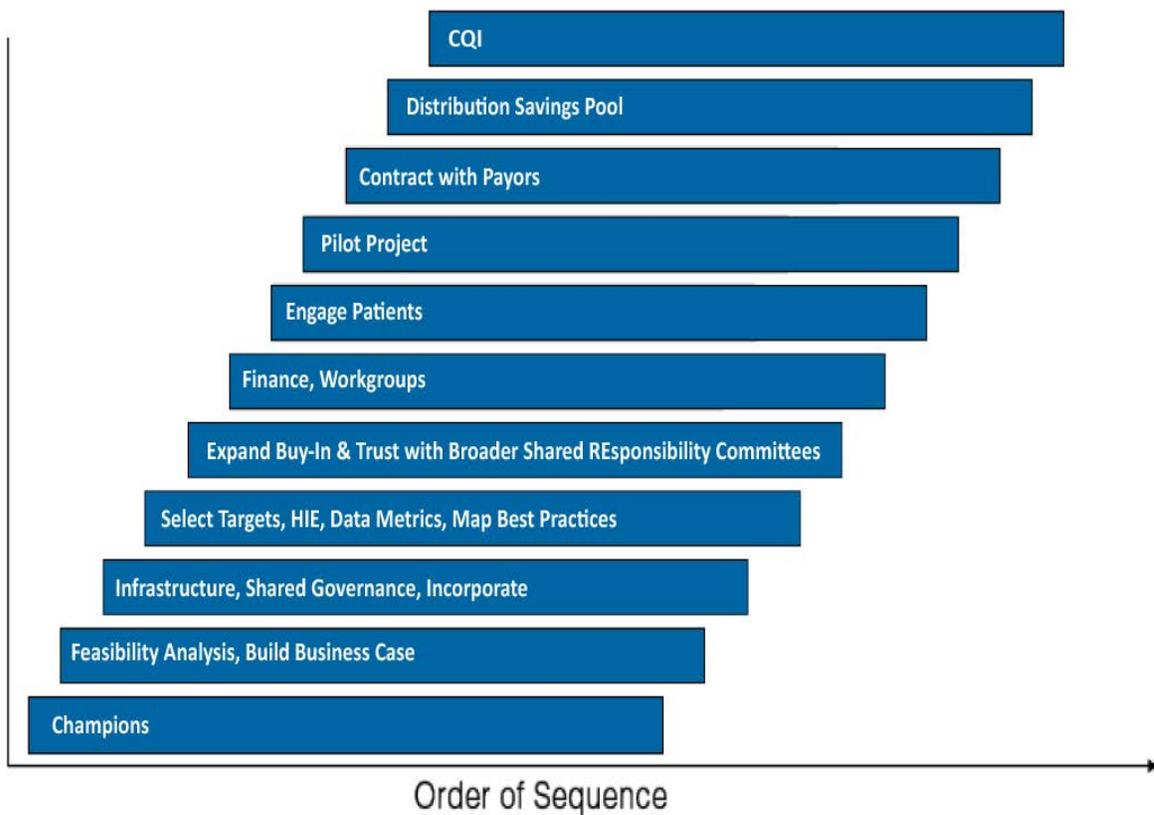
# The Accountable Care Guide For Pediatric Care

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

### A. Where Do I Start?

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

### B. Step-By-Step Guide



1. **Informed Champions** – Perhaps even ahead of this first step may be that there needs to be some ACO information available to plant the seed of awareness with a few local champions. These champions, whether hospital CEO, family physician, or neurosurgeon, will need to invest their “sweat equity” to get up to speed (the main purpose of this ACO Guide). The champions need to reach beyond silos and see whether cultural compatibility is possible.

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**2. Strategy Formulation/Gap Analysis** – Next, a small core group should honestly assess where they are and where they need to go. What is the target market (i.e., chronic disease, Medicaid, the elderly)? Does an ACO make sense? What do we target? How do we make sure this is fair and successful so that we get buy-in? Some experts recommend a phased approach starting with primary care, then adding select specialists and hospitals around targeted high-impact initiatives, then a comprehensive panel, and then, finally, including public health and social services. Other experts recommend matching the natural strengths of the ACO with the greatest gaps in care for the local area. Then they would have the ACO model a strategic business case, to create a roadmap to development. How will it achieve all of the 8 Essential Elements? Keep the team very small at this stage.

**3. Clear Vision** – The organizing group needs to have credibility and will need to unite around a clear and compelling shared vision.

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

- a. Start with your initial targeted initiatives.
- b. From them, establish best practices for the continuum of care for all providers involved with that type of patient.
- c. “Blow up” the best practices into component parts and assign clinical leadership responsibility for each.
- d. Identify which clinical data sets and decision support tools are needed at each step.
- e. Assign performance metrics and financial accountability for same.
- f. Determine HIT technical requirements.
- g. Determine best financial tools to incentivize desired behavior by all involved (i.e., share savings with predetermined performance benchmarks and distribution methodology). The TACC has engaged the law firm of Smith Anderson Blount Dorsett Mitchell & Jernigan, LLP and the health care valuation firm of HORNE, LLP to develop a multi-based shared savings distribution model for use by ACOs with multiple specialties. It will be made available by the TACC.

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5. **Structural Foundation** – Choose the legal entity approach and formal governance structure most appropriate to your culture and business plan. It must be driven by the form most likely for the success of the ACO, not controlled by success for any particular stakeholder. Establish membership criteria and a shared decision-making structure. Design and undertake training. Develop payor strategy and contract terms. Do “ROI” predictive modeling to estimate savings and quality benefits. Create credible value talking points for all stakeholders. If you choose to participate in the Medicare Shared Savings Program, make sure you meet all the structural requirements, which are not onerous.
6. **Expand Buy-In** – Broaden structured involvement. Create a multi-disciplinary integration committee with HIT, best practices, patient engagement, and finance subcommittees.
7. **Accountability Function** – Develop data metrics, measurement capability, and sophisticated financial administration capabilities to manage financial shared savings distribution. Set performance targets. Normalize data. Make sure your performance-based incentives target your ACO objectives.
8. **Start Small** – Start with a demonstration or pilot project.
9. **Contract with Payors** – Once ready, contract to provide integrated accountable care services on a shared savings basis, at least initially, for your target patient population. The patient population scale must be adequate to achieve economies of scale. Consider a Medicare ACO starting in January of 2014 as part of a broader strategy. (See Part Two for a blueprint on applying to the Medicare ACO and Medicare ACO Advance Payment Model programs.
10. **Assess and Improve** – Assess results of the process. Make adaptations to create a constant quality improvement (“CQI”) loop. Collect and distribute the savings pool roughly in proportion to contributions to it.

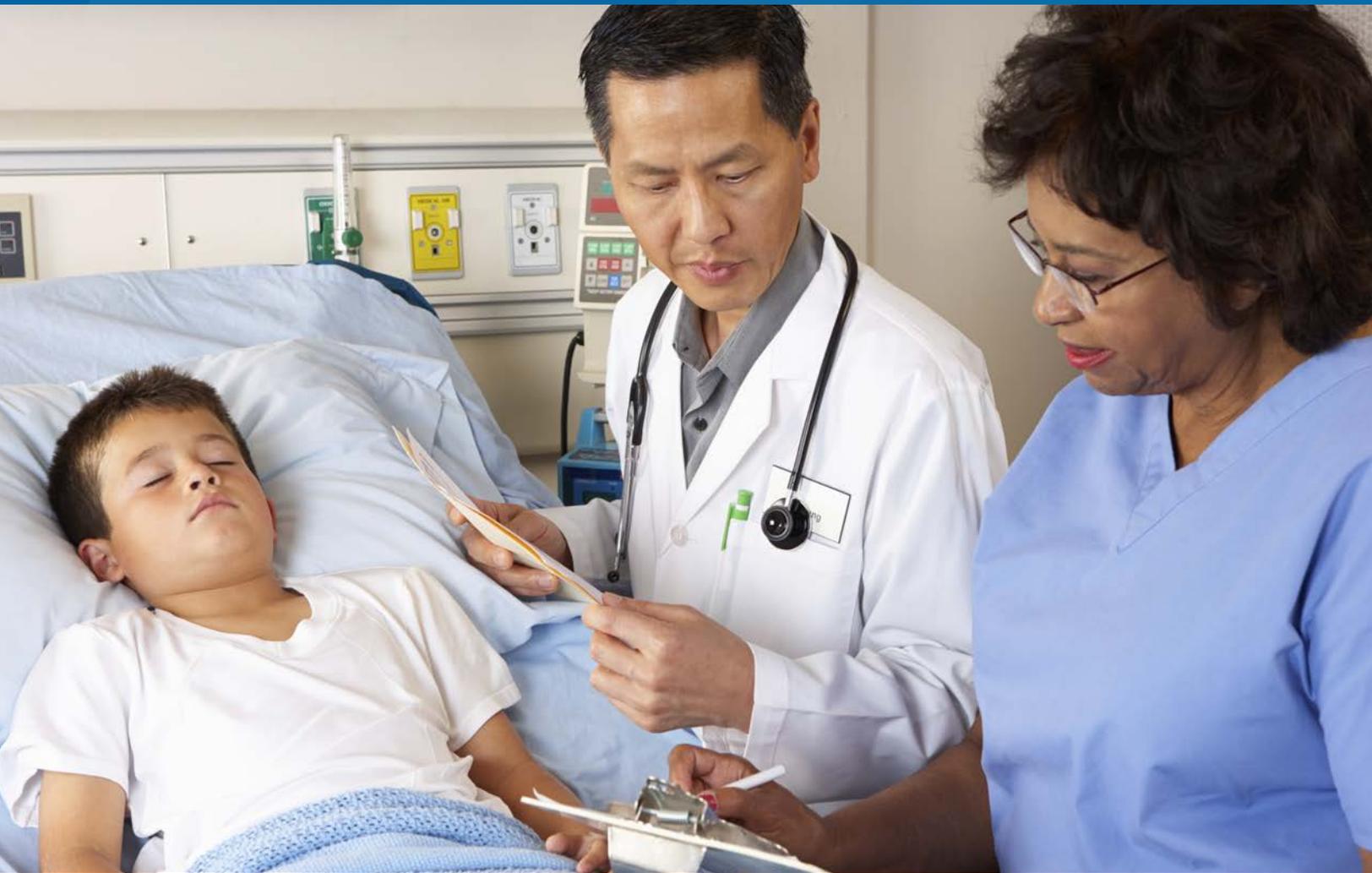
## VII. Conclusion

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

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



# Part Two: The Accountable Care Guide for Pediatric Care



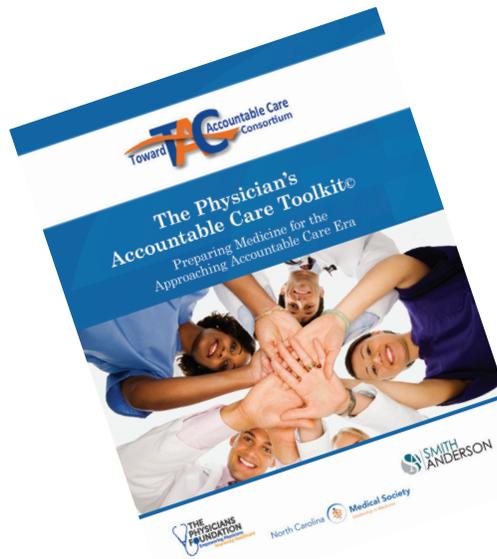
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*State Chapter of the American Academy of Pediatrics*

# The Accountable Care Guide For Pediatric Care

## I. Introduction

### A. Purpose of this Guide

The companion *The Physician's Accountable Care Toolkit*<sup>©</sup> 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, specialist physician or surgeon. This *Accountable Care Guide for Pediatric Care*, on the other hand, spells out specific strategies for all physicians regularly providing care for children and young adults. For convenience, the term “pediatrician” may be used, but the strategies are intended to apply to family physicians, internists, general practitioners and any other subspecialty providing pediatric care. It is intended to be useful whether you are located in a small rural hospital, a large independent practice, or employed in a health system.



### B. Recap of The Physician's Accountable Care Toolkit<sup>©</sup>

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.”<sup>1</sup> Similarly, the National Committee for Quality Assurance (“NCQA”) included the following definition

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<sup>1</sup> Mark McClellan, Director of the Engleberg Center for Health Care Reform at the Brookings Institution, *A National Strategy to Put Accountable Care Into Practice*, Health Affairs (May 2010), p. 983.

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

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 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 over 50 percent more than in any other country, but we now are ranked 32nd<sup>3</sup> 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.”

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.

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

<sup>3</sup> World Health Organization, World Health Statistics 2009.

# The Accountable Care Guide For Pediatric Care

## 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 element of having adequate financial incentive, by far, the most important and overlooked 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.”<sup>4</sup>** Culture keys are: champions, governance and merit-incentives.

2. **Primary Care Physicians** – When reviewing Element 6 below, the core role of primary care becomes clear. Prevention, wellness, care transition and patient coordination management are the “low-hanging fruit” for ACO improvements and savings and are all in primary care’s sweet spot. Primary care is the only 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. For ACO patient populations with large numbers of children

<sup>4</sup> Phillip L. Rowing, *Becoming Accountable*, HFMP Compendium Contemplating the ACO Opportunity, Appendix, p. 40 (Nov. 2010).

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and young adults, the primary care emphasis swings to pediatrics, child psychiatry and obstetrics and gynecology.

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.... Anticipated early versions of ACO payment incentives are likely to be directionally correct but unlikely to be sufficient to create the needed burning platform."<sup>5</sup> One rule of thumb may be found in antitrust law, where the behavior changing tipping point in health care is considered to be roughly 20 percent of total compensation. Fifty percent savings for ACOs not taking downside financial risk is a fairly common measure and viewed by most as adequate.

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

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

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

"The best bet for achieving returns from integration is to prioritize initiatives specifically targeting waste

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

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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.”<sup>6</sup>

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 be 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 and are proving their “ROI,” or return on investment, in the value-based payment era.

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

## D. These Apply to Everyone

Because a successful ACO must be “win/win,” with 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 all readers to be able to unlock ACO success for their patients, themselves, and their ACOs.

## II. Could Accountable Care Be A Good Thing For Pediatricians?

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

We recognize that there are various models for pediatric care. 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.

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<sup>6</sup> *Toward Accountable Care*, The Advisory Board Company (2010).

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## A. Cons

- It is difficult to extract big savings for children since many will seek care in the emergency room rather than waiting to schedule an appointment with a pediatrician. There are many healthy children.
- Children are not simply small adults, and ACO care improvement initiatives for them are often quite different from those for adults.
- You have seen this “next big thing” before and it did not work out as advertised.
- The patient overlap that physicians providing pediatric care have with providers in other specialties, in particular, hospitals, means that gaining the buy-in of specialists can be particularly challenging for territorial reasons.
- It will be difficult for physicians in different specialties to give up independence and be interdependent with other physicians and hospitals.

## B. Pros

- In the near future, the science of prevention, aided by genomics, will increase emphasis on early life in order to prevent chronic disease later in life. Pediatricians who embrace accountable care may be uniquely positioned to finance new territories in health care (i.e., pediatricians creating life-long management plans for chronic disease beginning at childhood).
- A comprehensive approach to pediatric care can have influence far beyond the children being cared for, as often other family members will be positively influenced (i.e., a focus on the social and environmental aspects of childhood asthma may impact smoking behaviors of parents).
- Many physicians providing pediatric care 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 pediatric care models.
- Movement towards a family-centered pediatric ACO will benefit millions of children. As of 2013, children accounted for 27.9 million, 46 percent of Medicaid enrollees.<sup>7</sup> ACOs covering both adults and children will be more attractive to commercial payers. Children comprise a significant portion of the accountable care provided.

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<sup>7</sup> 2013 CMS Statistics, US Dep't of Health And Human Serv., [http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS\\_Stats\\_2013\\_final.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Statistics-Reference-Booklet/Downloads/CMS_Stats_2013_final.pdf) (last visited Feb. 26, 2015).

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- The pediatric community's experience with care coordination, not only in the management of children with complex conditions, but also in the daily encounters with children who may need short-term and intermediate care coordination, also supports the concept of an ACO with strong pediatric capabilities.
- Physicians providing pediatric care are in a special position to take advantage of savings in the areas of asthma management, vaccinations and family engagement.
- Pediatricians are in a position to organize care coordination with specialists, child psychiatrists and hospitals as a standard of pediatric practice that will result in increased family satisfaction with the quality of care and also decreased barriers to care.
- As with all physicians who have been heroically battling a deeply fragmented system to provide cost-effective care, physicians providing pediatric care 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 pediatrics.
- Care coordination will enable ACOs with strong pediatric capabilities to reduce hospitalizations along with significant reductions in emergency department use and out of health plan use including referrals and home care while appreciating cost savings in areas like inpatient newborn care, prescription drugs and emergency room treatment.
- ACOs are designed to shift focus away from treatment of episodes and towards the overall health of patients. Physicians providing pediatric care will be rewarded more when children are healthier than they would be if the patient required expensive medical procedures.
- As database quality metrics increase in the next few years, patients will be steered towards physicians who can provide quality of care at the lowest cost.
- The current status quo is not an option.
- Profitable payments to hospitals and physicians for high-cost, low-impact care associated with chronic diseases will soon be a thing of the past.

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## CHILDREN ARE NOT SMALL ADULTS

	ADULT	CHILDREN
Primary Care	Treatment and management of chronic diseases; “sickness care”	Focus on prevention including immunizations and checkups
Admission Diagnoses	Heart disease, diabetes, pneumonia, stroke	Newborn births, mood disorders, asthma, injury
Physiology Variation	Adult; elderly adults generally most expensive	Infants, children, adolescents, and some adults; 1 <sup>st</sup> year of life especially critical

## POPULATION CHARACTERISTICS COMPARED

TIER	ADULTS	CHILDREN
Highest Cost Patients	Multiple chronic conditions such as heart disease and diabetes. With better management, patients can drop to the middle tier—often elderly.	Prematurity. Rare and complex congenital or genetic diseases. Good management can keep them out of the ED and hospital, but their conditions are generally life-long.
Chronic Disease	Large population with varying degrees of disease control, big opportunity for cost savings.	Relatively small population with 1 or 2 chronic conditions such as asthma or ADHD.
Healthy Patients	Depending on whom you ask, 60%-75% of patients.	Most kids, with focus on prevention, growth & development.

## III. The Recommended Approach For Developing Specialty Accountable Care Strategies

In the value-based reimbursement era, each specialty is rethinking its role. Some of the questions confronting specialists are: **What is our maximum value-adding contribution across an entire patient population? How can we generate quality and savings improvements for the ACO and thus maximize performance rewards for our specialty?** This rethinking is perhaps most dramatic regarding savings. The gain will not be from seeing a patient cheaper or quicker, but how to reduce costs for a patient population over a given period of time, 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 coordination and transitions
- Multi-specialty coordination of complex patients

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

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

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

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Ideally, this process should be led by a well-respected and diverse peer “Accountable Care Workgroup” of a national or state professional society, of that category of providers.

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

In the late 1990s, several North Carolina leaders saw the need for a stronger focus on quality of care for the state’s children. The expense to the state caused by children with chronic conditions or children born prematurely was unpredictable at best. These leaders helped form Community Care of North Carolina (CCNC). CCNC has brought together regional networks of health care providers to provide coordinated care to North Carolina children.

CCNC has provided guidance regarding population management for pediatric care aimed at increasing quality of care while lowering costs. These guidelines are incorporated into the suggestions below. The CCNC recommendations have been given special attention in part because they are consistent with recommendations from national organizations and in part because CCNC has been so successful in its mission.

**Strategic Note:** Many, if not most, of the non-preventive care best practices from the fee-for-service environment may not be particularly useful without adaptation, as they tend to focus on specialist care and treatment interventions in a fee-for-service setting of an individual patient. In contrast, accountable care focuses on such things as patient engagement and involvement in setting goals of medical decision making, pushing knowledge “upstream” to the primary care or referring physician, or transitioning across a “siloes,” fragmented system. Likewise, metrics abound evaluating that individual care, but are not yet common in areas such as transition, care coordination, care team education or increased access through telemedicine.

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

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## V. Recommended Accountable Care Initiatives For Physicians providing Pediatric Care

### A. Recognize the Unique Attributes Needed for ACO Success for Pediatric Care

The HIMSS ACO Task Force noted the following unique attributes of care for children:

- “Kids’ unique medical needs and social environment necessitate care from pediatric-trained physicians and child-specific community resources such as schools.
- It is essential to select performance metrics meaningful to pediatrics and that accurately measure the quality of pediatric care.
- Population characteristics and scarce subspecialists require a regional vs. local provider base.
- Technology needs to include functionality to support pediatric care.
- Children with medical complexity usually have many subspecialists and rely on community resources and will need special care throughout their lives.
- The family is generally responsible for a child’s health care, rather than the patient him- or herself.
- Federal leadership provided by Medicare is lacking in Medicaid, but states have begun working with providers to form Medicaid ACOs.
- A largely healthy population means that a larger number of patients is needed to show significant cost savings.”<sup>8</sup>

### B. Family-Centered “Pediatric Medical/Health Homes” Linked to Specialty Care for Complex Conditions

The family-centered medical home is the foundation of a primary care-driven integrated delivery system anchoring the ACO. There must be sufficient pediatric primary and specialty care pediatricians for the number of children managed by the ACO. In many parts of the country, medical homes or tightly integrated relationships between children’s hospitals, pediatricians, and specialty care pediatricians may be the foundation for a network that can be strengthened further within the architecture of an ACO with strong pediatric capabilities.<sup>9</sup> The pediatric community’s experience with care coordination, not only

<sup>8</sup>HIMSS ACO Task Force, Pediatric ACOs, (April 2014).

<sup>9</sup> *Accountable Care Organizations (ACOs) and Pediatricians: Evaluation and Engagement*, Am. Acad. of Pediatrics, <http://www.aap.org/en-us/professional-resources/practice-support/Pages/Accountable-Care-Organizations-and-Pediatricians-Evaluation-and-Engagement.aspx> (last visited Feb. 25, 2015).

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in the management of children with complex conditions, but also in the daily encounters with children who may need short-term and intermediate care coordination, also supports the concept of a pediatric ACO value-adding contribution.<sup>10</sup> Finally, integrating community, oral and mental health into the ACO's delivery and payment structure is essential, because so much of a child's health and safety is affected outside of the medical system per se, and because some of the most common major chronic care conditions children and adolescents experience are oral and mental health problems. For example, the pediatric ACO, University Hospitals Rainbow Care Connection, in Cleveland, Ohio, integrates behavioral health services with primary care using social workers and tele-behavioral health. For more detail on integrating with behavioral health and community health resources, see TAC's *Accountable Care Guide for Psychiatrists*, *Accountable Care Guide for Child Psychiatrists* and *Accountable Care Guide for Community Health Partners* at <http://www.tac-consortium.org/resources/accountable-care-guide-for-commuity-health-partners>.

According to research in New Orleans, families of children and youth with special health care needs in an underserved population experienced enhanced services from nurse care coordinator support.<sup>11</sup> In short, fewer unmet needs for services ensue when primary care clinicians are sensitive to the culture and needs of children and youth with special health care needs and their families and incorporate levels of care coordination in care delivery.<sup>12</sup> Care coordination conducted as a standard of pediatric practice resulted in increased family satisfaction with the quality of care and also decreased barriers to care.<sup>13</sup> A 2011 study in children and youth with special health care needs and their families who received care coordination and individualized care plans via a Medicaid managed care plan study reported improved satisfaction with mental health services and specialized therapies, and participants were observed to have a decline in unmet needs, improved satisfaction with specialty care, and improved ratings of child health and family functioning.<sup>14</sup>

**Strategic Note:** Use Co-Management Plan Agreements – Co-management agreements are important to ensure partnerships between consultants and specialists and primary care physicians in any ACO arrangement. Clear plans for co-management align both the approach to care and provide a framework for quality and cost-effective care. Particularly in pediatrics, specialists and specialized care teams for children with chronic and complex illnesses are often in centralized locations such as children's hospitals, geographically separated from the community where patients live. Centralization of specialty resources evolved because of the small number of children (5 and 20 percent depending on the disease) and limited numbers of pediatric specialists. It is important to ensure patients attributed to the ACO get coordinated care through their medical home or are organized through the pediatric

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<sup>10</sup> *Id.*

<sup>11</sup> *Patient- and Family-Centered Care Coordination: A Framework for Integrating Care for Children and Youth Across Multiple Systems*, Counsel on Children with Disabilities and Medical Home Implementation Project Advisory Comm., <http://pediatrics.aappublications.org/content/133/5/e1451.full.html#ref-list-1> (last visited Feb. 26, 2015).

<sup>12</sup> *Id.*

<sup>13</sup> *Id.*

<sup>14</sup> *Id.*

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specialist, with communication links to the primary care physician, specialists, and family. Inclusion of the family, patient, primary care physician and specialists in these decisions to develop the best care structure for the patient is critical in preventing duplication of services, utilization of higher cost services (e.g., emergency rooms at children’s hospitals for illnesses treatable in the community), and access to care. For example, a child with diabetes may have the management of diabetes on a day-to-day basis from a nurse or other individual at the pediatric endocrinologist’s office, but routine care for well child visits and acute illnesses will be managed in the primary care medical home. Careful development of co-management agreements, formal or informal, between the specialists and primary care physicians, including the family in the planning, will allow access to care at the most appropriate site, tailored to the individual child and medical needs.

## C. Specific Strategies for Premature Infant

**“In a population of pretty healthy people, children, we see the avoidable costs for premature deliveries as an area of savings opportunity.”**<sup>15</sup> This subset of children often becomes long-term chronic high-risk, high-cost patients. Fortunately, there are a number of straightforward proven initiatives to promote better health and reduce costs, particularly readmissions. Value-based payment for population management, such as in ACOs, has the potential to unleash these practices by making them financially feasible.

- **Protocolize Neonatal Hospital Care** – Neonatologist Docia Hickey, M.D., noted that “set protocols in the hospital make a lot of difference.” Especially beneficial is protocolized team care in the delivery room. Protocols can be instituted for feeding, monitoring oxygen levels, minimizing touching, keeping the infant calm, use of the ventilator, central line care and removal, and minimizing interventricular hemorrhage (“IVH”), chronic lung disease and central line infections. The children should be screened for IVH and retinopathy of prematurity (“ROP”), initially and during follow up.
- **Home Care/Case Management** – Significant benefits have resulted when a case manager is assigned to premature infants upon discharge. One Pediatric Accountable Care Workgroup member recounted particular success when former neonatology nurses were enlisted as case managers. The management specifically included home health. The babies were on monitors in all cases. This practice resulted in the ability to discharge infants at lower weights, earlier, and a significant reduction in readmission rates.
- **Participate in National Database** – Participation in a national database for premature infants allows you to benchmark yourself. According to our Workgroup, it is recommended to review statistics, stratified according to gestational age, for mortality, IVH, ROP, central line infections, and rate of readmissions.

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<sup>15</sup>Telephone interview with neonatologist Docia Hickey, M.D. on September 10, 2014.

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- **Follow-Up Clinic** – For an ACO with a large neonatal population, a follow-up clinic is suggested.

In summary, a specific neonatal strategy is a “no brainer” for ACOs with a patient population including children because of the above proven, cost-effective strategies. However, these are strategies unique to this population. It truly can be said that **just as children are not simply small adults, premature infants are not simply small children.**

## D. Increased Focus on Asthma Care

A randomized controlled study of a pediatric outreach program reported by Greineder DK demonstrated that a 75 percent reduction in hospitalizations among children aged 1-15 years with asthma who participated in a comprehensive asthma outreach program.<sup>16</sup> The program was focused on ensuring that patients kept scheduled appointments, monitored their asthma, and took maintenance medications.<sup>17</sup> Reduced hospitalizations along with significant reductions in emergency department use and out of health plan use including referrals, home care and durable medical equipment contributed to an estimated direct savings of \$7.69 to \$11.67 for every dollar spent on the intervention.<sup>18</sup> Montefiore Medical Center, New York ACO, invests heavily in school-based health care centers, which reduce admissions for pediatric asthma tenfold and helps reduce teenage pregnancy by 47 percent.<sup>19</sup>

## E. Appropriate Usage of Antibiotics and Other Medications

In the event that antibiotics should be prescribed, AHRQ-funded researchers more recently found that older, less expensive, antibiotics such as amoxicillin provide better treatment outcomes than newer antibiotics for children with middle ear inflammation.<sup>20</sup> Researchers for the Center for Education and Research on Therapeutics (CERTs) at the University of North Carolina discovered children covered by Medicaid in North Carolina who received older drugs had fewer return visits to their physicians than children who received newer, more expensive drugs.<sup>21</sup> The average cost of drug therapy for older drugs such as amoxicillin was \$12.00, while the newer drugs cost an average of \$42.00.<sup>22</sup>

A member of the Pediatric Accountable Care Workgroup recounted a conversation with a physician about why a particular drug was prescribed. When the physician was asked what evidence he used to select that medication, he responded, ‘I don’t know, I just thought it was a good idea.’ Ultimately, an equally efficacious, but less expensive drug was used to treat the patient. This brief interchange demonstrates the value of coordinating appropriate drug use.

<sup>16</sup> Michael Mellon, MD and Bhash Parasuraman, PhD, *Pediatric Asthma: Improving Management to Reduce Cost of Care*, <http://ns.amcp.org/data/jmcp/Review-130-141.pdf> (last visited Feb. 26, 2015).

<sup>17</sup> *Id.*

<sup>18</sup> *Id.*

<sup>19</sup> *Faces of Public Health: NY State Health Commissioner Nirav Shah*, Robert Wood Johnson Foundation (Apr. 3, 2013, 10:15AM), [http://www.rwjf.org/en/blogs/culture-of-health/2013/04/faces\\_of\\_public\\_heal.html](http://www.rwjf.org/en/blogs/culture-of-health/2013/04/faces_of_public_heal.html).

<sup>20</sup> Barbara L Kass-Bartelmes, M.P.H., C.H.E.S. and Lynn Bosco, M.D., M.P.H., *Reducing Costs and Improving Outcomes Research in Action Issue 8*, <http://archive.ahrq.gov/research/findings/factsheets/pharmaceutical/rxtherapies/rxria.html> (last visited Feb 26, 2015).

<sup>21</sup> *Id.*

<sup>22</sup> *Id.*

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## F. Standardized Evidence-Based Best Practices and Data-Driven Research

Health information technology can play a pivotal role in care coordination. Tracking and monitoring patients via the use of patient registries can support care coordination activities and functions and improve patient safety. The Data Resource Center for Child and Adolescent Health (DRC) supports efforts to improve pediatric health care and quality by providing population-based child health from various national surveys that can be easily accessed through the DRC website.

Advantages of the DRC website include: (1) National standardization that allows for consistent measurement and reporting across states and geographic areas within states. Standardization of measurement is critical to allowing comparison across states and subgroups of children; (2) Comparison across a wide array of demographic and health status subgroups of children and youth, including race/ethnicity, presence of a special health care need, household income, etc.; (3) Many topics relevant to national health goals for children are validly reported by parents and are not possible to access using other information systems, such as billing, administrative, clinical or medical records; (4) An array of resources on how to use these data at the national, regional, state and local level; (5) The role of evidence-based medicine in impacting patient care is noted among one of the expectations of the Patient Protection and Affordable Care Act.<sup>23</sup> As the principal clinical partner for the Texas A&M Health Science Center College of Medicine, Scott & White has embraced research and is data-driven in achieving the quality outcomes that help manage cost and care.<sup>24</sup>

- **Pediatric Data is Different.** One Pediatric Accountable Care Workgroup member commented, “One of the things we’re finding in our experience is that we have to pull out pediatrics as a population; otherwise, the analytics are skewed.” Adult data should focus on chronic disease management, sickness care, heart disease, diabetes, frail complex elderly care, with more widespread health concerns as a percent of the population. In contrast, data for population management for children should include well visits, immunizations, family communication, asthma, newborns, complex congenital or genetic diseases, and higher percentage of overall good health. Scarce subspecialists require regional care and its expanded data capture basin. Pediatric-appropriate data capture is tied to the need for unique performance metrics appropriate for pediatric care. The purpose of data collection and measurement is to evaluate performance against the clinically valid and appropriate structure, process and outcome goals desired, which are reflected in the set of metrics chosen. Both are essential, and they are intertwined.

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<sup>23</sup> *Pediatric Health Care Quality Measurement and Improvement*, Data Res. Ctr. for Child & Adolescent Health, <http://www.childhealth-data.org/browse/qualityportal> (last visited Feb. 25, 2015).

<sup>24</sup> Steve Allen, MD, MBA, *Medicaid and Pediatric Accountable Care Organizations: A Case Study*, Accountable Care News Vol. 1, Num. 5, (Dec. 2010), [http://www.network-health.org/uploadedFiles/About\\_Us/Newsroom/In\\_the\\_News/Accountable%20Care%20News%20-%20December%202010\(1\).pdf](http://www.network-health.org/uploadedFiles/About_Us/Newsroom/In_the_News/Accountable%20Care%20News%20-%20December%202010(1).pdf).

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- **Evidence-Based Best Practices Work.** One Pediatric Accountable Care Workgroup member noted, “Even in high-cost areas, we need to use what evidence we have. Don’t just throw the kitchen sink at it.” Another shared experience with the benefit of evidence-based approaches to premature infants, to reduce length of stay and improve others. “Many things can be protocolized. That translates into lower costs.” Coordinated care for children is in its infancy. Consequently, evidence-based best practices are just now emerging and principle-based guidelines are being initiated, starting the lifecycle toward becoming evidence-based. One example of evidence-based practices may be found in the suggestions of the American Academy of Pediatrics found in the Choosing Wisely® Initiative:<sup>25</sup>

**1. Antibiotics should not be used for apparent viral respiratory illnesses (sinusitis, pharyngitis, bronchitis).** Although overall antibiotic prescription rates for children have fallen, they still remain alarmingly high. Unnecessary medication use for viral respiratory illnesses can lead to antibiotic resistance and contributes to higher health care costs and the risks of adverse events.

**2. Cough and cold medicines should not be prescribed or recommended for respiratory illnesses in children under four years of age.** Research has shown these products offer little benefit to young children and can have potentially serious side effects. Many cough and cold products for children have more than one ingredient, increasing the chance of accidental overdose if combined with another product.

**3. Computed tomography (CT) scans are not necessary in the immediate evaluation of minor head injuries; clinical observation/Pediatric Emergency Care Applied Research Network (PECARN) criteria should be used to determine whether imaging is indicated.** Minor head injuries occur commonly in children and adolescents. Approximately 50 percent of children who visit hospital emergency departments with a head injury are given a CT scan, many of which may be unnecessary. Unnecessary exposure to x-rays poses considerable danger to children, including increasing the lifetime risk of cancer because a child’s brain tissue is more sensitive to ionizing radiation. Unnecessary CT scans impose undue costs to the health care system. Clinical observation prior to CT decision-making for children with minor head injuries is an effective approach.

**4. Neuroimaging (CT, MRI) is not necessary in a child with simple febrile seizure.** CT scanning is associated with radiation exposure, which may escalate future cancer risk. MRI also is associated with risks from required sedation and high cost. The literature does not support the use of skull films in the evaluation of a child with a febrile seizure. Clinicians evaluating infants or young children after a simple febrile seizure should direct their attention toward identifying the cause of the child’s fever.

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<sup>25</sup> Choosing Wisely®, Am. Acad. of Ped., <http://www.choosingwisely.org/doctor-patient-lists/american-academy-of-pediatrics/> (downloaded June 2014).

**5. Computed tomography (CT) scans are not necessary in the routine evaluation of abdominal pain.** Utilization of CT imaging in the emergency department evaluation of children with abdominal pain is increasing. The increased lifetime risk for cancer due to excess radiation exposure is of special concern given the acute sensitivity of children's organs. There also is the potential for radiation overdose with inappropriate CT protocols.

**6. Don't prescribe high-dose dexamethasone (0.5 mg/kg per day) for the prevention or treatment of bronchopulmonary dysplasia in pre-term infants.** High-dose dexamethasone (0.5 mg/kg per day) does not appear to confer additional therapeutic benefit over lower doses and is not recommended. High doses also have been associated with numerous short- and long-term adverse outcomes, including neurodevelopmental impairment.

**7. Don't perform screening panels for food allergies without previous consideration of medical history.** Ordering screening panels (IgE tests) that test for a variety of food allergens without previous consideration of the medical history is not recommended. Sensitization (a positive test) without clinical allergy is common. For example, about 8 percent of the population tests positive to peanuts, but only approximately 1 percent are truly allergic and exhibit symptoms upon ingestion. When symptoms suggest a food allergy, tests should be selected based upon a careful medical history.

**8. Avoid using acid blockers and motility agents such as metoclopramide (generic) for physiologic gastroesophageal reflux (GER) that is effortless, painless, and not affecting growth. Do not use medication in the so-called "happy-spitter."** There is scant evidence that gastroesophageal reflux (GER) is a causative agent in many conditions though reflux may be a common association. There is accumulating evidence that acid-blocking and motility agents such as metoclopramide (generic) are not effective in physiologic GER. Long-term sequelae of infant GER is rare, and there is little evidence that acid blockade reduces these sequelae. The routine performance of upper gastrointestinal (GI) tract radiographic imaging to diagnose GER or gastroesophageal disease (BERD) is not justified. Parents should be counseled that GER is normal in infants and not associated with anything but stained clothes. GER that is associated with poor growth or significant respiratory symptoms should be further evaluated.

**9. Avoid the use of surveillance cultures for the screening and treatment of asymptomatic bacteruria.** There is minimal evidence that surveillance urine cultures or treatment of asymptomatic bacteruria is beneficial. Surveillance cultures are costly and produce both false positive and false negative results. Treatment of asymptomatic bacteruria also increases exposure to antibiotics, which is a risk factor for subsequent infections with a resistant organism. This also results in the overall use of antibiotics in the community and may lead to unnecessary imaging.

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**10. Infant home apnea monitors should not be routinely used to prevent sudden infant death syndrome (SIDS).** There is no evidence that the use of infant home apnea monitors decreases the incidence of SIDS; however, they might be of value for selected infants at risk for apnea or cardiovascular events after discharge, but should not be used routinely.<sup>8</sup> Editorial note by Pediatric Accountable Care Workgroup: Consider adding congestion and neonatal to the list of conditions for which home monitoring is of value.

## G. Incorporate Community-Based Resources

Children are never cared for in isolation. The family, community and educational system in which they live are natural extensions of accountable care principles that allow us to redefine the health care ecosystem. Schools, churches, healthy food choices and daycares should be included in pediatric accountable care strategies.

## 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 physician practicing pediatric care 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*<sup>®</sup>, 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. There are a handful of pediatrics-only ACOs, but being part of a full-service ACO, perhaps the dominant part if there is a large population of children in the ACO's patient population, is advised. "[A]t some basic level, a pediatric ACO kind of violates the principle of ACOs, which are supposed to take a broad-based population health approach."<sup>26</sup>

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<sup>26</sup> ACO Business News, Vol. 3, Num. 8, *More Pediatric ACOs Are Forming, But Challenges Loom With Narrower Focus*, p. 1, (June 2012).

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- **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.

**Remember, even if the pediatrician panel of an ACO provider 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 pediatricians affects ACO partnering options.

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

1. **Build Relationships** – Pediatricians 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 pediatricians, as both PCPs and specialists, 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. Pediatricians have a great story and should reduce it to one or two pages. These initiatives are simple “plug and play” add-ons to the ACO’s existing activities, are synergistic and will help the ACO meet quality and savings goals.

**Strategic Note:** Start simple. Start with your one or two best initiatives, and then expand later.

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 will be your client. You are the necessary primary care core of any ACO with a large pool of children in its patient population.

## **C. How to Design and Implement a Physician ACO: A Case Study**

### ***Background***

Seeking an early pilot of a physician-led ACO, Bo Bobbitt went to McAllen, Texas. This was intentional—McAllen had become famous through a *New Yorker* article by Dr. Atul Gawande as one of the most

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expensive Medicaid counties in the U.S. Mr. Bobbitt was approached by Dr. Luis Delgado to engage him and other primary care physicians in the formation of a new ACO, the Rio Grande Valley Health Alliance (RGVHA). The basic concept was to reward physicians for generating measurable savings through improvements in care, using the ACO as the primary vehicle for improvement and measurement under the Medicare Shared Savings Program.

## *Key Learnings*

- A common objection to getting involved with ACOs is “no time, no money.” However, we found there is so much documented “low-hanging fruit” for primary care to generate savings through value-based care that the strategic time and expertise expenditures proved not to be significant. In addition, the legal structure and backroom business logistics for a small network-model primary care physician ACO also are relatively straightforward.
- The new ACO data collection, sorting, and reporting requirements can be somewhat daunting, but in this case RGVHA worked with Dr. Gretchen Hoyle of MD Online Solutions (MDOS), who helped RGVHA implement data coordination and reporting in a cost-effective manner. Dr. Hoyle helps interpret the data and leads a weekly data-driven staff conference call with the ACO’s nurse care coordinators.
- Despite initial fears, RGVHA found that the MSSP application process was not intimidating at all. It turned out to be consistent with its business structure and primary care physician ACO strategy.
- One of the most pleasant surprises came when the physicians realized that so many savings and quality improvement opportunities are available to primary care physicians under accountable care, and especially control over the physician-patient relationship was being returned to them rather than the payer.
- They targeted diabetes management, patient engagement, best practices for enhanced prevention and wellness and home health management. One physician summed up the mood when she exclaimed, “I haven’t had this much fun practicing medicine in 10 years.”
- Care coordinators became RGVHA’s “secret weapon” because they can both improve quality and contain costs. Dr. Hoyle’s work enabled RGVHA to measure and document the cost savings accomplished by care coordinators. Conversely, the data also showed overuse of home health services, which became the next cost and quality target. Through a targeted campaign of outreach to home health providers, RGVHA was able to “bend the cost curve” of home health services.
- The data have also proven crucial to being able to rank patients by cost. That has allowed RGVHA to identify the top 10 percent of patients whose care accounts for 50 percent of the total care costs in the ACO, and to target interventions appropriately.

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- The ACO doctors finally feel empowered in their ability to impact the quality and costs of patient care. Furthermore, they are excited they are getting paid for doing what they are trained to do: provide high-value care to their patients. They found out that a physician ACO is doable, affordable, fun and renders better care at lower costs for their patients.

## VII. What Are The Relevant Metrics?

### A. The Basic Categories and Sources

You will need baseline data, of course, to create the comparison point on quality, efficiency and patient satisfaction “before” the ACO took over so you can compare it to what happened “after.” Hopefully, some of this data also will be useful to determine local gaps in care to help you pinpoint initiatives to pursue. Broadly, the measures chosen will need to cover quality, efficiency and patient satisfaction. An ACO may choose to match clinical initiatives and metrics (e.g., prevention of readmissions for heart failure and the readmission rate for heart failure), but early metrics could be more general. As noted, much data and many measures are unique to pediatric accountable care. Numerous national organizations are developing pediatric measures. The Joint Commission National Quality Core Measures, the National Institutes of Health, the CDC, the National Quality Forum and American Pediatric Association 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 pediatrics, think about those that also are important to the ACO (e.g., the MSSP quality measures, utilization or cost saving indicators) your hospital partner (Joint Commission measures) and payers.

### B. Examples of Measures That Serve Multiple Interests In the ACO

- Preventive services measures such as influenza and pneumonia vaccination, tobacco cessation counseling.
- Ambulatory sensitive admissions for CHF and for COPD.
- Acute care indicators such as aspirin for acute MI.
- Patient safety and care transition activities such as medication reconciliation, patient receipt of transition records and fall risk assessment.
- Utilization and financial measures such as percentage revisits to ED, pm/pm for ED care, imaging rates (CT, MRI).
- ED utilization rates.
- ED-to-hospital admission rates.

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## C. Examples of Metrics to Measure Pediatrician Performance:

**Strategic Note: Don't Wait for the Payer to Pick.** A lot of bad can come with an initiative being so new and untested, like pediatric care ACO implementation; but let's take advantage of one positive: The payers often will listen to you about what are the most appropriate clinically-valid pediatric care metrics. Do not wait. Do not be passive. Who knows better than you? Pediatric Accountable Care Workgroup members recounted stories of success in establishing benchmarks and measures, especially with commercial managed care. There is a window of opportunity that will not stay open for you and your professional associations.

Though somewhat dated and limited to quality metrics, the American Academy of Pediatrics clearly articulates how and why pediatric measures are different from adult measures in its article, *Principles for the Development and Use of Quality Measures*.<sup>27</sup> “Despite excellent intentions and pockets of superb care, numerous studies, including the Commonwealth Fund’s *Quality of Health Care for Children and Adolescents: A Chartbook*, the *National Healthcare Disparities Report*, and the *National Healthcare Quality Report*, have shown considerable variation in outcomes of care across providers and communities and in utilization, safety, and quality care for all children as well as significant disparities in these dimensions for minority children. A major opportunity exists to improve care in a way that will make a real difference in the lives of children and families. To close the gaps in children’s health care, an initial step is the use of measures to identify opportunities for improvement and track changes in quality over time as interventions are implemented.”<sup>28</sup>

They found that, “To date, most national quality measurement efforts have not focused on children.”<sup>29</sup>

Insight into the particular data/metrics needs for effective child care may be gleaned from its discussion of the “4 Ds.”

“The 2004 IOM publication *Children’s Health, the Nation’s Wealth* emphasizes the critical differences between children and adults that warrant special attention to children’s health. This report notes that data on children’s health and its influences are needed to maximize the health of individuals from childhood through adulthood. Children represent a population with unique health care needs, often called the ‘4 Ds.’

- **Development:** Children experience rapid developmental changes during infancy, childhood, and adolescence. These changes should be taken into account when developing and using measures.

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<sup>27</sup> Am. Acad. of Ped., Pediatrics, Vol. 121, Num. 2, pp. 411-418, (Feb. 1, 2008), *Principles for the Development and Use of Quality Measures*, <http://pediatrics.aapublications.org/content/121/2/411-full>.

<sup>28</sup> *Id.*

<sup>29</sup> *Id.*

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For example, different schedules and types of immunizations should be measured at different ages. Developmental changes also affect the extent to which children's own assessments can be used to measure aspects of quality, such as patient-centeredness and timeliness.

- **Dependency:** Children depend on caregivers for many aspects of care. Parents and guardians play substantial roles in aspects of quality, such as the actual use of prescribed drugs, devices, and services. Careful specification of data sources and risk adjustment are essential for adequately adjusting for factors that influence specific care.
- **Differential epidemiology:** Most adult and generic quality indicators focus on specific diseases rather than health. The relatively low rates of children with most specific serious chronic illnesses and disabilities can make quality measurement and use of measures difficult, because the provider, practice and plan-level sample size may be too small for meaningful comparison. Measures of preventive services and crosscutting measures of quality for children with special health care needs can be used in addition to condition-specific measures.
- **Demographics:** Currently, two-fifths of the nation's children are from minority groups and almost one-fifth live in poverty, which are rates higher than those for adults. Health care quality for children differs according to race, ethnicity and income, and these factors are important to capture in measurement strategies.”<sup>30</sup>

By way of example, attached at Attachment A is the Pediatrics Measures List of Community Care of North Carolina, which is constantly under review and refinement.

**Strategic Note:** Start small. One Pediatric Accountable Care Workgroup member recounted that the pediatrics team in his multi-specialty ACO ambitiously started with over 40 measures. They were overwhelmed and taxed their ability to enter data and the ACO data analytics engine's ability to retrieve all necessary data. They reduced the list to the roughly 10 measures that they felt had the most impact for them. As initiatives changed, so did the measures to track the behavior and outcomes they were focusing on. This narrowing positively affected reporting results. Their core foundation consisted of: immunization rates, depression screening, BMI, blood pressure, asthma management and pharyngitis testing. So use the attached longer list as a “menu” if you are starting out. But, tailor the core list to your situation.

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<sup>30</sup> *Id.*

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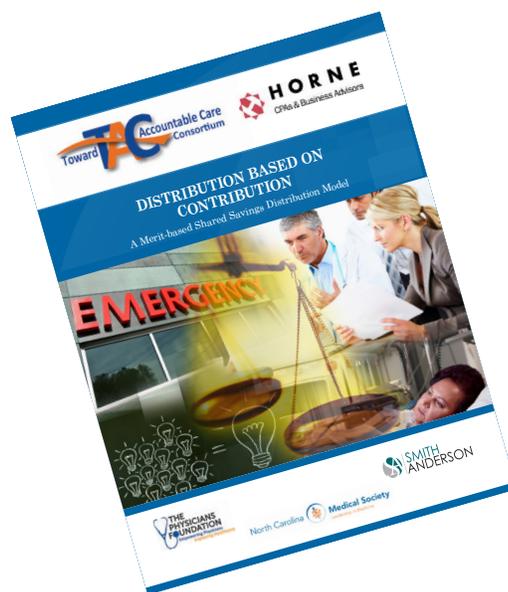
## VIII. How Do I Ensure That The Savings Pool Distribution Is Fair?

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

The longer the timeframe being considered, the more the value of long-term care for our children becomes evident. Pediatricians need to leverage this impact by framing savings discussions and contract negotiations as a long-term value proposition.

**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](http://www.tac-consortium.org/wp-content/uploads/2013/09/Shared-Savings-Guide_091013_revised_reduced-file.pdf).



## IX. Protect your interests: Negotiation Tips

### A. Negotiating with ACOs

Physicians may be asked to sign ACO participation agreements with an ACO. 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 interests by negotiating a merit-based shared savings distribution.

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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 also is 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.<sup>31</sup>
- **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 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 the Centers for Medicare and Medicaid Services’ (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.

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<sup>31</sup> Portions reprinted with permission from The Advisory Board Company©.

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- **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 also is 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 is also 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 should also include consideration of the following:
  - **Flexibility for the ACO to localize the most appropriate value-adding programs;**

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- o Description of duties of payer and providers;
- o Description of the association of shared savings with fee-for-service payments;
- o Benefit design and co-pays to facilitate achieving your care management goals; and
- o 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 pediatrician. 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. Pediatricians 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 pediatricians 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 pediatricians in accountable care, to assist them in avoiding the pitfalls, and to help them develop accountable care strategies for pediatrician care in different settings. For further information, contact the TAC Consortium and Initiative lead liaison, Melanie Phelps, at either [mphelps@ncmedsoc.org](mailto:mphelps@ncmedsoc.org) or 919-833-3836.



# Part Three: Executing the Accountable Care Strategic Plan



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## I. General Strategies For All Specialties

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

America's largest payor, Medicare, has committed to the ACO model, with a minimum of 50% sharing of savings to ACO providers on top of fee-for-service payments. It may be totally or partially physician-driven, and only primary care physicians are required. To promote physician-only ACOs in non-metropolitan areas, CMS will prefund them through the Advance Payment Model. This level of sustainable funding through ongoing shared savings distributions can "pay for" your ACO operations that can in turn be used for Medicaid, private payor, or other patient population engagements. **The applications are consistent with the principles and strategies of this Physicians' ACO Toolkit, and it is a useful reference to assist in responding to substantive portions of the applications.**

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

#### 1. MSSP Application

Applying to the MSSP requires ACOs to submit a significant amount of information. As a result, organization, information gathering, and timing will all be critical for ACOs wishing to participate. The application process can be broken down into the following seven tasks: (a) identify timelines and deadlines; (b) creation and formation of the ACO; (c) file Notice of Intent to Apply; (d) obtain CMS User ID; (e) prepare and execute participation agreements; (f) prepare application; and (g) file application with CMS.

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

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b. **Creation and Formation of the ACO** – ACOs applying to the MSSP must ensure that they are properly organized or incorporated under applicable state laws. Newly formed ACOs will need to file Articles of Organization or Articles of Incorporation with the applicable Secretary of State. Newly formed ACOs will also need an Employer Identification Number from the IRS, which may be obtained online at <https://sa.www4.irs.gov/modiein/individual/index.jsp>.

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

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

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

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d. **CMS User ID** – CMS currently requires all interested ACOs to file the MSSP application online using CMS's secure web portal, the Health Plan Management System ("HPMS"); CMS will not accept paper applications. In order to use HPMS, the ACO must obtain a user ID and password using the CMS Form 20037 Application for Access to CMS Computer Systems, available at: [www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/Downloads/EUAaccessform.pdf](http://www.cms.gov/Research-Statistics-Data-and-Systems/CMS-Information-Technology/InformationSecurity/Downloads/EUAaccessform.pdf). After the ACO files the NOI, the ACO will receive an email from CMS with instructions for completing the Form 20037, along with the deadline for filing the Form 20037. The individual who will be preparing the MSSP application for the ACO should file the Form 20037.

e. **Participation Agreement** – ACOs applying to the MSSP must have participation agreements with their participating providers. At a minimum, the participation agreement must include: (a) an explicit requirement that the ACO participant will comply with the requirements and conditions of the MSSP; (b) a description of the ACO participants' rights and obligations in and representation by the ACO; (c) a description of how the opportunity for shared savings or other financial arrangements will encourage ACO participants to adhere to the ACO's quality assurance and improvement program and evidence-based clinical guidelines; and (d) remedial measures that will apply to ACO participants in the event of non-compliance with the requirements of their agreements with the ACO. The ACO will need to submit its signed participation agreements with each of its participants when it applies to the MSSP. As a result, ACOs will need to prepare their participation agreements well in advance of the application filing deadline and ensure adequate time to collect signed copies from participants.

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

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

A significant portion of the MSSP application consists of certain narrative responses that must be completed by the ACO. These narratives include descriptions of: (a) the ACO's history, mission, and

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organization; (b) how the ACO plans to use shared savings payments; (c) how the ACO will use and protect Medicare data; (d) how the ACO will require its participants to comply with and implement its quality assurance and improvement program; (e) how the ACO defines, establishes, implements, evaluates, and periodically updates its process to promote evidence-based medicine; (f) how the ACO defines, establishes, implements, evaluates, and periodically updates its process to promote patient engagement; (g) how the ACO defines, establishes, implements, evaluates, and periodically updates its process and infrastructure to support internal reporting on quality and cost metrics; and (h) how the ACO defines, establishes, implements, evaluates, and periodically updates its care coordination processes. The ACO will need to carefully review the required elements of each narrative listed in the MSSP application and ensure that each element is discussed in detail; failure to address each required element may result in delay (or rejection) of the ACO's application. As mentioned, this Physicians' ACO Toolkit may be a useful aid in preparing this part of the application.

Assuming that the ACO has gathered all required information in advance, the process of filing the MSSP application through HPMS should be fairly straightforward. The ACO will first need to submit contact information for the ACO and complete certain attestations to ensure that the ACO meets all applicable requirements of the MSSP. The ACO will then submit supporting documentation (including the organizational chart, executed agreements, narratives, and other documentation described above). Prior to uploading this documentation, the ACO will need to review the MSSP application reference table for instructions regarding file names and other HPMS uploading requirements, which is available at: [www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/sharedsavingsprogram/Downloads/MSSP-Reference-Table.pdf](http://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](http://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms588.pdf).

## **2. Conclusion**

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

**B. Strategy Number 2: [UNDER CONSTRUCTION.]**

**C. Strategy Number 3: [UNDER CONSTRUCTION.]**

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## II. Specific Strategies for Specific Specialties

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

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

[http://www.tac-consortium.org/wp-content/uploads/2013/04/Anesthesiologist\\_ACO\\_Toolkit.pdf](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 is being developed by the Accountable Care Workgroup of the North Carolina Foundation for Advanced Health Programs and TAC personnel.

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

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

[http://www.ncafp.com/files/ACOGuide-CME\\_1.pdf](http://www.ncafp.com/files/ACOGuide-CME_1.pdf)

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

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

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

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

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

**L. Pediatricians.** Accountable Care Guide for Pediatricians is being developed by the Accountable Care Workgroup of the North Carolina Pediatric Society and TAC personnel.

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

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

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

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ATTACHMENT A (referenced on page 58)

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## PEDIATRICS MEASURES LIST OF COMMUNITY CARE OF NORTH CAROLINA

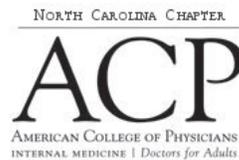
TYPE	Full CCNC Pediatric Measures List	CMS (yearly) CARTS	CCNC - QMAF (Quarterly)	PEHR Measures for use in Category D	Data Source
<b>Prenatal/Perinatal</b>					
CMS 1	Timeliness of prenatal care	x			Vital Records
CMS 2	Frequency of ongoing prenatal care	x			Vital Records
CMS 3	% of live births <2500g	x			Vital Records
CMS 4	Caesarean rate for low-risk first birth women	x			Vital Records
<b>Immunizations</b>					
CMS 5	Childhood Immunizations	x	coming 2014		DMA/NCIR
CMS 6	Adolescent Immunizations	x	coming 2014	x	DMA/NCIR
<b>Screening</b>					
CMS 7/QMAF	BMI - Weight assessment for children/adolescents	x	x	x	Claims
CMS 8	ABCD - Screening for potential delays in social and emotional development -	x			Claims
QMAF -	NC ABCD - Developmental and behavioral screening at the WCV ages 0-5		x	x	Claims
QMAF-EPSDT	99240 - MCHAT, school age and adolescent screening rates (PSC & Bright		x	x	Claims
QMAF-EPSDT	Hearing Screen		x	x	Claims
QMAF-EPSDT	Vision Screen		x	x	Claims
CMS 9	Chlamydia screening for women	x			Claims
<b>EPSDT - Well Child-Care Visits (WCV)</b>					
CMS 10/QMAF	EPSDT - WCVs in the first 15 months of life	x	x	x	Claims
CMS 11/QMAF	EPSDT - WCVs in the third, fourth, fifth and sixth years of life	x	x	x	Claims
CMS 12/QMAF	EPSDT - WCV for 12-21 yrs. of age—with PCP or OB-GYN	x	x	x	Claims
QMAF	EPSDT - WCV for ages 7-11		x	x	Claims
<b>Dental and Dental Varnishing</b>					
CMS 13	Total eligible receiving preventive dental services (EPSDT measure Line 12B)	x			416
CMS 17	Total EPSDT eligible who received dental treatment services (EPSDT CMS Form 416)	x			416
QMAF	Annual Dental Visit - Prevention and/or Treatment		x	x	Claims
QMAF	Patients with dental fluoride varnish claims in first 42 months of life (IMB-		x	x	Claims
<b>Availability</b>					
CMS 14	Children and adolescents' access to primary care practitioners (PCP)	x			Claims
<b>Upper Respiratory—Appropriate Use of Antibiotics</b>					
CMS 15	Pharyngitis—appropriate testing related to antibiotic dispensing d/c March 2014	x			N3CN
CMS 16 - D/C	Otitis Media w/Effusion—avoidance of inappropriate use of systemic antimicrobials—ages 2-12 - d/c 2013	x			N3CN
<b>Emergency Department</b>					
CMS 18/QMAF	Emergency Department (ED) Utilization—Average number of ED visits / MM	x	x		Claims
<b>Inpatient Safety</b>					
CMS 19 - D/C	Pediatric catheter-associated blood stream infection rates (PICU and NICU) d/c 2012	x			TBD
<b>Asthma</b>					
CMS 20/QMAF	Annual number of asthma patients (>1 year old) with >1 asthma related ER visit d/c March 2014	x	x		N3CN
QMAF	Continued care visit (Annual Chart review)		x	x	N3CN-Chart
QMAF	Asthma Action Plan (Annual Chart review)		x	x	N3CN-Chart
QMAF	Environmental triggers (Annual Chart review)		x	x	N3CN-Chart
QMAF	Appropriate pharmacological Rx (Annual Chart review)		x	x	N3CN-Chart
QMAF	Beta-agonist overuse (Claims Data - Quarterly)		x		Claims
QMAF	Absence of controller Rx (Claims Data -Quarterly)		x	x	Claims
QMAF	Asthma hospitalizations (Claims Data-Quarterly)		x		Claims

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TYPE	Full CCNC Pediatric Measures List	CMS (yearly) CARTS	CCNC - QMAF (Quarterly)	PEHR Measures for use in Category D	Data Source
	<b>ADHD</b>				
CMS 21	Follow-up care for children prescribed attention-deficit/hyperactivity disorder (ADHD) medication (Continuation and Maintenance Phase)	x			Claims
	<b>Diabetes</b>				
CMS 22/QMAF	Annual hemoglobin A1C testing (children and adolescents diagnosed with diabetes) - d/c March 2014	x	x		N3CN
QMAF	A1c control (poor) (Annual Chart Audit)		x		N3CN-Chart
QMAF	Lipid management (poor) (Annual Chart Audit)		x		N3CN-Chart
QMAF	Smoking status/cessation (>10 years old) (Annual Chart Audit)		x		N3CN-Chart
QMAF	Eye exam in children > 10 year old (Claims Data - Quarterly)		x		Claims
QMAF	Nephropathy screening > 10 (Claims Data - Quarterly)		x		Claims
	<b>Mental Health</b>				
CMS 23	Follow up after hospitalization for mental illness	x			Claims
QMAF	Annual glucose screening in children receiving antipsychotic therapy (age ≤ 18)		x		
QMAF	Annual lipid screening in children receiving antipsychotic therapy (age ≤ 18)		x		Claims
	<b>Family Experience of Care</b>				
CMS 24	HEDIS CAHPS@4 w/ supplements for children w/ chronic conditions and	x			Claims
	<b>New Proposed Measures</b>				
CMS New	Human Papillomavirus (HPV) for Female Adolescents	x		x	
CMS New	Medication Management for People with Asthma	x			
CMS New 2013	Behavioral Health Risk Assessment (for Pregnant Women)	x			
Proposed	Depression screening for all ages > 12				
Proposed	Maternal Depression screening				
	<b>CMS only Measure</b>				
	<b>QMAF only Measure</b>				
	<b>Measure overlap</b>				

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## ACKNOWLEDGMENT



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