



NCAALHD
North Carolina Association
of Local Health Directors

A GUIDE FOR OPTIMIZING THE ROLE OF LOCAL HEALTH DEPARTMENTS IN ACCOUNTABLE CARE

Preparing Local Health Departments for the
Approaching Accountable Care Era



North Carolina



Medical Society
Leadership in Medicine



ACKNOWLEDGMENT

This strategic guide involved input through participation by many thought leaders of the following sponsoring organizations who have come together to form the Toward Accountable Care Consortium and Initiative (“TAC”). This paper would not have been possible without the generous support of all TAC member organizations, including significant support from the North Carolina Medical Society, as well as a substantial grant from The Physicians Foundation. Special thanks to the North Carolina Academy of Family Physicians and North Carolina Society of Anesthesiologists, whose seminal ACO white papers are the underpinning of this Toolkit. We are grateful to Julian D. (Bo) Bobbitt, Jr. of the Smith Anderson law firm, for compiling the information in this non-technical “blueprint” format and to the following individuals for their expertise and input: Gerri Mattson, MD, NC Department of Health and Human Services; John Graham, PhD, UNC Gillings School of Public Health; John Rouse, Harnett County Health Department; Lisa Harrison, NC Association of Local Health Directors; Lisa Shock, PA-C, CHESS; Maggie Sauer, Foundation for Health Leadership and Innovation; Melissa Baker, Mountain Area Health Education Center; Ruth Petersen, NC Department of Health and Human Services; Sharon Boss-Nelson, NC Department of Health and Human Services. This guide would not have been possible without the efforts of these individuals.

County / Regional Medical Societies

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

continued next page

Specialty Societies

Carolinas Chapter, American Association of Clinical Endocrinology
North Carolina Academy of Family Physicians
North Carolina Chapter of American College of Cardiology
North Carolina Chapter of the American College of Physicians
North Carolina College of Emergency Physicians
North Carolina Council on Child and Adolescent Psychiatry
North Carolina Dermatology Association
North Carolina Neurological Society
North Carolina Obstetrical and Gynecological Society
North Carolina Orthopaedic Association
North Carolina Pediatric Society
North Carolina Psychiatric Association
North Carolina Radiologic Society
North Carolina Society of Anesthesiologists
North Carolina Society of Asthma, Allergy & Clinical Immunology
North Carolina Society of Eye Physicians and Surgeons
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State Societies / Organizations

Community Care of North Carolina
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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

A GUIDE FOR OPTIMIZING THE ROLE OF LOCAL HEALTH DEPARTMENTS IN ACCOUNTABLE CARE

INTRODUCTION

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

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

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

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



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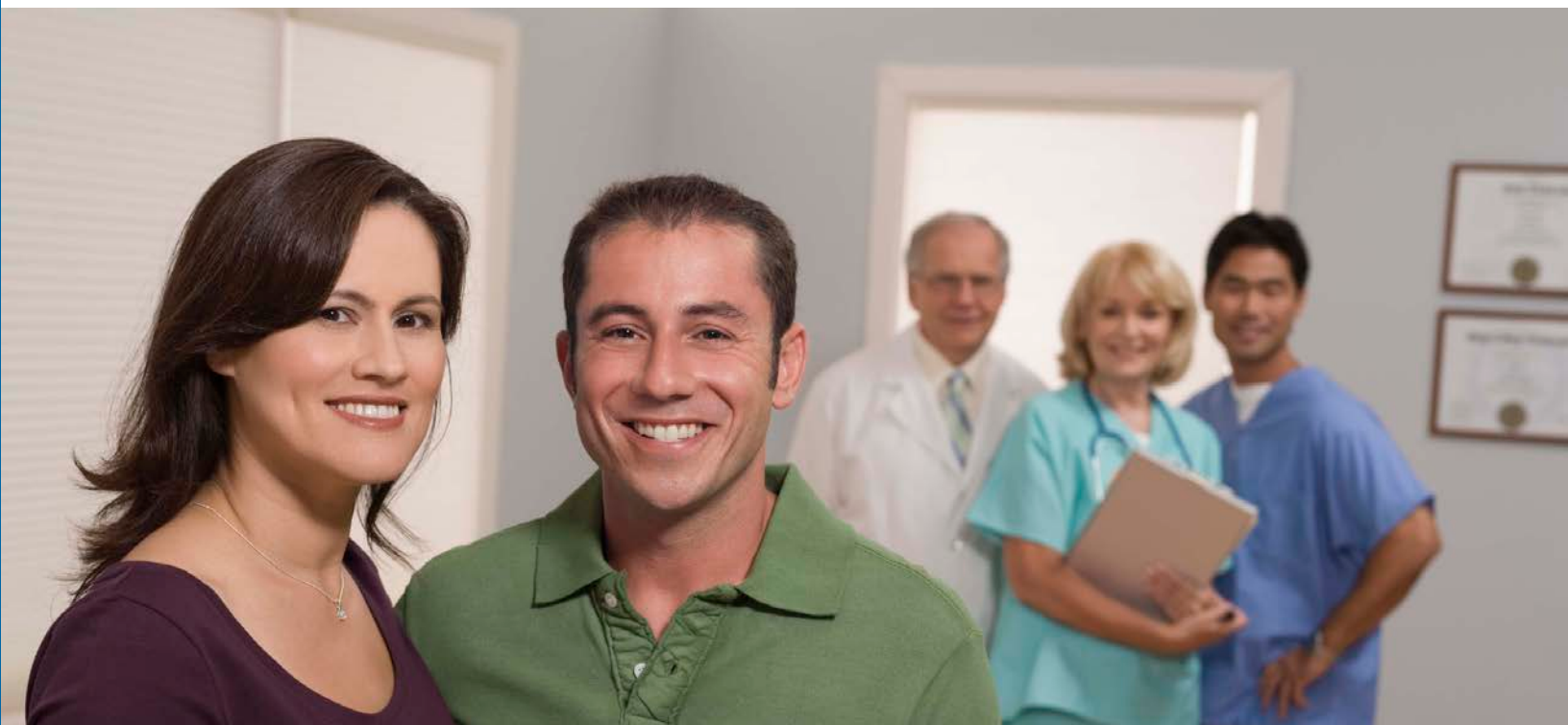
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The Physician's Accountable Care Toolkit

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



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I. Purpose Of The Accountable Care Guide

Accountable Care Organizations (“ACOs”) are emerging as a leading model to address health care costs and fragmented care delivery. For example, in 2012, Accountable Care is being considered for implementation by virtually every private and public payor in North Carolina. It transcends federal health regulatory legislation and Medicare. The purpose of this ACO Guide is to bring together in one source a non-technical explanation of the essential elements required for any successful ACO and practical step-by-step guidance on how to achieve each element. Because a successful ACO must be “win/win”, with every collaborative participant incented and empowered to achieve their optimum value-added contribution to the enterprise, these principles transcend medical specialty, employment status, payor relationship, or facility type. This Guide works for you whether you are a primary care physician, a hospital CEO, or a specialist physician. Although ACOs are still evolving and definitive predictions are impossible at this time, the goal of the Guide is to give any reader a firm sense of the strengths and weaknesses of any ACO model they may encounter and confidence about whether to join one or to create one. There are answers to questions about who should join, who should lead, what infrastructure will work, and the phases of development to be followed.¹

II. What Is An ACO?

A. Definitions

Former Administrator of the Centers for Medicare and Medicaid Services (“CMS”) Mark McClellan, M.D., Ph.D. described an ACO as follows: “ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients.”² Similarly, the National Committee for Quality Assurance (“NCQA”) included the following definition in its draft ACO criteria: “Accountable Care Organizations (ACOs) are provider-based organizations that take responsibility for meeting the healthcare needs of a defined population with the goal of simultaneously improving health, improving patient experiences, and reducing per capita costs....[T]here is emerging consensus that ACOs must include a group of physicians with a strong primary care base and sufficient other specialties that support the care needs of a defined population of patients. A well-run ACO should align the clinical and financial incentives of its providers....ACOs will also need the administrative infrastructure to manage budgets, collect data, report performance, make payments related to performance, and organize providers around shared goals.”³ (Emphasis added.)

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

¹ It is not the purpose of this Guide to provide legal advice. Any person or organization considering participation in an ACO should seek the advice of legal counsel.

² Mark McClellan, Director of the Engleberg Center for Health Care Reform at the Brookings Institution, *A National Strategy to Put Accountable Care Into Practice*, Health Affairs (May 2010), p. 983.

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

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

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

B. PPACA Requirements

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

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

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

⁴ 76 Fed. Reg. 67802 (Nov. 2, 2011)

⁵ 76 Fed. Reg. 67974

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

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C. How Is It Different From a Medical Home?

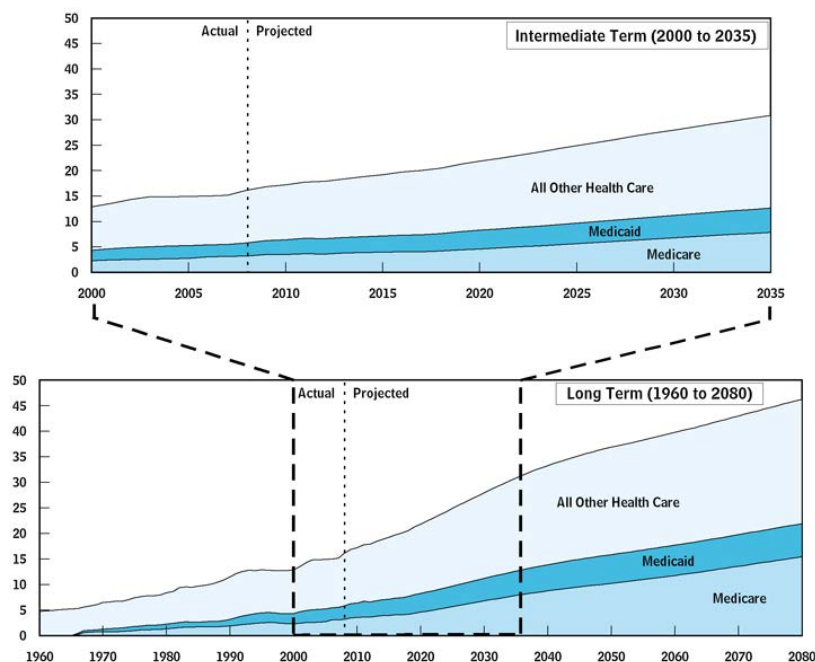
The Patient-Centered Medical Home (“Medical Home”) emphasizes strengthening and empowering primary care to coordinate care for patients across the continuum of care. It is complimentary to the ACO and can become the core of an ACO, but it is different in two main respects: (1) Financial Incentives -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

III. Why Should I Care?

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

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



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



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

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

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

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

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

IV. Are ACOs Really Coming?

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

No. Federal health reform has three prongs: Expand Coverage (individual and employer mandates, no pre-existing condition exclusions, etc.), Fraud Control, and Waste Controls (ACOs, bundled payments, value-based purchasing, CMS Innovation Center, etc.). Many experts think that expanding coverage into our broken system has made health care even more unsustainable. However, as noted, the cost curves, even without health reform, will bankrupt our resources, and the value-based reimbursement movement was well underway before the federal legislation was passed. Increasing awareness of problems with the fee-for-service system has resulted in a growing number of initiatives that have common features of accountability at the medical community level, transparency to the public, flexibility to match local strengths to value-enhancement opportunities, and shifting to paying for value, not volume.

B. Isn't This Capitation Revisited?

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

ACOs with shared savings are unlike capitation in several crucial ways. First, the payments are commonly only bonus payments in addition to fee for service payments.

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

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

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

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

Strategic Note: Though many experts propose that newly-formed ACOs assume financial risk through financial penalties, or partial or whole capitation, the 15 years clinical integration experience of this author strongly suggests that ACOs TRY NOT TO ACCEPT DOWNSIDE RISK UNTIL THEY HAVE THREE CONSECUTIVE YEARS OF MEETING BUDGET ESTIMATES.¹¹ There are just too many new partners, roles, moving parts, untested data metrics, and variables beyond the control of the ACO. Even taking a smaller share of the savings pool to recognize the absence of downside risk is preferred to accepting the responsibility of unanticipated medical expenses without the tools to control them. Having some “skin in the game” is clearly a logical way to incentivize accountability for providing value, but thrusting that on an unready health care system could do more harm than good.

C. Can't I Wait Until Things Get Clearer?

With hospitals and physicians having lots of other things on their plates and this bearing a resemblance to other reforms that never quite panned out, a wait-and-see attitude might at first seem reasonable. However, as the next chapter describes, successful ACO creation will require deep transformational change. The changes will have less to do with infrastructure and technology than culture. This is equally true in integrated systems with a fully-employed medical staff, as it is with other models. “Given the major cultural differences between hospitals and physicians, achieving clinical integration is one of the most difficult challenges that either party will ever undertake...Organizations that have not yet started down this path in earnest will need to move much more aggressively to prepare for the post fee-for-service world.”¹² You cannot wait to plan. Being unprepared is not an option. But there is a difference between having a plan and implementing a plan. If you are a hospital CEO or in a particular specialty you may want to wait until value-based reimbursement has reached the tipping point relative to fee for service before you “pull the trigger” in implementing your plan.

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

There are eight essential elements of any successful ACO. All eight are required. You cannot skip a step. Because element one is not as objectively verifiable, it is very counterintuitive that the most vital element is by far the most difficult element to obtain will be creation of an interdependent culture of mutual accountability committed to higher quality and patient satisfaction at the lowest cost. “[C]linical transformation has less to do with technical capabilities and more with the ability to effect cultural change.”¹³

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

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

¹³ *Id.*

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The Eight Essential Elements of a Successful ACO



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



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

1. Challenges for Physicians. Physician attitudes favor autonomy and individualism over collaboration. These attitudes are inculcated in clinical training and reinforced daily in care delivery. Reimbursement rewards an individualistic “eat what you kill” mentality. Physicians need to understand that the level of involvement needed to effect changes in quality and cost is much different than just banding together for contracting purposes. Physicians will have to be willing to change utilization, referral, and care-management patterns. In many settings, specialists will need to release primary control of patient care decision-making to the Medical Home primary care physician.

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

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

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

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

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

- **Champions.** Vision comes first, but to sell that vision, you need physician leaders able to articulate a clear and compelling vision of change. They need to be champions of the transformational changes needed. As few as one, and rarely more than five, are needed. If a hospital is involved, the CEO needs to show commitment to the shared vision.
- **Governance Structure.** The structure must have meaningful input from the various parties to have status and credibility. It must exhibit shared control. Management teams can be pairings of physicians with hospital administrators. As noted, shared governance is such a point of emphasis that the Final Rule includes that phrase in the definition of “Accountable Care Organization.”¹⁷
- **Incentives Drive Alignment.** “[I]f incentives are correctly aligned, organic innovations to solve other problems can and will engage.... Anticipated early versions of ACO payment incentives are likely to be directionally correct but unlikely to be sufficient to create the needed burning platform.”¹⁸ Compensation plans for hospital-employed physicians must not be limited to individual productivity, but also have incentives for accountability for success of the ACO team.

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

¹⁶ *Id.*

¹⁷ 76 Fed. Reg. 67974.

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

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

B. Essential Element No. 2: Primary Care Physicians



1. **What Is the Role of Primary Care In ACOs?** As discussed in detail in Section V.G. below, the highest-impact targets identified for ACOs lie in the following areas: (a) prevention and wellness; (b) chronic disease management; (c) reduced hospitalizations; (d) improved care transitions across the current fragmented system; and (e) multi-specialty co-management of complex patients. Primary care can be drivers in all of these categories.

Harold Miller of the Center for Healthcare Quality and Payment Reform concluded, “it seems clear that, in order to be accountable for the health and healthcare of a broad population of patients, an Accountable Care Organization must have one or more primary care practices playing a central role.”²⁰ He envisions different levels of ACOs, with the core Level One consisting primarily of primary care practices. Level Two would include select specialists and potentially hospitals. As the diverse patient populations are included, Level Three expands to more specialists and facilities, and Level Four includes public health and community social services. As noted, primary care is the only provider or health care facility mandated for inclusion to qualify for PPACA's ACO Shared Savings Program.

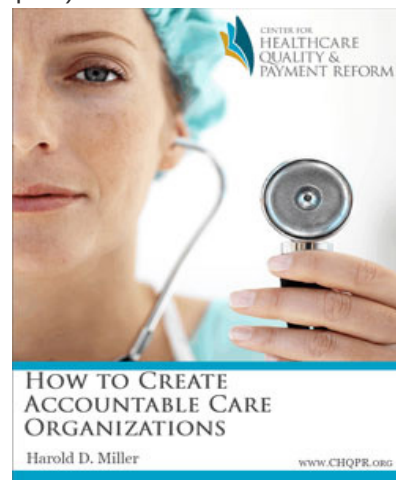
¹⁹ *Toward Accountable Care*, The Advisory Board Company (2010).

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

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

3. **What Are the Roles of Hospitals In ACOs?** Hospitals are logical ACO partners for several reasons: Patients will need hospitalization, hospitals have extensive administrative and HIT infrastructure, ACOs are consistent with their missions, and hospitals are often a medical community's natural organizational hub. But the typical ACOs tend to reduce hospitalizations. As Mr. Miller observes, "the interests of primary care physicians and hospitals in many communities will not only be unaligned, but will be in opposition to one another."²¹ A litmus test for hospital membership (or whether to join an ACO that includes a hospital) is whether it is committed to overall increased savings, improved quality, and improved patient satisfaction for patient populations, even if hospitalization rates are reduced. It is also unacceptable if a hospital permanently seeks to capture most of the shared savings "off the top" to make up for lost revenue. A hospital at over-capacity should not have this conflict. Moreover, many hospitals see full institutional commitment to accountable care as the best way to prepare for the future, maximize their fair share of the shared savings dollar, and grow market share. Once the tipping point of the shift from payment for volume to payment for value has been reached, these conflicts should dissolve.



In summary, because primary care will drive so many of an ACO's most high-yielding initiatives, it is an essential element of a lasting and successful ACO. "Accountable care absolutely must be about improving and maintaining the health of a population of patients and not just controlling costs. It must be about proactive and preventive care and not reactive care. It must be about outcomes and not volume or processes. It must be about leveraging the value of primary care and the elements of the Patient-Centered Medical Home."²²

²¹ *Id.*, p. 15.

²² Terry McGeeney, M.D., *The Patient-Centered Medical Home and the Accountable Care Organization*, <http://transformed.com/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).”²³ Similarly, a wide array of organizations may become eligible for CMS Shared Savings Program under PPACA and the Final Rule:²⁴ group practice arrangements, networks of practices, joint ventures between providers and hospitals, hospitals employing providers, and other approved structures. There are three essential infrastructure functional capabilities: (1) performance measurement, (2) financial administration, and (3) clinical direction. A legal entity of some sort is necessary, and a number of choices are available. The form ultimately chosen should be driven by what most readily facilitates achievement of the functional needs of the ACO initiatives in your community. The ultimate goals of accountable care are to improve patient outcomes and patient satisfaction while also achieving greater cost efficiencies. The key to achieving this goal is enhanced coordination of care among diverse providers through the application of evidence-based clinical protocols and transparent measurement and reporting. **“While ACO formation and ongoing structural, operational, and legal issues related to ACOs are important, it is this transformation in clinical care that must remain the overriding focus of ACO development.”**²⁵

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

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

²³ NCQA, pp. 7-8.

²⁴ 76 Fed. Reg. 67975.

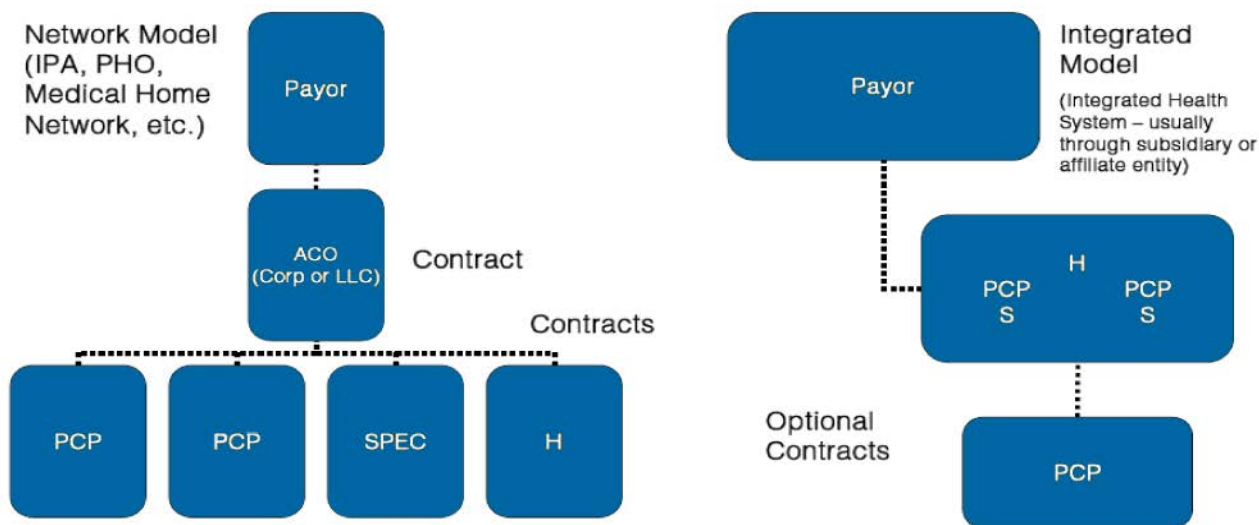
²⁵ Doug Hastings, Accountable Care News (December 2010), p. 6.

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

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

Possible Organizational Forms



1. Network Model

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

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

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

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

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

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



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

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

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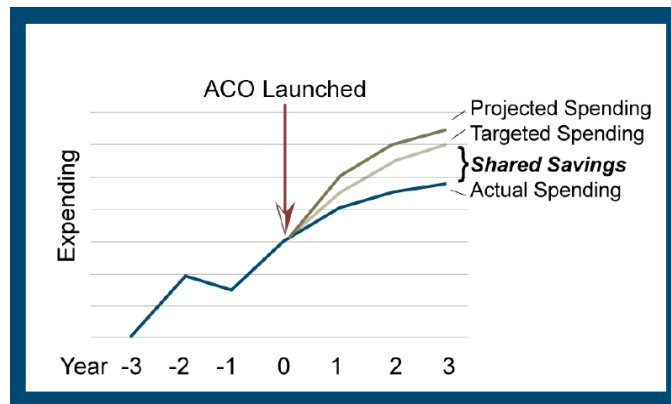
a. **Shared Savings** – If quality and patient satisfaction are enhanced or maintained and there are savings relative to the predicted costs for the assigned patient population, then a portion (commonly 50% according to some surveys and the MSSP Final Rule) of those savings is shared with the ACO. This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

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

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

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The Shared Savings Model



*Courtesy of the Brookings Institution

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

Strategic Note 2: Be Patient Before Taking on Risk. Do not repeat the disaster of the '90s, when providers took on risk without proper technology, infrastructure, best practices, or experience. We recommend that you come within 5% ± of your predicted costs for three consecutive years before leaving the shared-savings upside-only model. You may have unexpected costs over which you have no control. You will likely want to improve your Health Information Exchange, include relevant data elements, and see which of your ACO providers “get it.” In our experience, fears are overblown that lack of downside risk will deter performance improvement. To the contrary, a meaningful bonus payment is very motivating, as much as a recognition of and respect for the clinical leadership of the physicians as it is for the benefit of dollars involved. Individual distributions that differ based on performance determined by peers is also a “grade” that high-achieving individuals work hard to earn.

²⁶ 76 Fed. Reg. 67985-67988.

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

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

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

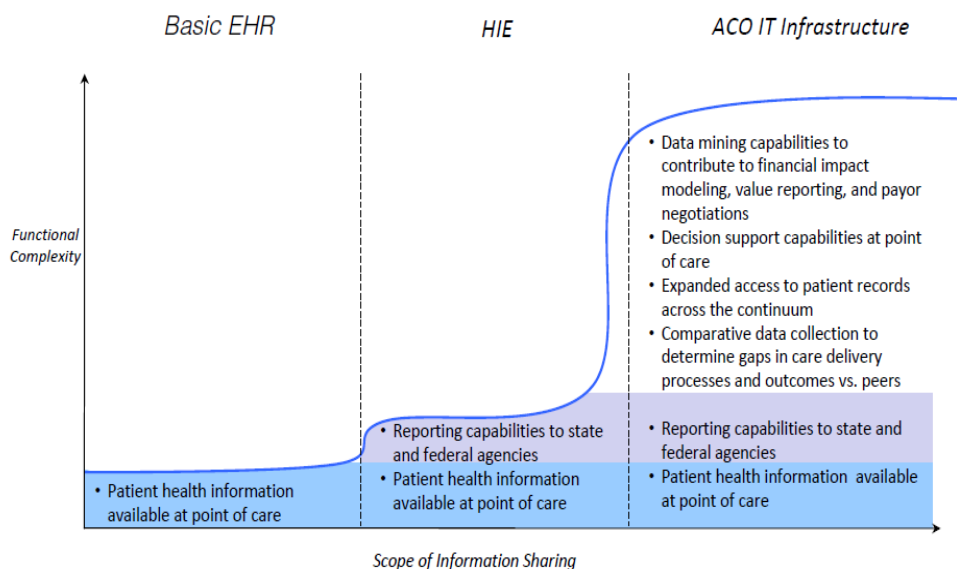
4. **“Meaningful Use” Regulations Incentives.** We include the “Meaningful Use” payments as an ACO financial incentive because the basic Health Information Exchange within your ACO will likely qualify the ACO’s providers for the Phase Two and Phase Three “Meaningful Use” incentives.²⁸ If your ACO can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

²⁷ 76 Fed. Reg. 67986-67987.

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

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



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

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

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

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

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

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

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

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

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



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

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

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

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

As discussed earlier in Section V.B., the richest “target fields” from this array will vary by specialty and type of facility. Looking at these suggested initiatives, it is no wonder why primary care is emphasized as key for ACOs, since they could play a significant role in every area. The ACO should match its strengths against the gaps in care in the ACO’s market to find the proverbial “low-hanging fruit.”

G. Essential Element No. 7: Patient Engagement



Patient engagement is another essential element. Without it, an ACO will not fully meet its potential. Unfortunately, many of today’s health care consumers erroneously believe that more is better, especially when they are not “paying” for it, insurance is. Patient noncompliance is a problem, especially regarding chronic diseases and lifestyle management. It is difficult to accept a compensation model based on input on improved patient population health when that is dramatically affected by a variable outside of your control, patient adherence. Currently, asking a patient to be a steward of his or her own care puts a fee-for-service payor at a competitive disadvantage. But patient engagement is part of patient-centeredness, which is required by PPACA for an ACO to qualify for CMS’ Shared Savings Program.³⁰

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

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

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What Can an ACO Do to Engage Patients?

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

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

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



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

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



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

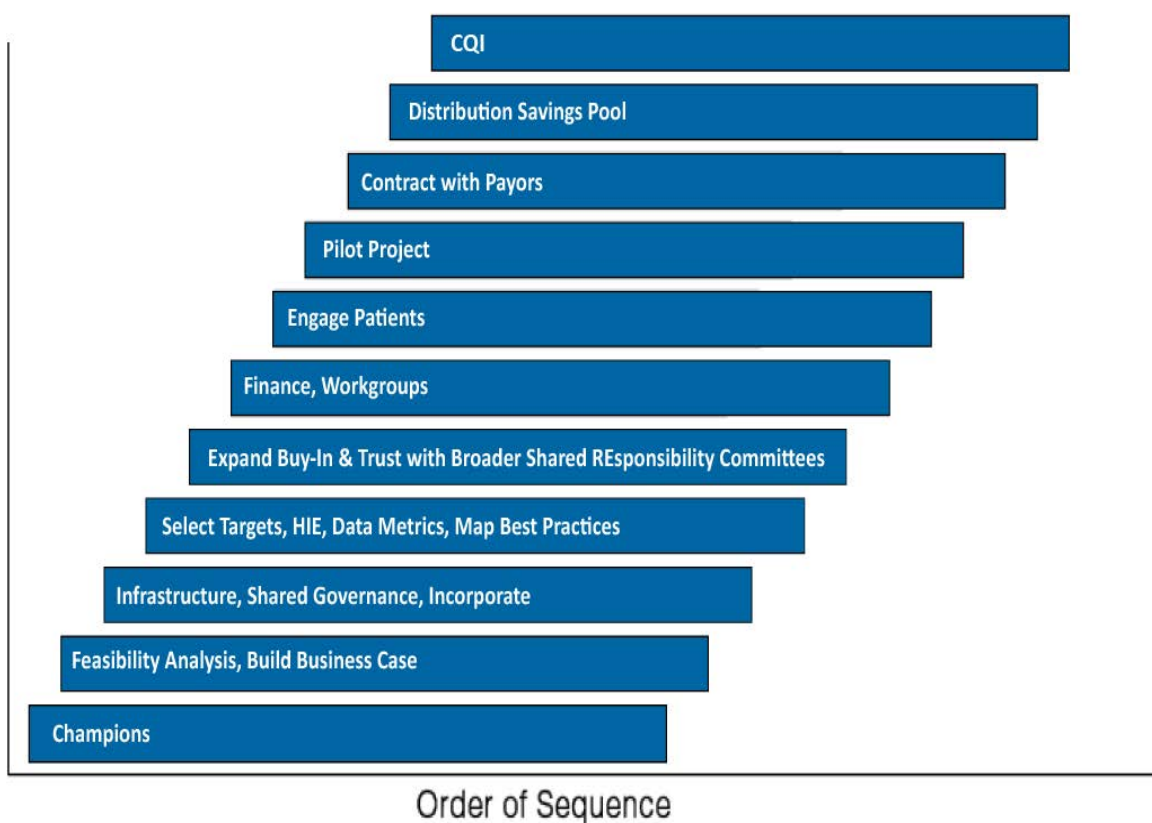
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VI. Successful Implementation – A Step-By-Step Guide

A. Where Do I Start?

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

B. Step-By-Step Guide



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

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

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

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

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

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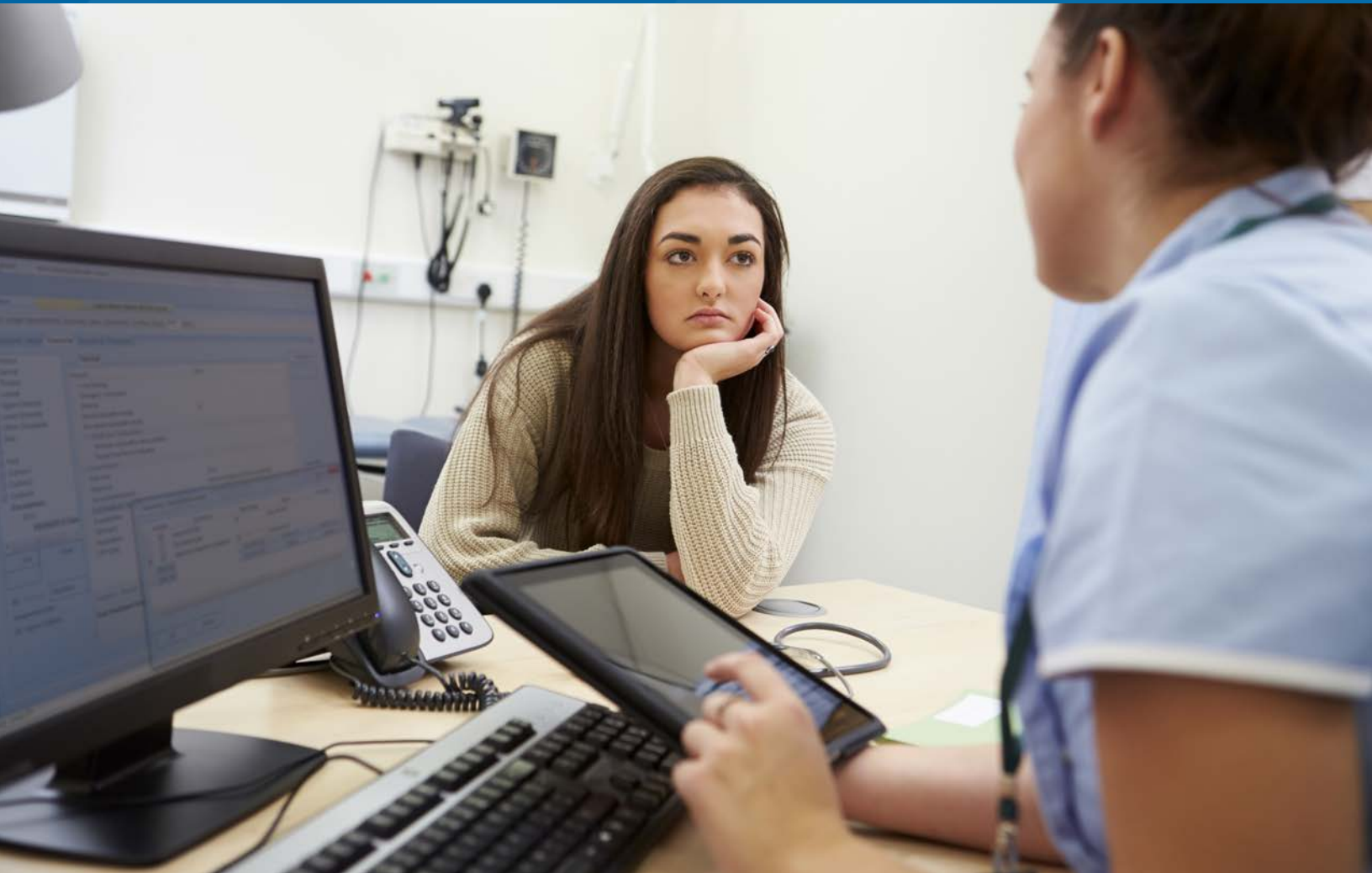
5. **Structural Foundation** – Choose the legal entity approach and formal governance structure most appropriate to your culture and business plan. It must be driven by the form most likely for the success of the ACO, not controlled by success for any particular stakeholder. Establish membership criteria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

VII. Conclusion

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

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

Part Two: The Accountable Care Guide for Local Health Departments



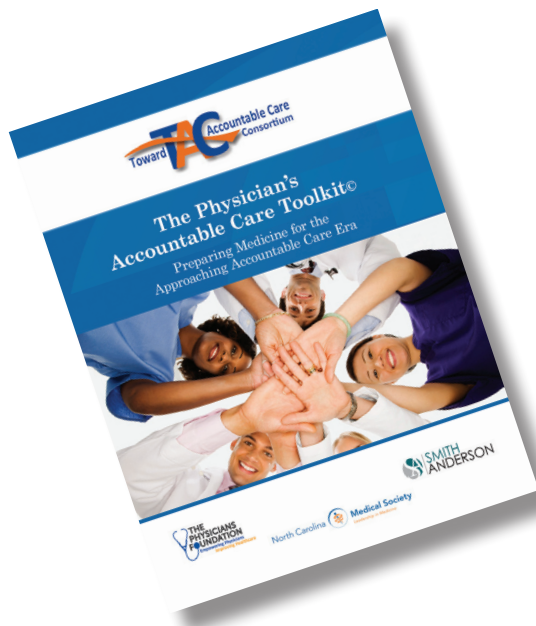
NCALHD
North Carolina Association
of Local Health Directors

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I. Introduction

A. Purpose of this Guide

The companion *The Physician's Accountable Care Toolkit*® describes what it takes to create a successful Accountable Care Organization (“ACO”) or Accountable Care Community (“ACC”) and the steps to get there. Since it is fundamental that an ACO be a win/win for all involved, it applies whether one is a local health director, hospital administrator, caregiver or physician. *A Guide for Optimizing the Role of Local Health Departments in Accountable Care*, on the other hand, spells out specific strategies to maximize the benefit ACOs will receive toward improved cost-effective population health from optimized contributions of local health departments.



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

1. **What Is an ACO?** – Former Administrator of the Centers for Medicare and Medicaid Services (“CMS”) Mark McClellan, M.D., Ph.D. described an ACO as follows: “ACOs consist of providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth. Our definition emphasizes that these cost and quality improvements must achieve overall per capita improvements in quality and cost, and that ACOs should have at least limited accountability for achieving these improvements while caring for a defined population of patients.”¹ Similarly, the National Committee for Quality Assurance (“NCQA”) included the following definition in its draft ACO criteria: “Accountable Care Organizations (ACOs) are provider-based organizations

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

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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.”²

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

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

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

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

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In addition to 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.

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



There are eight essential elements of any successful ACO. All eight are required. You cannot skip a step. **As early ACO success and failure reports confirm, by far, the most important element for ACO success is the creation of an interdependent culture of mutual accountability committed to higher quality at the lowest cost.**

1. **Culture** – Full collaboration and true partnering among hospitals, physicians and other providers will drive success. This must be coupled with a buy-in to change habits to work in teams to drive value with a “win/win” population management philosophy. This is way, way out of physicians’ and hospital

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administrators' comfort zones. Physicians love independence, autonomy and often just want to see patients. In the ACO model, better communication and teamwork is needed between orthopaedists and primary care physicians. Administrators have so far succeeded through a command and control model of leadership; that will not work in an ACO environment. Hospitals must buy in to the notion of reducing hospitalizations and avoiding use of hospitals for outpatient tests. For them, the ACO model represents a major cultural and financial shift. **"The most significant challenge of becoming accountable is not forming an organization, it is in forging one."**³ Culture keys are: champions, governance and advance planning for merit-incentives.

2. **Primary Care Physicians** – When reviewing Element 6 below, the core role of primary care becomes clear. Prevention, wellness, care transition and patient coordination management are the "low-hanging fruit" for ACO improvements and savings and are all in primary care's sweet spot. Primary care is the only sub-specialty required in Medicare's ACO program. Sophisticated ACOs will thrive with hospitals, specialists and community health partners, but primary care, at least one-third of the total membership, will always be at the core.

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

4. **Adequate Financial Incentives** – "[I]f incentives are correctly aligned, organic innovations to solve other problems can and will emerge.... Anticipated early versions of ACO payment incentives are likely to be directionally correct but unlikely to be sufficient to create the needed burning platform."⁴ One rule of thumb may be found in antitrust law, where the behavior changing tipping point in health care is considered to be having 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."

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

⁴ Ann Robinow, *Accountable Care News*, *The Top 30 Obstacles to ACO Implementation*, (Dec. 2010).

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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 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.”⁵

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

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

D. These Apply to Everyone

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

⁵ *Toward Accountable Care*, The Advisory Board Company (2010).

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II. Could Accountable Care Be A Good Thing For Health Departments?

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 local health departments and the populations they serve?

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

A. Cons

- Local health departments are generally underfunded and overburdened, being tasked with providing care to the most vulnerable populations within a community. Consequently, local public health officials lack the time, resources and intellectual bandwidth to take on yet another project.
- Many local health departments lack the statutory authority or infrastructure to receive reimbursement or other payments from local providers for services rendered in accordance with a care consortium.
- You have seen this “next big thing” before, and it didn’t work out as advertised. Public health officials, who routinely must shoulder the slack and fill in the care gaps in an environment of decreased revenue security, may be wary of or unable to take on additional responsibilities.
- Local health departments routinely address the needs of the most vulnerable portion of the population with complex, co-morbidities complicated by poverty and other socio-economic and environmental circumstances. These health care ‘super-users’ may not readily respond to simple preventative services, an immediate focus of the ACO’s approach.
- Collaborative care raises concerns of malpractice and HIPAA privacy liability.
- ACOs that are fully functioning and involve orthopaedists remain relatively rare.

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B. Pros

- The *status quo* is not an option. The “default future” for health care delivery in general is more fee cuts, less control and degraded patient care as the system further fragments. Public health leaders have the opportunity to participate in redesigning health care delivery, regaining empowerment over the process and being compensated for their leadership.
- ACOs will find the greatest positives of a well-organized ACO, such as health status assessment, chronic disease management, immunizations, collaborative and improved communications, better care coordination and a focus on preventative care, are already components within health departments.
- As with all providers who have been heroically battling a deeply fragmented system to provide cost-effective care, public health officials 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 public health as a profession.
- System-wide care delivery improvements will vastly leverage the expertise and experience of public health officials and may remove much of the frustration they experience with the current limitations presented by the health care system. With an ACO’s focus on preventative care and population-based management, public health officials are better able to influence patient care and risk identification to avoid the crisis-events – and be compensated for this vital contribution.
- Community public health leaders are in a preferred position to impact the significant and largely avoidable chronic care costs in this country, to demonstrate ‘value’ and thus be belatedly recognized and rewarded for their contributions. With their background in epidemiology, population management and patient and community engagement, public health officials bring vital skillsets essential for successful ACO population management. Health departments are experts already at doing more with less.

As Dennis Weaver, M.D. commented, “At its most basic, population health management means actively working to keep your community healthy. When you think about it that way, it makes you wonder, ‘Who or what is influencing the health of individuals in my community the most? To date... [The] strategy has focused mainly on the role health care providers themselves play as the main influencers of health outcomes. And health care providers are certainly important, but the reality is that we are not the only ones influencing the health status of the people we serve...[Health] systems will need to engage with organizations that impact the health determinants in...[a] community and [which] influence individuals’ behavior when they’re between provider visits.”

⁸ Mahoney, C., et al., *Shared Risk and Orthopaedic Surgeons*, Am. Acad. Ortho. Surgeons, AAOS Now (Feb. 2014), <http://www.aaos.org/news/aaoshow/Feb14/advocacy2.asp>.

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- “The traditional role of LHDs [‘local health departments’] in the provision and coordination of population health interventions could be leveraged, with the LHD playing a key role in formally linking prevention, acute care, disease management and wraparound services for patients....”⁶

You Have a Seat at the Table. Take It! There is a seat at the ACO table reserved for you, but they are not going to invite you to it – you must step forward and take it. Then show the ACO why it will be more successful by including you.

III. The Recommended Approach For Developing Integrative Accountable Care Strategies

In the value-based reimbursement era, each stakeholder is rethinking its role. Some of the questions confronting you 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? Under accountable care, the gains for providers will not be from seeing a patient cheaper or quicker, but from reducing costs for a patient population over a given period of time.

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

A hint of what an ACO participant should prioritize in the context of any partnership with an ACO is given by this review of the top five high-yield targets for ACOs:

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

From these potential initiatives, prioritize the ones that are likely to have the quickest and biggest results within your community. The selected initiative should have proven metrics and health care leaders willing to champion the effort. See what is working elsewhere and present the question: what

⁶N.C. Assoc. of Local Health Directors, Public Health Task Force, *A Blueprint of the Future for Local Public Health Departments in North Carolina*, p. 9, (June 2013).

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are the top things you could or would do within your community to improve wellness, if you had the resources. This should reveal the potential prioritized list of value-add ACO initiatives.

Interventions work, but some sooner than others. This is factored into an ACO's prioritization strategy:

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

Source: Geisinger

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 for the ACO's target population in that region. 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 Local Health Departments

A number of public health leaders realized local health directors and other public health officials must be prepared for the approaching accountable care era. They partnered with the Toward Accountable Care Consortium and Initiative ("TAC"). Following initial guidance from members of this TAC Local

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Health Directors Accountable Care Workgroup, staff and attorneys for the TAC Consortium conducted a national literature search, with emphasis on value-based care and benchmarking recommendations. The findings were further reviewed and revised by the TAC Local Health Directors Accountable Care Workgroup and presented to the TAC Physician Advisory Committee.

Macro predictive cost savings estimates were made, but a refined financial predictive modeling analysis, though needed, is beyond the scope of this project. Likewise, while guidance on the nature and type of performance metric selection is provided, the actual full development of these metrics is beyond the scope of this project.

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

V. Recommended Accountable Care Initiatives For Local Health Departments

This section is the heart of the strategic *Guide*. Without value-add contributions by local health departments, there simply is no accountable care strategy for them. Everything flows from the value-add initiatives: metrics, a compelling business case for why ACOs need to recruit health departments, shared savings models, etc.

A. Be the ACO's Social Determinant Link

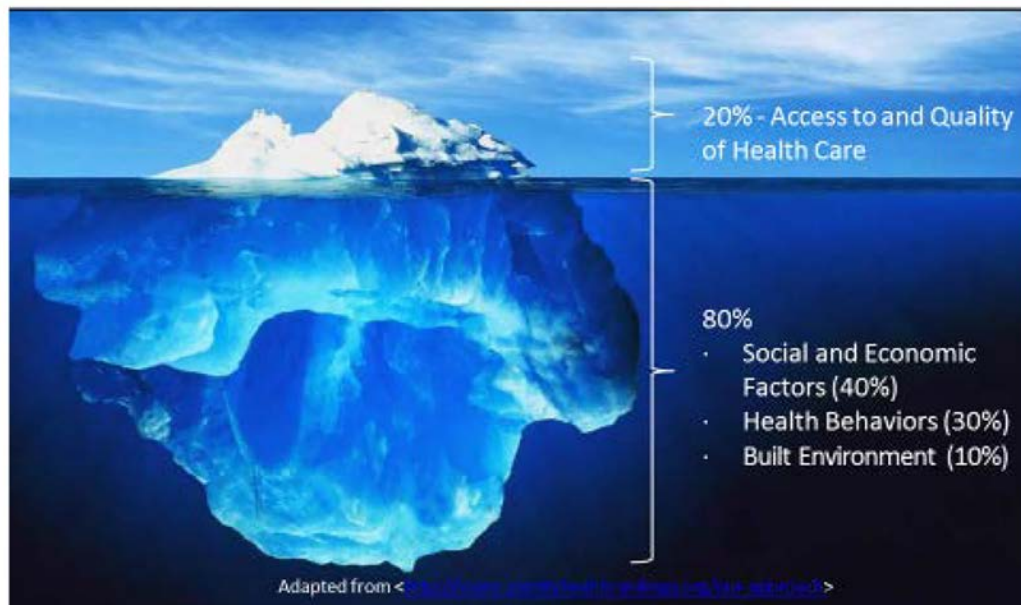
The January 2016 edition of Accountable Care News asked its expert panel: "What is the greatest challenge facing the ACO community in 2016?" Douglas Hastings, J.D. stated as the number one challenge, "Making dramatic progress on linking social determinants of health to medical determinants. This has long been known to be an important connection, but only recently has any critical mass of programs, particularly in the areas of hunger and housing, begun to be developed. CMS' launch of funding for bridge organizations through the Accountable Health Communities Model is an important push for Medicare and Medicaid in this regard."⁷

One of the more difficult adaptation challenges for our society in the shift to value-based health care reimbursement is the comprehension that we are financially rewarding a whole population's health; no longer paying for treating sickness on an individual basis. As Mr. Hastings' comments signify, ACOs, still comprised almost entirely of medical facilities and providers, are just now waking up to the fact that they are in the health business. For reasons discussed below, local health departments are ideally situated to claim a leading, and compensated, role in integrating medical and social services to address social determinants.

⁷ Douglas A. Hastings, J.D., Accountable Care News, p. 9, (January 2016).

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Factors Influencing Health Outcomes



8

Hennepin Health linked social services to its performance reimbursed integrated delivery models for three stated reasons:

- “Need to Meet Individual’s Basic Needs Before We Can Meaningfully Impact Health.
- Social Challenges Often Result in Poor Health Management and Costly ‘Revolving Door’ Care.
- By Financially Aligning and Coordinating Surplus, We Can Improve Health Outcomes and Reduce Costs.”⁹

1. **How Do I Link?** – No one will argue communitywide health promotion and disease prevention are central to effective, high-value population health. But few understand the financial magnitude of that impact, which directly drives an ACO’s savings distributions based on that assigned patient population’s health care expenditures. Even fewer know how to link community health resources with the medical system.

⁸ PowerPoint presented to Buncombe County Health Department in July 2015: *Hennepin Health (July 2015)*.

⁹ *Id.*

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- **Use Your Health Needs Assessment** – As this *Guide* confirms, every effective ACO strategy begins with a needs assessment, sometimes called a “patient stratification” or “gap analysis.” The ACO looks at how the assigned population’s health varies from the ideal in terms of avoidable gaps in health status and process breakdowns. Some needs assessments might address, from a medical perspective, such things as the numbers of emergency department visits for non-emergencies, or the percentage of patients with diabetes, but few embrace social determinants. Your broader gap analysis could be an ideal beginning point for linking social and medical needs across the patient population’s full spectrum of health-impacting variants. “This role represents a key opportunity to become the ongoing ‘convener’ for community health-related issues and initiatives in the LHD’s community health system.”¹⁰
- **Case Study: Trenton Health Team** – The Trenton Health Team linked medical groups with community groups, including the city’s health departments. Its director, Ruth Perry, stated, “We have a strong partnership with the health department. This allows us to look at how we plan to provide services from a population health perspective—caring for individuals and the community as a whole.”¹¹

2. **What Do I Do to Impact Social Determinates?** – The following Subsection V.B. will discuss the more classic clinical care or ACO-type care opportunities available for health departments to perform for ACOs. This subsection addresses just those particularly important for the social determinant contributions for health departments. Attached at Exhibit A are results of a recent survey showing the typical services provided by local health departments. The services potentially supporting an ACO’s social determinant health improvement goals are noted.

Let’s see what the two national leaders, Hennepin Health and Trenton Health Team, prioritized:

Hennepin

- Placing community health workers inside and outside the clinics.
- Including targeted behavioral health and social service interventions in clinical care coordination.
- Coordination through a shared IT platform, with emphasis on medication reconciliation and adherence. Including social service case information.
- Placing medically complex patients in available supportive housing, resulting in 36 percent ED and 16 percent hospital admissions reductions post-housing.

¹⁰ N.C. Assoc. of Local Health Directors, Public Health Task Force, *A Blueprint of the Future for Local Public Health Departments in North Carolina*, p. 10, (June 2013).

¹¹ L. Thresybule, N. J. Spotlight, *Trenton Health Team Gears Up to Become an ACO*, p. 1, (Nov. 2012); <http://www.njspotlight.com/stories/12/11/21/trenton-health-team-gears-up-to-become-an-aco/>. d.

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Trenton

- Finding housing for several of 50 disadvantaged patients who had more than 1,200 ED visits in one six-month period. One woman's ED use dropped from 400 to 26 visits the next year.
- Providing transportation for identified patients without access to their physicians.
- Clearing health clinic schedules to allow for same-day scheduling.

One guide for local health department success in the new value-based reimbursement era suggested health departments not only start the process by engaging the ACO in improving health by impacting community social determinants through its leadership in determining needs; but continuing to lead through outcomes evaluation. "Successful health promotion will leverage the availability of digital patient information and background in epidemiology to precisely target the areas of greatest need with the potential for greatest impact. LHDs will also be able to assess the efficacy of interventions, refine interventions and add to the RBS ("evidence-based best practices") knowledge."¹²

It suggests a "proactive" role in the following community health initiatives:

- Community engagement;
- Controlling communicable diseases;
- Population health promotion;
- Disease prevention (immunization, promoting appropriate use of antibiotics, restaurant inspection).¹³

One member of the Local Health Department Accountable Care Workgroup from the medical community provided a good summary of the argument for health department leadership in linking medical care with community partners to impact social determinants of health: "A good deal of the variation in patient outcomes in terms of costs and quality has much more to do with social and economic factors than the medical care provided the patients. While hospitals and physician groups may be able to identify those factors, most do not have the skill sets or interest to actually identify and coordinate the services needed to address those factors. **The Health Department has this skill set.**"¹⁴ He categorized this phase of health care transformation as "healthy populations" or "healthy communities." At the outset of this section, this category was designated as the number one ACO need. Is there a role for local health departments? According to this Workgroup member, "**Much of this phase could belong to the Health Department.**"¹⁵ [Emphasis added.]

¹² *Op. Cit.*, pp. 10-11.

¹³ *Id.*, pp. 10-11.

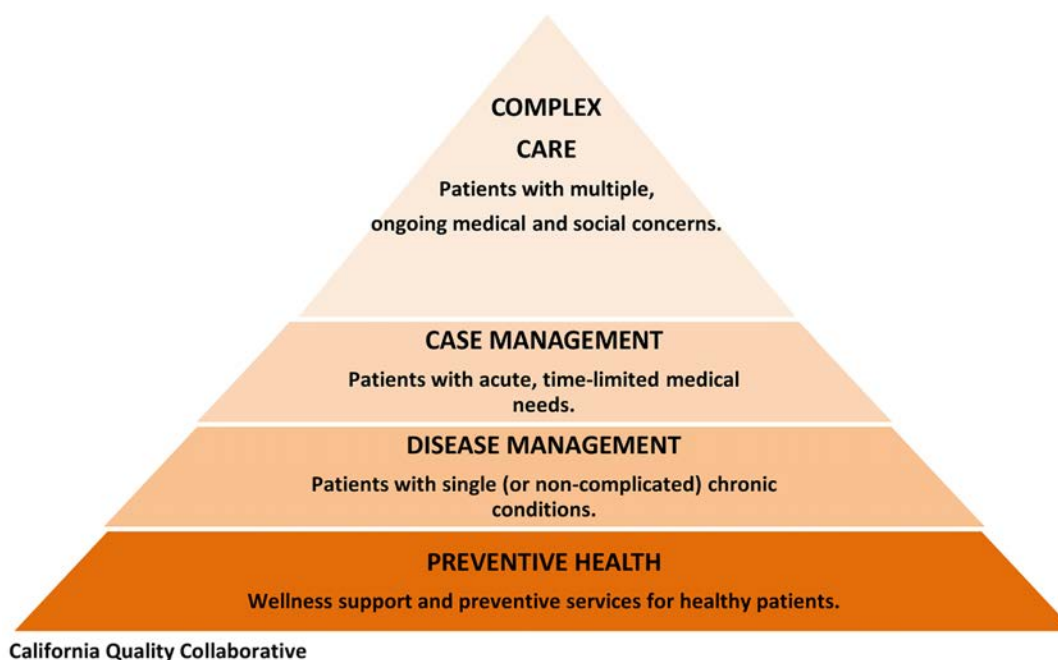
¹⁴ John Rezen email to Bo Bobbitt, p. 2, (Feb. 18. 2016).

¹⁵ *Id.*, p. 1.

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B. Prioritize the Most Effective Traditional ACO Initiatives

Beyond social determinants, as Exhibit A illustrates, there is an embarrassment of riches of opportunities for health departments to contribute to ACO improvement. The health department and ACO need to select a smaller subset of those that are measurable and doable. Many activities affect citizenry of a whole county or community. Many have health benefits that are difficult to measure or attribute to a single entity. Many take a long time to impact health. Which ones can be quantified relative to a specific population?



• **Which Ones Will Have the Biggest and Fastest Impact?**

1. **Complex Chronic Patient Identification and Management** – ACO experts have determined that management of the complex chronic high-risk patient drives the quickest and most robust returns. Comprising 5 percent of a typical patient population, they average consuming over 50 percent of its health care expenditures. The absolute highest ROI in an ACO is identifying those incipient high-risk patients before they become irreversibly so. So certain health department skillsets jump out, such as community needs assessments, early detection of chronic diseases, its control, patient education on its management, patient navigation and coordination and transition management across clinical and community settings. Lack of prenatal care correlates to catastrophic complex care for children and these services will therefore prove high-value.

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2. **Linking Behavioral and Medical Health** – This has proven value in improving outcomes while lowering costs. A health department can identify environmental and other socioeconomic factors leading to stress, depression and other behavioral health deterrents to good health.

3. **Prevention and Wellness** – There is a shortage of primary care in America, exacerbated by the expansion of coverage wrought by the Affordable Care Act. As this Guide emphasizes, primary care and its patient-centered medical home need to be at the heart of any ACO. But they do not have the resources to engage in all the prevention, wellness, patient engagement and care coordination required.

Health departments can be tremendous extenders for the ACO's medical homes. You perform vital services such as well-child services, child health, STD control, immunology, nutrition counseling, tobacco cessation and dental health, among others.

ACOs are just now realizing the specific things they need to be doing to promote wellness and prevention. You can be a salvation to them if you anticipate those needs and provide highly needed competent manpower, cooperation and services. Seizing this opportunity will be disruptive. You will need to alter your delivery model to new patient populations, reporting requirements, and reimbursement rules.

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

A. Pick the Right ACO

As detailed in the companion white paper, The Physician's Accountable Care Toolkit®, also Part I of this guide, 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.

1. **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 procedure will lower incomes.

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

2. **Twelve questions everyone should ask before signing up with an ACO:**

- i. Are you selective in picking and keeping only high-performing members; or are you signing up everybody to get “old school” referrals?
- ii. What is your specific value-add strategic plan?
- iii. What are the opportunities identified in your needs assessment?
- iv. Does it include my skillsets?
- v. How will you distribute savings?
- vi. Is it on a merit basis—distribution in proportion to contribution?
- vii. Is it exclusive—can I join another ACO?
- viii. Are there fees?
- ix. Am I personally responsible for medical losses of the ACO under risk contracts?
- x. Have you spent millions on information technology (IT)—may I see your budget?
- xi. Do you have knowledgeable and empowered providers on the clinical, IT and finance committees?
- xii. What is your community health partnering strategy?

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

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

1. **Build Relationships** – Public health officials 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 public health practitioners generally and the local health department specifically are ideally suited for ACOs. Health departments have

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the benefit of already operating in a manner compatible with an ACO setting and objectives and are thus not only ideally suited to adapt to an ACO, but to serve as a leader. Utilizing them in an ACO is a “no-brainer.” We have heard of the “elevator pitch” for startups, whereby the entrepreneur can tell a convincing reason to invest in their company in the length of the time it takes to ride an elevator. Public health officials 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. Local health departments need to get clear on what specific value they have to offer. Choosing from Section V the most impactful initiatives for the ACO’s particular population, it might be: clinical care; community prevention efforts that address the “upstream” needs of high-cost health conditions; serving as a liaison to connect the ACO with local community health organization leaders; writing themselves into grants with the ACO to partner in addressing social determinants of health; sharing geographic population health data and Geographic Information Systems (GIS) maps; sharing data on social services (especially in integrated health and human service agencies) such as heating assistance, food stamps/SNAP benefits, etc.; environmental health efforts such as advocating for improvements in physical infrastructure at local parks to reduce fall risk. “Furthermore, local health departments (LHDs) must be able to justify their role in newly-developed health care models, such as Accountable Care Organizations by tracking outcomes of interventions targeting health interventions, and pursuing data-driven quality improvement activities. ... LHDs need to be proactive about claiming a role, including compensation for this role, and reaching out to providers.”¹⁶

Strategic Note: Start simple. Start with your three best initiatives, and then expand later.

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

4. **Public Health Needs, Compelling “ROI” Studies** – At the time of this writing, ACOs are still mostly comprised of the formal clinical providers. We are expanding to a population health management compensation model, beyond just reactive treatment of the sick and ill, that is not yet widely recognized. Accordingly, local health departments need to prepare a statistically valid predictive model showing the financial value-add “return on investment” or “ROI” derived from including them in the ACOs. As this Guide clearly shows, that ROI will be substantial. “[I]t will be necessary for LHDs to prove their value by documenting and sharing early wins and analyzing the return on investment (ROI) of partnership efforts.”¹⁷ A local health department Return on Investment Guidebook may be found at: <http://nciph.sph.unc.edu/incubator/informatics/index.html>.

¹⁶ N.C. Assoc. of Local Health Directors, Public Health Task Force, *A Blueprint of the Future for Local Public Health Departments in North Carolina*, p. 10, (June 2013).

¹⁷ *Id.*, p. 11.

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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 will also 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 suicide attempts and the readmission rate for suicide attempts) but early metrics could be more general. The National Quality Forum, National Committee for Quality Assurance, and the metrics required for the CMS Medicare Shared Savings Program are recommended sources for nationally validated metrics.

B. A Process to Develop Metrics That Measure Local Health Departments’ Performance

First, start with the ACO initiatives which involve a local health department. Next, select the behaviors (i.e., smoke cessation counseling) and outcomes (i.e., reduced Emergency Department visits for non-emergencies) you desire. Which of those are measurable and are clinically valid? Start simple and move to more granularity later. Next, make sure you have metrics that are required by the payers. Hopefully, there will be substantial overlap of the two sets. One community health partner in a network uses the following metrics:

- Decrease in non-emergent Emergency Department visits;
- Primary care appointment attendance rate;
- Specialty care appointment attendance rate;
- ACO’s health assessment completion;
- Change in self-reported health status;
- Enrollee satisfaction measure.

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

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should be in proportion to the relative contributions to the pool. The more incentive, the greater the odds of increasing the size of the savings pool going forward.

Strategic Note: Some ACOs may choose to use a portion of their shared savings to partially compensate hospitals and specialists who are seeing revenue reductions due to changes in practice patterns (which is not offset by increase in market share and overhead reductions). Some ACOs will distribute savings to capital investors. We caution that such tactics will slow the transformational changes needed, sap motivation and ultimately challenge the competitive viability of the ACO altogether.

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



IX. Protect your interests: Negotiation Tips

A. Negotiating with ACOs

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

- **Investment** – Any ACO upfront cost obligations?

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- **Ongoing Risk** – What happens if the ACO takes on medical cost risk and does not meet targets? Are you proportionately responsible? What additional risk assumed based on the patient population (*i.e.*, low, rising, high risk)?
- **Distribution of Savings** – It should be distributed in proportion to contribution to savings, after expenses, but will savings go to investors, owners, to cover lost hospital or providers' revenues relative to fee for service? Are the expectations for when the distribution of savings is met mutually understood by all negotiating parties?
- **Data** – Who collects it? Is the severity adjusted? Are the metrics clinically valid for your specialty?
- **Corrective Action** – Your continued participation is tied to performance. ACO contracts will have “teeth.” Review the fairness and peer review aspects of the contract.
- **Exclusivity** – Are you contractually bound to just one ACO? (Distinguish from extra-contractual restrictions of a payer, including CMS.)
- **Support** – ACOs are team-based systems that should provide you every reasonable tool and human support to help you optimize your performance and patient care. These should be spelled out. *The Physician's Accountable Care Toolkit*® is specific about what types of support you should seek from your ACO.

B. Negotiating with Private Payers

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

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

- **Value-based Payment.** Commercial payers are moving to shared savings and risk contracts, usually with clinically integrated multi-disciplinary organizations. As we have seen, a “siloeed” arrangement cannot leverage the main savings opportunities you have. So, the value proposition outlined in this guide holds true also for the strategy to maximize reimbursement from commercial payers in these types of arrangements.

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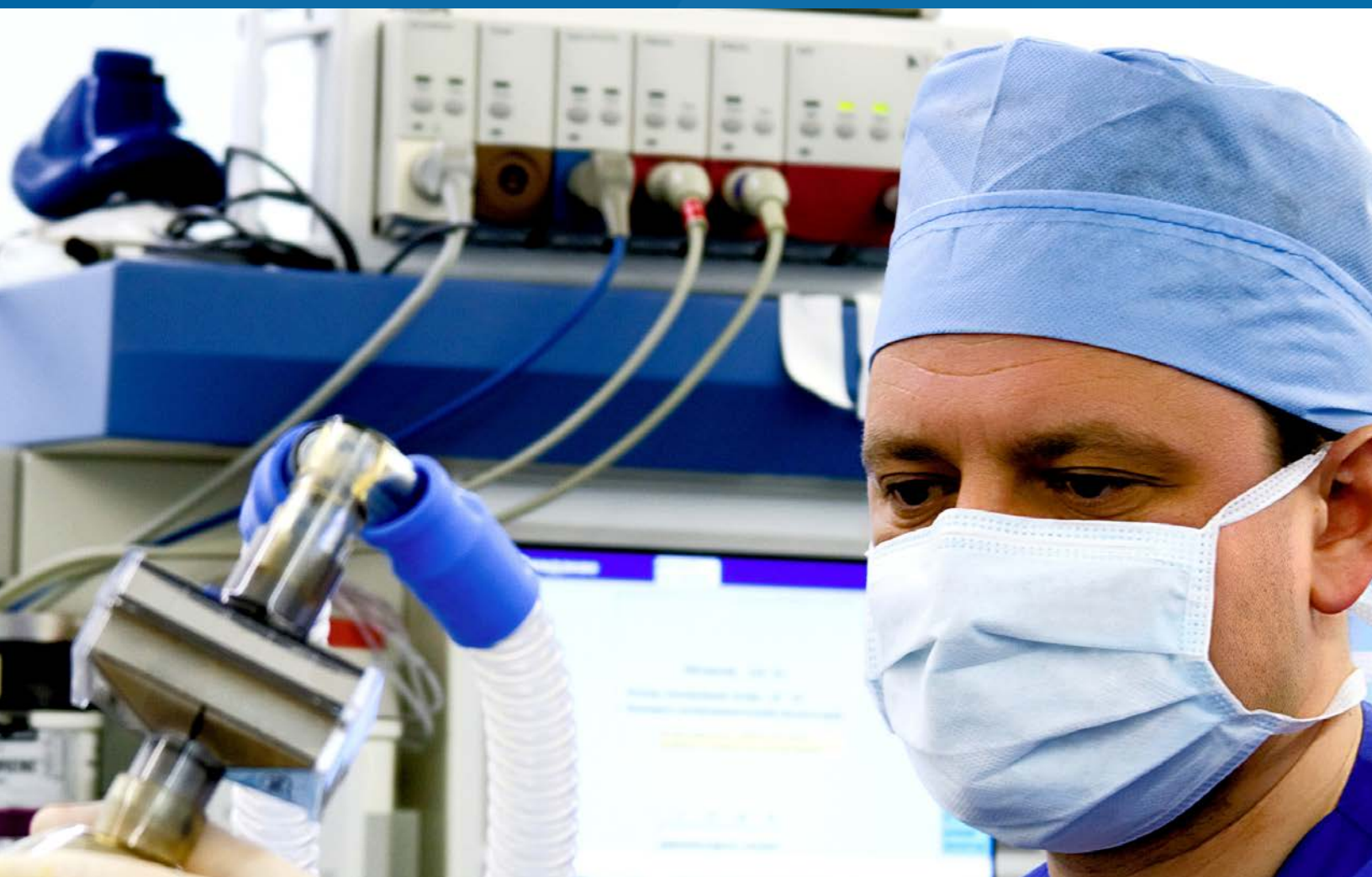
- **Fee-for-Service.** Of course, use of savings data, and seeking expanded coverage, are also useful in fee for service negotiations.

X. Conclusion

America's health care system will soon become unaffordable absent major change. The accountable care movement holds promise to address runaway costs and thus must be taken seriously. There are opportunities for professional and financial reward for the informed local health department. 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. Public health officials have skills and experience that position them to lead in the success of ACOs, but this is not yet widely utilized in the first wave of ACOs. To make sure a fair and sustainable ACO model becomes reality, it is important for public health officials 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 local health departments in accountable care, to assist local health departments in avoiding the pitfalls, and for the development of accountable care strategies for local health departments in different settings. For further information, contact the TAC Consortium and Initiative lead liaison, Melanie Phelps, at either mphelps@ncmedsoc.org or 919-833-3836.

Part Three: Executing the Accountable Care Strategic Plan



North Carolina  **Medical Society**
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I. General Strategies For All Specialties

A. Strategy Number 1: How to Successfully Navigate the Medicare MSSP

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. **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.

1. MSSP Application

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

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

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>.

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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.**

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

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

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

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

A significant portion of the MSSP application consists of certain narrative responses that must be completed by the ACO. These narratives include descriptions of: (a) the ACO's history, mission, and organization; (b) how the ACO plans to use shared savings payments; (c) how the ACO will use and protect Medicare data; (d) how the ACO will require its participants to comply with and implement 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

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its process and infrastructure to support internal reporting on quality and cost metrics; and (h) how the ACO defines, establishes, implements, evaluates, and periodically updates its care coordination processes. The ACO will need to carefully review the required elements of each narrative listed in the MSSP application and ensure that each element is discussed in detail; failure to address each required element may result in delay (or rejection) of the ACO's application. As mentioned, this Physicians' ACO Toolkit may be a useful aid in preparing this part of the application.

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

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

2. Conclusion

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

B. Strategy Number 2: [UNDER CONSTRUCTION.]

C. Strategy Number 3: [UNDER CONSTRUCTION.]

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II. Specific Strategies for Specific Specialties

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

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

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

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

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

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

E. Dermatologists. Accountable Care Guide for Dermatologists is being developed by the Accountable Care Workgroup of the North Carolina Dermatology Association and TAC personnel.

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

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

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

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

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

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

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

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

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

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

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

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

Q. Ophthalmologists. Accountable Care Guide for Ophthalmologists is being developed by the Accountable Care Workgroup of the North Carolina Society of Eye Physicians and Surgeons and TAC personnel.

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

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

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

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

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

X. Rural Health. Accountable Care Guide for Rural Health is being developed by the Accountable Care Workgroup of the North Carolina Medical Society, the NC Rural Health Alliance, and TAC personnel.

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

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EXHIBIT A

SERVICES OFTEN PROVIDED BY LHDs IN NORTH CAROLINA

Services Offered by North Carolina Health Departments	Percent of LHDs Offering Service	Social Determinant Services	ACO Clinical Services
IOM Basic Programs			
Maternal and Child Health			
Pregnancy Care Management	100%		✓
Contraceptive Care	100%	✓	✓
Pregnancy Prevention—Adolescent	97.6%	✓	✓
WIC Services—Mother	96.5%		✓
Preconception Counseling	96.5%		✓
Care Coordination for Children (CC4C)	96.5%		✓
WIC Services—Children	95.3%		✓
SIDS Counseling	94.1%	✓	
Child Health	89.4%	✓	
Prenatal and Postpartum Care	89.4%		✓
Well-Child Services	83.5%	✓	
Newborn Home Visiting Services	80%	✓	
Pediatric Primary Care	54.1%		✓
Fertility Services	45.9%	✓	
School Nursing Services	41.2%	✓	
Services to Children with Developmental Disabilities	37.6%	✓	✓
Postnatal Home Visits	27.1%		✓
Pregnancy Medical Home	25.9%		✓
Genetic Services	23.5%		✓

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Injury Control			
Injury Control	47.1%	✓	
Communicable Disease Control			
Communicable Disease Control	100%	✓	
Tuberculosis Control	100%	✓	
STD Community Level Surveillance, Investigation, Prevention, and Control	100%	✓	
Immunizations	98.8%	✓	✓
Hepatitis A and B Immunizations	97.6%	✓	✓
Rabies Control: When People are Bitten by Dogs or Cats	96.5%	✓	✓
Communicable Disease Surveillance	94.1%	✓	
Rabies Control: When People are Exposed to Rabies Vector Species (Bats, Terrestrial Carnivores)	94.1%	✓	
AIDS/HIV Community Level Surveillance, Investigation, Prevention, and Control	92.9%	✓	
Reportable Disease	90.6%	✓	
Rabies Control: Services for Domestic Animals That Are Reasonably Suspected of Being Exposed	68.2%	✓	
Chronic Disease Prevention, Including Tobacco Control			
Comprehensive Community Health Assessment	97.6%	✓	
Chronic Disease Control: Early Detection and Referral	95.3%	✓	✓
Community Health Education	92.9%	✓	
Chronic Disease Control: Patient Education	87.1%	✓	
Nutrition Counseling	83.5%	✓	
Tobacco Cessation	80%	✓	
Health Planning	77.6%	✓	

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Chronic Disease Surveillance	57.6%		
Behavioral Risk Assessment	50.6%		
Chronic Disease Monitoring and Treatment	42.4%		
Environmental Health			
Bioterrorism/Other Emergency Preparedness	98.8%		
Restaurant/Lodging/Institutions Sanitation and Inspectors	97.6%		
On-Site Sewage and Wastewater Disposal	97.6%		
Lead Poisoning Services	91.8%		
Water Sanitation and Safety	83.5%		
Lead Abatement	71.4%		
Environmental Risk Assessment	70.6%		
Health Code Development and Enforcement	70.6%		
Pest Management	29.4%		
Pesticide Poisoning	18.8%		
Bedding Control	14.1%		
Mental Health and Substance Abuse			
Behavioral Health Services	17.6%		
Clinical Services (not endorsed by the IOM)			
Dental Health	87.1%		
Public Health Nurse Pharmacy Dispensing	69.4%		
Adolescent Health Services	69.4%		
Other Pharmacy Services	47.1%		
Adult Primary Care	43.5%		
Home Health Services	36.5%		
Refugee Health	24.7%		
Migrant Health	17.5%		

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ACKNOWLEDGMENT



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