Accountable Care Coalition of Georgia

Established by Georgia Healthcare Systems, Inc.

PROVIDER HANDBOOK

Informed Care. Improved Health.

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Chapter 1 Informed Care. Improved Health.

Helping You Provide Improved Care

You are unique. Staying current with your patients, especially those who are chronically ill, is a constant challenge. We want to help you positively impact the lives of your patients who are assigned to the Medicare Shared Savings Program Accountable Care Organization (ACO) each day by contributing to high quality care and improved health while focusing on lowering healthcare costs. Together, we will grow and lead in the co-development of improved care solutions. We work closely with you while supporting your approach to caring for your patients.

Partnership to us means building together locally. Putting together the pieces of the puzzle in a unique way, we respect where you are in the evolution of your practice. The ACO is designed to reinforce your best efforts by providing a framework for care coordination, added clinical support and new resources to close gaps in care coordination for the patients assigned to the ACO – beneficiaries with Original Medicare often referred to as "Medicare Fee-for-Service beneficiaries" (beneficiaries).

We work closely with you to develop solutions that enhance and complement the unique needs of your practice and patients who are assigned to the ACO. Building together is what sets us apart.

We expect this to lead not only to improved outcomes and an improved experience, but also to lower costs, which are achieved — not by reducing care — but by providing it more effectively.

What is an Accountable Care Organization (ACO)?

An ACO is a group of doctors, hospitals, and other healthcare providers and suppliers who come together voluntarily to coordinate care for the people they serve. Our ACO has entered in to a contract with the Centers for Medicare & Medicaid Services (CMS) to participate in the Medicare Shared Savings Program (Shared Savings Program).

An ACO is neither a Medicare Advantage plan nor a Health Maintenance Organization (HMO), nor does the ACO affect a beneficiary's Medicare Supplement coverage. An ACO is not an insurance plan nor does it provide insurance coverage. Prior Authorizations are not part of this model. Even while assigned to the ACO, beneficiaries may see any doctor who accepts Original Medicare. Simply put, there is no change to Medicare benefits whether a person uses a provider participating in the ACO or not.

Additionally, there will be no change to Medicare service, coverage, or claims payment processes for beneficiaries treated by participating ACO providers. CMS will

continue to be solely responsible for these processes. However, CMS will compare healthcare expenses associated with these beneficiaries relative to a three-year historic cost benchmark. If beneficiary expenses are less than the historic amount — and quality of care standards are met — CMS will retroactively share these savings with the ACO.

CMS created the Shared Savings Program to achieve a three-part aim:

1. **Improved overall care** in a safe environment, equitable to all who seek it, and always available when needed.
2. **Improved health** accomplished through the practice of proactive, preventive medicine and care coordination.
3. **Lower per-capita cost** aimed at reducing the upward trend of medical costs associated with the Original Medicare population.

To ensure that savings are accompanied by improved care, CMS will track data for the ACO-assigned population through reports submitted by the ACO and from other sources. All information will remain HIPAA compliant and will be monitored by the ACO Compliance Program (see Chapter 7).

Who is Collaborative Health Systems?

In today's fast-paced market, providers around the country are faced with enormous challenges. Cultural and organizational fit can make or break an ACO.

Collaborative Health Systems (CHS) is accessible and transparent. Together we will embrace an entrepreneurial culture necessary to fundamentally alter the economics and quality of healthcare. CHS will support the ACO with services ranging from health information analytics to care coordination and administrative support. CHS is a wholly-owned subsidiary of Universal American Corp. (NYSE: UAM), a company with extensive experience working with Medicare programs and serving people with Medicare.

Our shared knowledge, combined experience and entrepreneurial mindset, coupled with our understanding of the economics of healthcare, are well-suited for our ACO partnership. Our goal is to combine our expertise to develop an ACO model that is at the forefront of healthcare innovation.

Scope of Activities

Our commitment is to enable you to focus on caring for your patients who are assigned to the ACO, while we provide behind the scenes data/analytics, strategic growth planning, care coordination and leadership to effectively transform the ACO into a dynamic, adaptable and forward-thinking healthcare organization.

Pursuant to CMS regulations, an ACO agrees to coordinate the healthcare needs of 5,000 or more beneficiaries (i.e., not Medicare Advantage plan members)

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for at least three years. ACOs must also demonstrate to CMS that they have the infrastructure and ability to:

- **Promote beneficiary-centeredness criteria and ongoing commitment to quality improvement by:**
  - Ensuring beneficiary representation in ACO governance
  - Implementing standards for access and communication, including access to medical records
  - Communicating understandable clinical knowledge and evidence-based medicine to your patients who are assigned to the ACO and engaging them in shared decision-making
  - Using systems and processes to assess health needs, including consideration of diversity, and developing individualized care plans
  - Conducting surveys and creating improvement plans that address distinct quality measures established by CMS
  - Establishing internal processes to measure clinical and service performance by physicians across practices
- **Provide data and tracking information to CMS**
- **Determine potential payments for shared savings**
- **Implement processes to promote:**
  - Evidence-based medicine
  - Reporting of quality and costs
  - Effective and efficient care coordination
  - Engagement of beneficiaries and providers

To achieve improved care at a lower cost, our coordinated effort will include:

- Analytics, reporting, and care coordination centered around beneficiaries
- Quality measurement and improvement programs
- Stakeholder engagement

Assignment of Beneficiaries

CMS will auto-assign beneficiaries to the ACO based on utilization. If beneficiaries traditionally utilize the providers participating in the ACO, they will be assigned to the ACO. However, they may elect to decline to share their Medicare claims information with the ACO.

ACTIVITY CHECKLIST

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As ACO participants, providers are asked to:

- ☐ Read this Provider Handbook to learn more about the ACO, the way it works, and your responsibilities as a participating provider.
- ☐ Prepare your office staff to support the ACO effort.
- ☐ Use the Provider Checklist in the Appendix to manage your ACO responsibilities.

Chapter 2 Beneficiary Engagement

Engaging Your Patients Assigned to the ACO

You've seen it time and time again. How well your patients respond to treatment has a great deal to do with their personal involvement in treatment programs and the degree of responsibility they take for their own health.

That's why beneficiary engagement is a critical part of our care program. Your patients who are assigned to the ACO should:

- Understand the real benefits that improved care coordination and our other care initiatives can provide
- Learn more about relevant healthcare topics such as health and wellness, chronic care, self-management and medication management
- Be encouraged to rely on their ACO Primary Care Physicians (PCPs) to coordinate care across all healthcare settings
- Feel secure that their wishes regarding care delivery are heard and incorporated into the respective care plans

Our engagement program begins as a centralized effort driven by the ACO and is supported by physicians and office staff through ongoing contact with their patients who are assigned to the ACO.

Scope of Activities

Initial Outreach

Per the CMS guidelines, your patients who are assigned to the ACO will receive a Medicare & You Handbook that will:

- Provide basic information regarding the Shared Savings Program
- Provide an opportunity to decline claims data sharing through 1-800 Medicare. If they wish to decline to share their personal health information (also known as their Medicare claims information) with the ACO, they will notify CMS.

Participating providers are required to post ACO signs in their facilities using required CMS template language to inform beneficiaries about both the Shared Savings Program and also that the ACO may request access to beneficiary identifiable claims data from CMS in order to coordinate their care. Physicians and their office staff will be educated as to this process during the implementation of the ACO.

Beneficiaries who elect not to share their Medicare claims information are still assigned to the ACO and the ACO will work to coordinate their care. They have the opportunity to reverse their decision and change their data sharing preference at any time (this includes both a decision to consent to share and to decline to share claims information).

Ongoing Communication

The ACO will provide ongoing communication and education by:

- Promoting the ACO website and physician portal
- Distributing materials to teach beneficiaries about health, wellness, chronic care, disease and medication management, and other healthcare issues
- Conducting additional outreach to beneficiaries' families, caregivers, and community resources to help them understand and act on their treatment regimens
- Hosting Lunch 'N Learns, webinars, and conferences to engage participating providers and practice managers

To identify the unique attributes of the ACO's population, the ACO will analyze historic Medicare claims information and survey beneficiaries to identify:

- Basic demographics (e.g., age, gender, location)
- Preferred language and communication methods
- Historic care needs and utilization of services
- High-risk populations with chronic or other serious conditions that are more likely to require care coordination

Under the ACO's Care Coordination Program, the Care Coordination Team will conduct an initial Personal Health Assessment (PHA) of beneficiaries. The PHA is a comprehensive tool to identify the health, social and behavioral needs of the beneficiary, including, but not limited to:

- Chronic conditions
- Barriers to healthcare
- Language and cognition needs
- Caregiver involvement

This initial assessment, as well as a series of Care Coordination Reports (see Chapter 5), will help you to assess care needs and participate in the development of individualized care plans, including long-term health goals.

Ongoing dialogue between you and your patients who are assigned to the ACO will contribute to the refinement of their health status and care plans. Continued follow-up and interaction will take place through office visits and ACO mailings, telephone outreach and, when possible, electronic communications (such as e-mails or via online portals).

Chapter 2 Beneficiary Engagement

ACTIVITY CHECKLIST

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You are asked to:

Be sure that you and your staff understand ACO basics and are well-prepared to work with your patients who are assigned to the ACO.

- ☐ Attend all meetings and ACO training programs
- ☐ Prepare to address questions about the ACO, the Shared Savings Program and the ACO experience

Complete office set-up to ensure ACO launch readiness.

- ☐ Display signage for the ACO
- ☐ Distribute educational materials to help engage beneficiaries, including the CMS Medicare Patient Fact Sheet entitled "ACO and You: Frequently Asked Questions (FAQ) for People with Medicare"

ACTIVITY CHECKLIST

1 2 3 4 5 6 7 8

You are asked to: (continued)

Use Care Coordination Reporting and Analytics as you evaluate the health needs of your patients who are assigned to the ACO.

- ☐ Review ACO beneficiary rosters, identify and provide outreach to those with care needs
- ☐ Review the list of beneficiaries identified as potentially at-risk, when available, to ensure that they are receiving the proper care and follow-up
- ☐ Review Personal Health Assessment (PHA) reports shared by the ACO Care Coordination Team
- ☐ Stay abreast of reports that will help you evaluate the health needs of your patients who are assigned to the ACO

Deliver beneficiary care to meet identified health needs. Freely access ACO Care Coordination Program services and assistance to meet both beneficiary and ACO goals.

- ☐ Collaborate actively with the ACO Care Coordination Team as part of the care coordination process
- ☐ Use language services provided by the ACO's external resource, when warranted

Chapter 3 Provider Engagement

The Goals of Provider Engagement

No matter where you are in the evolution of your practice, we will work side-by-side with you and your office staff to support you in achieving quality benchmarks, and delivering improved care while decreasing healthcare costs.

Our years of experience and success in Medicare provide immediate access to a vast selection of proven best practices focused on: achieving quality improvement, education and training, compliance/regulatory expertise, and business solutions. We call this *Healthy Impact*.

Healthy Impact connects you with the ACO. It is a way for you and your staff to access proven solutions and practical advice when caring for your patients who are assigned to the ACO. We leverage our network of experts and relationships to connect physicians with peers, to share best practices and to improve the health and wellness of patients who are assigned to the ACO.

The integrated program is flexible enough to interface with your existing practice and dynamic enough to grow as your ACO needs and experience change.

The first goal of *Healthy Impact* is to make sure you and your staff are prepared to help your patients who are assigned to the ACO understand the experience and how it works.

Healthy Impact makes our partnership stronger as we find new ways to work together in creating a leading ACO. Developing plans that help educate and engage beneficiaries is just one important component of the program. The other goal is to give you a thorough orientation and action plan for engaging in care coordination. As the heart and hands of the ACO program, you will play a critical role in:

- Assessing the overall health status of your patients who are assigned to the ACO
- Preparing individualized care plans
- Activating the ACO's care coordination resources

CMS has prepared a special ACO fact sheet for participating providers entitled, "Accountable Care Organizations: What Providers Need to Know." This CMS Provider Fact Sheet will help to educate you on the basics of the ACO program.

You and your staff will also help educate and engage patients assigned to the ACO to get them more involved in decisions that affect their own health and wellness. We will provide you with useful tools to help facilitate this education process, including the CMS Beneficiary Fact Sheet mentioned earlier.

Scope of Activities

Beneficiary Education — "ACO 101"

ACOs are a new concept for beneficiaries, and there is no enrollment process or opportunity for face-to-face education before assignment by CMS. Therefore, you and your staff will help educate beneficiaries, assuring them of the program's benefits and addressing any questions or concerns they may have.

The CMS Beneficiary Fact Sheet, entitled "Accountable Care Organizations and You: Frequently Asked Questions (FAQ) for People with Medicare," is a useful resource in responding to questions or requests for more information. The Fact Sheet includes:

- Basic information about the ACO, its goals and benefits
- Resources (e.g., CMS website links) for more information on ACOs and the Shared Savings Program

You will also receive Provider Office Instructions.

The previous chapter describes other responsibilities that apply to the initial outreach period.

Provider Education — ACO Care Coordination Program

To prepare you and your staff, the ACO will offer a number of education and training opportunities on our Care Coordination Program. These may include:

- Individual office meetings
- "Town Hall" meetings for providers and their staff
- Educational materials via mail, fax and/or Internet

As your patients who are assigned to the ACO raise questions or concerns, you and your staff can respond with simple, straight forward answers that will provide reassurance and more information.

Annual Wellness Visits

Regular interactions with your patients who are assigned to the ACO are important. An Annual Wellness Visit is an opportunity to provide preventive for all your patients with Medicare. We recommend setting up at least one annual visit to reinforce the critical doctor-patient relationship, help document existing conditions, and identify any new or previously unrecognized conditions. Where needed, the ACO can offer additional care coordination services. Some additional advantages to the Annual Wellness Visit include:

- Enabling the physician to identify the preventive services the beneficiary has not had in the past

Chapter 3 Provider Engagement

- Providing the beneficiary with advice and counseling to reduce unhealthy lifestyle behaviors and improve quality of life
- Allowing you to identify high-risk beneficiaries in real time and use care coordination tools and population health management to prevent deterioration of their health status
- Satisfying certain quality measures and capturing the appropriate coding

Care Coordination Interaction

Successful care coordination requires ongoing communication between you and the Care Coordination Team. This keeps all parties up-to-date regarding a beneficiary's status and helps in the development of care plans.

Healthcare events will often trigger communication between you and the Care Coordination Team. For instance, the following situations will trigger the Care Coordination team to contact you:

- Receiving inpatient care coordination (e.g., admissions, transitions between facilities, discharge plans)
- Receiving outpatient care coordination (e.g., home assessments, care plans, community resource utilization)
- Referred to care coordination by other providers
- Identified as care coordination candidates
- Discharged from a hospital stay

As part of its discharge planning, the Care Coordination Team may contact your office to schedule a post-discharge visit to reduce the chance of readmission.

ACTIVITY CHECKLIST

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You are asked to:

Be sure that you and your staff understand ACO basics and are well-prepared to work with your patients who are assigned to the ACO.

- ☐ Review Chapter 2 — "Beneficiary Engagement" and provide support, as indicated
- ☐ Review Chapter 4 — "Care Coordination Program" Goals and Processes
- ☐ Attend educational sessions to learn more about the ACO Care Coordination Program
- ☐ Be prepared to address questions or concerns about the ACO Care Coordination Program
- ☐ Be familiar with the CMS Patient Fact Sheet and make it available to your patients assigned to the ACO
- ☐ Educate and engage new patients who have been assigned to the ACO about ACO benefits

Chapter 3 Provider Engagement

ACTIVITY CHECKLIST

1 2 3 4 5 6 7 8

You are asked to: (continued)

Use Care Coordination Reporting and Analytics as you evaluate the health needs of your patients assigned to the ACO.

- ☐ Review the beneficiary roster to identify those who have not yet completed their annual exam
- ☐ Identify beneficiaries who may be candidates for care coordination

Deliver care to meet identified health needs. Freely access ACO Care Coordination Program services and assistance to meet goals for both the ACO and your patients assigned to it.

- ☐ Reach out to beneficiaries requiring an annual exam and assist with scheduling an appointment
- ☐ Update medical records and care plans, accordingly (see Chapter 4 — Care Coordination)
- ☐ Reach out to and collaborate with the ACO Care Coordination Team to initiate care coordination support. This may be done by phone or by submitting a Care Coordination Request Form, which will be made available to office staff with instructions provided on the form
- ☐ Alert the ACO Care Coordination Team when your patients who are assigned to the ACO are admitted to the hospital or may benefit from added care coordination assistance

Notes

Chapter 4 Care Coordination Program

Greater Care Coordination and Added Resources

Our ACO has established a Care Coordination Program that works in conjunction with you, your staff and other providers to:

- **Engage beneficiaries who are identified as high risk or require transition of care support** with the understanding that early, immediate and/or frequent intervention is essential in achieving improved health outcomes.
- **Facilitate care coordination with beneficiaries**, through the timely exchange of information regarding health events and treatments, along with collaboration in the development of individualized care plans.
- **Promote access to quality, cost-effective care and appropriate social services resources** to enhance the physical, psychosocial and emotional health of beneficiaries.
- **Reach the beneficiaries with the highest needs** who may be non-adherent, lack resources or have difficulty understanding their condition, and have the highest chance for change and improvement in their condition.

In addition to supporting strong relationships between you and your patients who are assigned to the ACO and enhancing their family/caregiver satisfaction, the Care Coordination Program is designed to:

- Identify and monitor primary and co-existing conditions and/or complex healthcare needs
- Reduce unnecessary hospital readmissions and emergency room visits
- Facilitate transition of care to improve health outcomes after discharge
- Promote beneficiary engagement in improving health outcomes
- Support the quality measures of the ACO
- Where possible, eliminate unnecessary duplication of services

Scope of Activities

Initial Outreach

Our Care Coordination Team will begin by reaching out to beneficiaries in order to:

- Introduce themselves, explain the support available through ACO care coordination and begin to develop a relationship

- Conduct appropriate assessments to determine their needs from a medical, social and environmental perspective
- Develop a care plan to address the beneficiary's unique and immediate physical and psychosocial needs, as well as chronic conditions and other high-risk factors. The care plan is a collaborative effort with you and your patient assigned to the ACO, who shares in defining the care plan goals.

Individualized Care Plans

The Care Coordination Team uses information obtained from various sources and coordinates with you to develop individualized care plans. These will serve as a road map for addressing the medical conditions of each of your patients who are assigned to the ACO and providing protocols for the Care Coordination Team. As health conditions change, the plans will be adjusted and coordinated with you.

Transition of Care Coordination

Admission to a hospital, skilled nursing facility or rehabilitation facility can be stressful for beneficiaries. In addition you, as a provider, may be unaware of the admission and subsequent care required, leading to gaps in care coordination or even readmission to a care facility.

The Care Coordination Team works to prevent this type of situation by assisting with transition of care to support continuity of care during movement from the inpatient setting to the home or other healthcare facility. Activities include, but are not limited to:

- Exchange of information with you regarding beneficiaries' inpatient admissions or pending discharges
- Collaboration with beneficiaries, their family members/caregivers and the hospital staff, when possible, to facilitate safe discharge to the appropriate level of care
- Identification and coordination of Durable Medical Equipment (DME), medication, home health and/or transportation needs

Upon notification of discharge, the care coordinator conducts a "post-discharge call" to perform the following:

- Assessment of clinical and social needs
- Medication reconciliation
- Assessment of the beneficiary's understanding and adherence to the treatment/discharge plan
- Assessment of the beneficiary's home safety, mobility and need for assistance with activities of daily living

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- Education of the beneficiary/caregiver on the disease process and identification of signs/symptoms to report to the appropriate provider
- Verification that the beneficiary received needed post-discharge supplies and services
- Assistance with scheduling the beneficiary's follow-up appointment(s)
- Communication with you regarding beneficiary's status

Based on the findings of the post-discharge call, the care coordinator will conduct in-home visits, as warranted.

Outpatient Care Coordination

Beneficiaries may receive outpatient care coordination for a number of reasons:

- Discharge from a care facility
- Chronic conditions or frequency of care
- Referral from local physicians

The Care Coordination Team may include a variety of caregivers, from Registered Nurses to Social Workers, and be assigned to beneficiaries based on their clinical and social needs. The team will perform ongoing assessments and facilitate follow-up care in conjunction with you. Outpatient care coordination may be conducted face-to-face or by phone.

Outpatient care coordination activities include:

- Assessing home safety, mobility and need for assistance with Activities of Daily Living (ADL)
- Educating beneficiaries and/or caregivers on disease process, medications and monitoring/measuring health status and progress
- Developing individualized care plans, encouraging beneficiary input with the goal of improving understanding and adherence
- Identifying and coordinating DME and Home Health needs
- Assisting with scheduling follow-up appointments and coordinating transportation, as needed
- Collaborating with beneficiary/caregiver/family, ACO participants, other healthcare providers/suppliers, and social services resources to ensure all care needs are met in support of whole person health

Care Coordination Requests

The Care Coordination Team asks that you notify us promptly when one of your patients who is assigned to the ACO needs care coordination assistance. Your request can be facilitated by submission of a Care Coordination Request Form. Please complete the form and send it to the ACO's Care Coordination Team (instructions provided on form). A care coordination staff member will contact the beneficiary to assess his/her situation and attempt to ensure fulfillment of his/her needs. We will notify you of this and let you know the outcome.

Care Coordination Leadership

The Care Coordination Program will continually evolve as processes and programs are evaluated and improved. New programs may be implemented based on input and data analysis. You and your staff should feel comfortable reaching out to ACO Care Coordination leaders with questions, comments and suggestions.

Medical Director

The Medical Director is responsible for direct oversight of care coordination activities. ACO providers and care coordination staff can consult the Medical Director on decisions requiring physician input. The Medical Director is available to interact directly with you and the ACO's care coordination staff.

Clinical Manager

In conjunction with the Medical Director, the Clinical Manager is responsible for supporting the Care Coordination Program. The Clinical Manager captures and reports data to the Medical Director, the Care Coordination Subcommittee and the Quality Improvement Subcommittee of the ACO and is also available to ACO providers and care coordination staff to help supervise day-to-day activities.

Chapter 4 Care Coordination Program

ACTIVITY CHECKLIST

1 2 3 **4** 5 6 7 8

You are asked to:

Be sure that you and your staff understand ACO basics and are well-prepared to work with your patients who are assigned to the ACO.

- ☐ Review Chapter 2 — "Beneficiary Engagement" and take action, as requested
- ☐ Review Chapter 3 — "Provider Engagement" and take action, as requested

Deliver beneficiary care to meet identified health needs. Freely access ACO Care Coordination Program services and assistance to meet goals for both the beneficiary and the ACO.

- ☐ Collaborate actively with the ACO Care Coordination Team as part of the care coordination process
- ☐ Participate in the development of individualized care plans
- ☐ Alert the ACO Care Coordination Team when your patients who are assigned to the ACO are admitted to the hospital or may benefit from added care coordination assistance

Notes

Chapter 5 Reporting and Analytics

Understanding Beneficiary Needs and Tracking the Care We Provide

The Shared Savings Program Accountable Care Organization (ACO) produces customized reporting and analytics to:

- Help you understand the unique needs and medical risks of your patients who are assigned to the ACO
- Track and measure key ACO operating metrics, such as beneficiary costs and utilization by setting of care
- Track and measure key physician-specific metrics, such as beneficiary panel risk scores and costs and utilization by setting of care

Scope of Activities

You will receive reports at regular intervals to help you ensure that your patients who are assigned to the ACO, especially the chronically ill, get the right care at the right time and avoid unnecessary duplication of services.

ACO analytics and administrative staff will create new reports based on input from the ACO leadership team and participating providers.

Reports will focus on informing physicians about utilization patterns, care expense categories, disease-specific costs and quality performance. These reports will compare performance with that of fellow physicians across the ACO, as well as some benchmarking between ACOs.

Analytic Resources

Through partnership with Collaborative Health Systems (CHS), the ACO has access to analytic resources that use data from various sources, including:

- Beneficiary claims files
- Beneficiary files (Beneficiary demographics, HCC scores, PCP affiliation)
- Provider files (Provider demographics, Group affiliations, Network affiliations)

ACO analytics staff analyzes the data to create actionable information, enabling users to quickly identify opportunities for improvement in the efficiency and quality of care delivery. The analytic team provides data outputs that allow users to:

- Compare performance among providers against key efficiency measures including, but not limited to, emergency room utilization, inpatient efficiency and prescription efficiency

- Develop detailed compliance information regarding quality measures at the beneficiary, physician and ACO level
- Mine claims data for trends and develop customized reports

The ACO analytics reports are released on a monthly basis in multiple methods (Microsoft PowerPoint, Microsoft Excel, secure Internet portal). The ACO analytics staff will continuously update reports to supplement existing data sources and better integrate the analytics with care coordination activities.

ACTIVITY CHECKLIST

1 2 3 4 **5** 6 7 8

You are asked to:

Be sure that you and your staff understand ACO basics and are well-prepared to work with your patients who are assigned to the ACO.

- ☐ Review standard reporting generated by the analytics team
- ☐ Participate in educational training series explaining the monthly ACO analytics reports

Use Care Coordination Reporting and Analytics as you evaluate the health needs of your patients who are assigned to the ACO.

- ☐ Review and act on reporting provided by local Provider Relations representatives
- ☐ Review list of physician-specific and high-risk beneficiary reports and develop individualized care plans in conjunction with the Care Coordination Team

Chapter 6 Quality Improvement Program

Maintaining and Improving Quality

Our Quality Improvement Program (QIP) is designed to meet the quality performance and improvement goals established by the ACO's Governing Body, as well as those required by CMS, state agencies and other regulatory agencies.

Built on the structure-process-outcome model of continuous quality improvement, our QIP provides for continuous monitoring and evaluation of care and services, including:

- Medicare beneficiary and physician satisfaction
- Implementation of clinical guidelines
- Quality of clinical care

CMS has made continuous quality improvement a key component of the Shared Savings Program. The ACO will report quality data to CMS in accordance with program requirements.

Scope of Activities

Beneficiary Satisfaction Survey

To better understand how beneficiaries view their Primary Care Physicians (PCPs) and their associated office staff members, the ACO will conduct an annual satisfaction survey, which will:

- Measure the level of satisfaction with services provided
- Identify and classify areas of high and low satisfaction
- Compare ACO results to the National Benchmarking Database
- Provide direction for quality improvement
- Determine key drivers of satisfaction

An executive summary of the Satisfaction Survey results will be made available to the leadership of the ACO and, upon request, to all its providers.

Evidence Based Guidelines

To ensure a consistent approach to care coordination, the ACO will adopt evidence-based clinical guidelines. These will be developed by the Medical Director and the Care Coordination Committee using literature and research from nationally recognized associations, along with input from appropriate local physicians and providers.

When guidelines are finalized, the ACO Management Committee will approve and distribute them to participating providers. Within the ACO, the Quality Improvement Committee will monitor the use of guidelines appropriate to the care coordination staff and providers.

Quality Measures within the Shared Savings Program

CMS currently has established individual measures of quality performance to be used within the Shared Savings Program. While CMS continues to revise these standards, as they exist now, they span four quality domains:

- Beneficiary Experience of Care
- Care Coordination/Beneficiary Safety
- Preventive Health
- At-Risk Population

ACO quality measures align with those used in other CMS quality programs, such as the Physician Quality Reporting System (PQRS) and the Electronic Health Record (EHR) Incentive Programs. They also align with the National Quality Forum and other stewards used by CMS.

The ACO will report some of these measures to CMS through a web interface designed for clinical quality measure reporting and through the results of care surveys that capture beneficiaries' ACO experience. In addition, CMS will directly calculate claims and compile administrative data through its own measures in order to reduce the ACO's administrative burden.

As an incentive for physicians to participate in the ACO, quality reporting efforts will automatically qualify for their PQRS submission. This reduces the amount of administrative tasks participating provider offices have to complete in order to qualify for these additional reimbursements.

As required by the Patient Protection and Affordable Care Act (ACA), in order for an ACO to qualify for a distribution of shared savings from CMS, the ACO must demonstrate that it meets the quality performance standards for an identified performance period.

For the first performance period, the quality performance standard requires the ACO to provide complete and accurate reporting for all quality measures. During subsequent performance periods, the ACO will continue to report on all measures but will be assessed on phased-in performance standards. This will allow ACOs to gain experience with the measures and gather useful information to help improve outcomes for our ACO-assigned populations. In addition to standards related to quality performance, CMS will use certain measures to ensure that ACOs are not avoiding at-risk beneficiaries or engaging in overuse, underuse or misuse of healthcare services.

Chapter 6 Quality Improvement Program

ACTIVITY CHECKLIST

1 2 3 4 5 **6** 7 8

You are asked to:

Actively participate in shaping and strengthening the overall ACO quality program:

- ☐ Review annual Medicare Patient Satisfaction Survey results and provide further guidance to beneficiaries, if requested. When appropriate, incorporate improvement activities within your practice
- ☐ Review evidence-based clinical guidelines and provide input, as needed
- ☐ Provide suggestions and feedback regarding disease states or conditions to be researched for incorporation into the ACO's clinical guidelines
- ☐ Review the Shared Savings Program Quality Measures and discuss methods of incorporating processes into office procedures to support the standards represented within the program

Monitor individual practice activity and evaluate against ACO goals.

- ☐ Become familiar with the quality measures established for ACOs by the Shared Savings Program, utilize ACO resources (including an analytic tool, reporting, clinical and administrative staff) to monitor individual practice activity and evaluate it based on the goals established by the ACO

Notes

Chapter 7 Compliance Program

Ensuring Compliance

The Compliance Department (Compliance) ensures that the ACO complies with the following sources of regulation:

1. The CMS Medicare Shared Savings Program (Shared Savings Program) requirements;
2. Federal and state laws and regulations; and
3. Internal business practices and ethical standards.

Compliance is charged with overseeing the implementation of and ensuring adherence to the CMS regulatory requirements outlined by the Shared Savings Program. The text of this regulation is available online at http://www.gpo.gov. This also requires adherence to all applicable Federal and state laws and regulations. Such laws include, but are not limited to, Anti-Kickback, Stark, Civil Monetary Penalties (CMP), and Sunshine laws.

Compliance ensures that the ACO implements and follows internal policies and procedures to ensure compliance with the above mentioned sources of regulation. These policies and procedures are the basis for determining how the organization will adhere to the regulatory requirements of an ACO.

Who is CMS?

CMS is an agency within the U.S. Department of Health and Human Services (HHS). CMS oversees Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP). Furthermore, the Shared Savings Program regulations give CMS the authority to oversee ACOs. When an ACO agrees to participate in the Shared Savings Program, they enter into a contract with CMS. Through the Shared Savings Program regulations, CMS has the power to specify requirements for ACO applications and data submissions, require and approve corrective action plans, and accept and terminate ACO participation agreements. Essentially, all regulations, requirements, requests, and oversight related to the Shared Savings Program and ACOs come from CMS.

The Five Elements

The ACO's compliance plan is built on the Five (5) Elements outlined in the Shared Savings Program regulations. Those elements are:

1. Designation of a Compliance Officer who reports directly to the ACO's governing body;
2. Mechanisms for identifying and addressing potential and/or actual compliance problems related to the ACO's operations and performance;

3. A method for ACO Participants, Providers/Suppliers, and other individuals or entities performing functions or services related to the ACO's activities to report suspected problems to the Compliance Officer;

4. Compliance training for the ACO Participants, Providers/Suppliers, and other individuals or entities performing functions or services related to the ACO's activities; and,

5. A process for the ACO to report probable violations of law to an appropriate law enforcement agency.

Each of these elements was defined by CMS and all are required components of the ACO's compliance plan. It is Compliance's job to make sure that the ACO adheres to all of these elements at all times.

Designated Compliance Officer

What the law says: The ACO must have a designated compliance official or individual who is not legal counsel to the ACO and who reports directly to the ACO's governing body.

What the law means to you: The ACO must have a designated Compliance Officer who reports directly to the ACO's Governing Body. The Compliance Officer cannot, by law, act as legal counsel for the ACO. CMS has further clarified that the Compliance Officer may be an attorney, as long as he or she is not acting as both legal counsel and a Compliance Officer.

The Compliance Officer for the ACOs is Paul Dominianni. Paul is available as a resource for the ACO to discuss anything from ACO innovations to suspected compliance problems. Paul's contact information is as follows:

Paul Dominianni
ACO Compliance Officer
44 South Broadway, Suite 1200
White Plains, NY 10601
Phone: 914-288-4656
Fax: 914-288-4605
pdominianni@UniversalAmerican.com

Identifying and Addressing Compliance Problems

What the law says: The ACO must have mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance.

What the law means to you: The Shared Savings Program regulations outline a number of requirements that each ACO has to meet, such as requirements of the Governing Body and other committees, data collection and reporting, beneficiary assignments and notification, records retention, monitoring quality performance standards, and marketing materials requirements. This element requires that the ACO have mechanisms in place to identify and address compliance problems related to these, and all other Shared Savings Program requirements. These mechanisms are outlined and detailed in the ACO's Policies and Procedures (P&Ps).

Chapter 7 Compliance Program

CHS has created template P&Ps that the ACO may use and modify to meet its own needs. The ACO **is not required** to use these template P&Ps and may instead: (1) use existing P&Ps; (2) create its own completely distinct P&Ps; or, (3) use a combination of existing/self-created P&Ps and the template P&Ps. No matter which option the ACO chooses any and all P&Ps must go through Compliance to ensure that they meet the minimum requirements set forth by CMS in the Shared Savings Program regulations.

The Compliance Officer is also responsible for developing an annual monitoring work plan that will:

1. Identify potential risks associated with ACO activities;
2. Prioritize and develop oversight activities;
3. Initiate and implement reviews of operational processes; and,
4. Assist in the evaluation of the effectiveness of the compliance plan.

When monitoring processes or identifying issues, Compliance will work with the Executive Director and the Governing Body of the ACO to implement remedial actions as necessary, including Corrective Action Plans (CAPs). CAPs will specify implementation tasks, the names of the individuals accountable for implementation, and the time frames for resolution and remediation.

Reporting Suspected Problems

What the law says: The ACO must have a method for employees or contractors of the ACO, ACO Participants, ACO Providers/Suppliers, and other individuals or entities performing functions or services related to ACO activities to anonymously report suspected problems related to the ACO to the Compliance Officer.

What the law means to you: The ACO must have an anonymous reporting system. Although Compliance encourages anyone who has information regarding suspected compliance problems to contact us right away, we understand that sometimes anonymity is necessary and preferable. In these situations, both the ACO and CHS have anonymous reporting hotlines that anyone may call at any time to report anything that he/she suspects to be a compliance issue. No one needs permission to call this hotline. The hotline number(s) and directions on leaving anonymous messages on the hotline are outlined in the template P&Ps.

Compliance Training

What the law says: The ACO must have compliance training for the ACO, ACO Participants, and the ACO Providers/Suppliers, and other individuals or entities performing functions or services related to the ACO's activities.

What the law means to you: The ACO is required to have a training course in place for ACO Participants and Providers/ Suppliers, and other individuals or entities performing functions or services related to the ACO's activities. The ACO can decide how to train these individuals; however, the training **must** be performed (1) at the point of hire or contract and (2) annually thereafter.

There are two options available to the ACO: (1) in-person seminars or (2) online training. The details and merits of each are outlined below.

In-Person Seminars	Online Training
• Conducted by the ACO/Executive Director (ED) • Provided on site at every participating physician's office • ACO/ED works with CHS to create training materials	• Operated by CHS • Available online 24/7: www.chsacotraining.com • CHS system will track training and completion by staff • CHS system will store training records for requisite time period
ACO is responsible for...	**ACO is responsible for...**
• Ensuring that all appropriate staff members complete training • Maintaining training records for at least 10 years • Notifying Compliance once the training is complete	• Providing a list of staff members who require training to Compliance • Educating staff on where to go for training and when to complete training • Enforcing training deadlines

Chapter 7 Compliance Program

Reporting Requirements

What the law says: The ACO must have a requirement for the ACO to report probable violations of the law to an appropriate law enforcement agency.

What the law means to you: The ACO must have P&Ps in place to ensure that probable violations of law are reported to the appropriate law enforcement agency. These requirements are outlined in the template P&Ps.

When the situation is unclear, or if you are unsure, it is best to contact Compliance directly or through the anonymous reporting hotline. Compliance is the ACO's best resource for determining how to proceed in these situations.

Waivers

There are many components of an effective Compliance Program as outlined and mandated by CMS. We understand that the primary goals for the ACO are to provide beneficiaries with quality healthcare and improve health outcomes, but we must do so within these requirements. CMS has established four fraud and abuse waivers that allow ACOs to conduct activities that would otherwise trigger federal regulations (e.g., Stark, Anti-Kickback, CMP).

For example, in some circumstances the Patient Incentives Waiver permits ACOs to provide beneficiaries with items such as a blood pressure cuff to help them track their blood pressure. CMS understands that it is the goal of an ACO to promote collaboration between Participants and Providers/Suppliers and beneficiaries to improve beneficiaries' healthcare quality and outcomes. Therefore, the Patient Incentives Waiver makes it possible for an ACO to provide in-kind items or services to beneficiaries under the following conditions:

1. There is a reasonable connection between the items/services and the medical care of the beneficiary; **and**
2. The items/services are preventive care items; **or**
3. The items/services advance a clinical goal for the beneficiary (such as adhering to a treatment plan or managing a chronic condition).

These in-kind items and services **cannot** be used to provide gifts or other remuneration to beneficiaries as inducements for receiving items or services from, or remaining in, an ACO or with ACO Providers/Suppliers.

Compliance is an excellent resource to help determine which in-kind items fall within the conditions set by CMS and which items do not. Compliance can help you delve into the Shared Savings Program regulations and create an ACO that truly works for its Participants, Providers/Suppliers, and, most importantly, its beneficiaries. Contact Compliance if you want to use this waiver or learn about the other waivers available to ACOs.

ACTIVITY CHECKLIST

1 2 3 4 5 6 **7** 8

You are asked to:

Be sure that you and your staff understand ACO compliance basics and are well-prepared to work with your patients assigned to the ACO.

- [ ] Complete compliance training and education as requested
- [ ] Monitor individual practice activity and evaluate against ACO goals
- [ ] Participate in monitoring and oversight activities to constantly track and improve on the quality of our operations
- [ ] Report any potential and/or actual instances of non-compliance using any of the methods made available

Chapter 8 Governance and Leadership

ACO Structure

The Federal government takes a protective stance toward people with Medicare, and this guardianship role naturally extends to the ACOs regulated by the CMS.

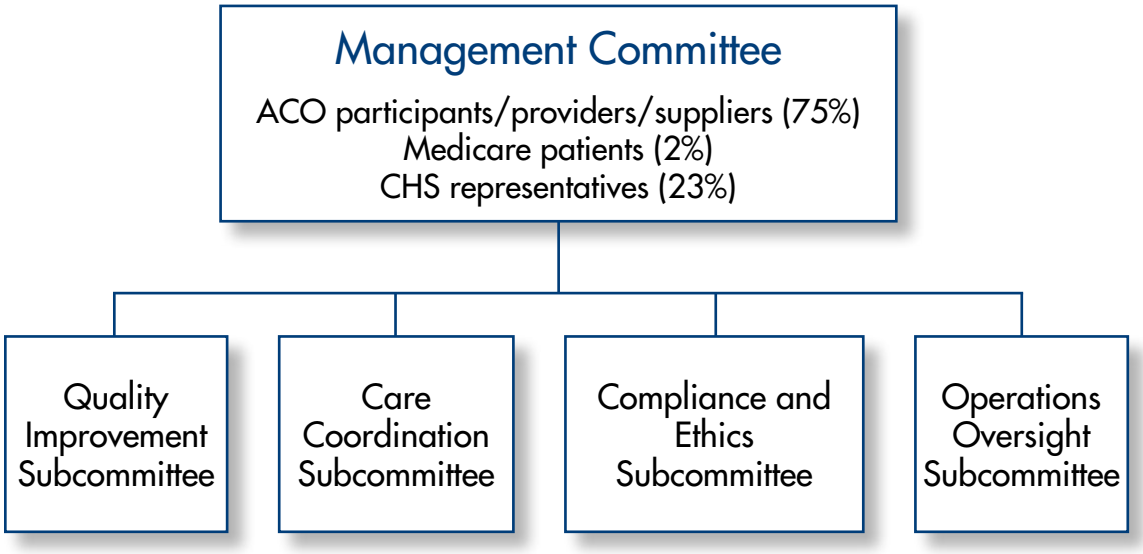
CMS requires all ACOs to have a governing board, or Governing Body, to guide and monitor the activities of the ACO. The Governing Body has the authority to act on behalf of and execute the functions of the ACO, thus providing governance and leadership for the organization.

Scope of Activities

Control and Voting Power

Control and voting power of the ACO is generally distributed as follows:

- ACO participants/providers/suppliers — 75%
- Medicare Beneficiaries — 2%
- CHS representatives — 23%



* The structure and names of the governing bodies as well as control and voting power may vary by ACO.

The Governing Body provides leadership to the ACO and ensures that governance objectives and shared values are met. The Governing Body is responsible for, at a minimum, the following:

- Incorporating and maintaining a transparent governing process
- Selecting and appointing a Chief Executive Officer (CEO) and any officers of the company to serve on behalf of the ACO and manage its affairs
- Reviewing and monitoring performance and having authority to remove such officers
- Entering into any material contracts, financial agreements and vendor relationships in accordance with the ACO Operating Agreement, including, but not limited to, CMS contracts
- Fostering and ensuring compliance with relevant laws, rules and regulations affecting the ACO
- Maintaining financial stability of the ACO, including approving budgets and monitoring expenditures
- Monitoring ACO performance and ACO participant/provider/supplier participation
- Establishing criteria and approving distribution of Shared Savings Program savings
- Ensuring the filing of any documents with any regulatory agency, including CMS and/or the Internal Revenue Service (IRS)

The Governing Body has a fiduciary duty to the ACO and shall act consistently with its duty. It shall have, maintain and abide by the ACO conflict of interest policy.

ACO Subcommittees

In addition to the Governing Body, ACO governance is comprised of a number of subcommittees.

Quality Improvement Subcommittee*

The Quality Improvement Subcommittee is responsible for developing and monitoring ACO quality. This includes developing programs to support the Shared Savings Program quality measures as well as reviewing the quality performance of ACO participants. The Quality Improvement Subcommittee also addresses any quality-of-care issues that may arise.

* The Quality Improvement and Care Coordination Subcommittees may be combined into a single "Quality Improvement/Care Coordination Subcommittee."

Chapter 8 Governance and Leadership

Care Coordination Subcommittee*

The Care Coordination Subcommittee is responsible for developing "best practices," clinical guidelines, and evidence-based protocols for the ACO. Using analytics, this Subcommittee reviews and identifies opportunities for efficiency in delivery of care. It also oversees all care coordination activities.

Compliance and Ethics Subcommittee

The Compliance and Ethics Subcommittee develops and manages all compliance-related activities and procedures. In order to ensure the integrity and ethical behavior of the organization and all responsible parties, the Compliance and Ethics Subcommittee is responsible for designing and implementing a comprehensive Compliance Program. The Compliance Program includes, but is not limited to:

- An annual Compliance Plan that is overseen by a Compliance Officer
- A monitoring and oversight program, including tools, processes and infrastructure to detect potential compliance violations
- A means to receive and act on reports of potential and actual compliance-related concerns
- Generation and dissemination of compliance-related reports
- A compliance training and education program
- A compliance and risk management program
- A process to report potential and actual compliance-related incidents to external agencies when appropriate

When there is a suspected violation of a regulation or of a policy and procedure, the Compliance and Ethics Subcommittee is also responsible for overseeing the investigation process, responding to compliance issues or breaches, and the development, implementation and oversight of a corrective action plan (CAP).

Operations Oversight Subcommittee

The Operations Oversight Subcommittee oversees the operations of the ACO. In maintaining operations, the Subcommittee has, among other things, the following responsibilities:

* The Quality Improvement and Care Coordination Subcommittees may be combined into a single "Quality Improvement/Care Coordination Subcommittee."

- Developing, implementing and monitoring all operational policies and procedures; this includes policies and procedures that support compliance with the Shared Savings Program and any other federal and state rules and regulations.
- Planning, evaluating, recommending and implementing organizational initiatives
- Establishing and maintaining effective working relationships with vendors, managers and physicians
- Monitoring beneficiary engagement survey feedback and contributing to the process of resolving complaints and service issues

Appendix Provider Checklist

Getting Started

Be sure that you and your staff understand the Shared Savings Program ACO basics and are well-prepared to work with your patients who are assigned to the ACO.

- ☐ Review the Handbook in its entirety to learn how the ACO works and your responsibilities as a participating provider. (Chapter 1)
- ☐ Complete all ACO training programs including ACO launch training, compliance, care coordination, reporting and analytics, and other training. (Chapter 2)
- ☐ Prepare to address questions regarding ACO basics and the Shared Savings Program. (Chapter 3)
- ☐ Complete office set-up to ensure ACO launch readiness:
  - Display ACO signage, as required by CMS. (Chapter 2)
  - Keep important information accessible to all office personnel, including Key Contacts List, Care Coordination Request Form, or other similar ACO tools (mostly contained in the Office Set-Up Kit delivered to each participating office).

Beneficiary Care

Use Care Coordination Reporting and Analytics as you evaluate the health needs of your patients who are assigned to the ACO.

- ☐ Review the beneficiary roster to identify patients who are assigned to the ACO and have not yet completed their annual exam. (Chapter 4)
- ☐ Review the beneficiary roster as well as the High-Risk Beneficiary Report to identify beneficiaries who may be candidates for care coordination. (Chapter 4)
- ☐ Review Personal Health Assessment (PHA) reports shared by the Care Coordination Team. Address health and social needs revealed through PHA when caring for patients who are assigned to the ACO and developing care plans. (Chapter 4)
- ☐ Review ongoing reporting provided by ACO Provider Relations representatives. (Chapter 5)

Deliver care to meet the identified health needs of a beneficiary. Freely access ACO Care Coordination Program services and assistance to meet both beneficiary and ACO goals.

- ☐ Ensure that all of your patients who are assigned to the ACO complete an annual physical exam. (Chapter 3)
- ☐ Collaborate with the Care Coordination Team to develop individualized care plans for beneficiaries in need of care coordination support. (Chapter 2)
- ☐ Initiate care coordination support by calling our Care Coordination Team or by submitting a Care Coordination Request Form. Always alert the Care Coordination Team when your patients who are assigned to the ACO are admitted to the hospital. (Chapter 4)
- ☐ Regularly update medical records and care plans. (Chapter 3)
- ☐ Access alternate language services provided by ACO's external resources, if beneficial in communicating with beneficiaries or their caregivers. (Chapter 2)

Program Effectiveness (see Chapter 6)

Actively participate in shaping and strengthening the overall ACO program:

- ☐ Provide input to the ACO's clinical guidelines.
- ☐ Respond to feedback received through the annual Beneficiary Satisfaction Survey.
- ☐ Follow guidance and best practices provided by ACO leaders and administrators.

Monitor individual practice activity and evaluate against ACO goals.

- ☐ Use ACO resources, including an analytic tool, reporting, and clinical or administrative staff to measure practice activity and progress against quality measures.
- ☐ Participate in oversight activities, as required, to track and improve the quality of ACO operations. Report instances of non-compliance using any methods made available.

Appendix Provider Checklist

Notes

Accountable Care Coalition of Georgia

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