Why Baylor Health Care System Would Like to File for Medicare Shared Savings Accountable Care Organization Designation but Cannot

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National focus on health care reform is being driven by recognition of the simultaneous needs to improve quality, reduce costs, and increase access. Multiple stakeholders in our society, from governmental authorities to payers, employers, and patients, are raising their voices in the call for answers to these problems, in what the Institute for Healthcare Improvement termed the Triple Aim: "better care for individuals, better health for populations, and lower per capita costs."[1] The Centers for Medicare and Medicaid Services (CMS) subsequently adopted this aim, in particular as the mission of the newly formed Center for Medicare and Medicaid Innovation.[2] Congress, too, has weighed in on the issue, with one of the primary goals of the 2010 Patient Protection and Affordable Care Act (PPACA) being substantial reduction in the number of Americans without health insurance, to be achieved largely through expansion of the state Medicaid programs and creation of health benefit exchanges.[3] Most health care experts recognize that the problems of cost, quality, and access must be solved. The unsustainable costs and the relentless rates of increase in costs,[4] in particular, are driving health care organizations to find solutions.

Clearly, it will take coalitions of stakeholders to effectively solve these problems. However, building such coalitions requires that we overcome the massive inertia of a health care system that has traditionally encouraged, and to some extent required, physicians, hospitals, other providers of care, and payers to maintain independent organizations and finances.[5] States have long had laws requiring individuals be licensed to practice medicine; in the 1930s, some states' judicial decisions interpreted these laws as prohibiting hospitals from employing physicians for the purpose of practicing medicine.[6] By the 1990s, only a few states clearly prohibited hospital employment of physicians, and even these states exempted certain types of hospitals and institutions,[6] but what had evolved was a hospital management structure in which authority and responsibility is split 3 ways among the board of trustees (responsible for corporate policies and adherence to them), the hospital administration (responsible for day-to-day functioning of the hospital), and the independent medical staff (responsible for peer review, credentialing, and similar issues).[7] That structure is often problematic, as illustrated when hospital-needed efficiency and standardization clash with physicians' sense of autonomy in the practice of medicine.[8] Bringing these key stakeholders into working alliances presents legal, antitrust, taxation, and state law challenges.[9-11]

The concept of accountable care, generally attributed to Fisher, McClellan et al in 2008,[12] was further promoted by provisions of the PPACA in 2010, which authorized health care institutions organized as accountable care organizations (ACOs) that voluntarily meet quality thresholds to share in the cost savings they achieve for the Medicare program.[3] This offers health care organizations a new avenue through which to address the problems mentioned previously. On March 31, 2011, the Department of Health and Human Services (DHHS) issued a notice of proposed rule making for the formation of ACOs.[13] Considerable industry pushback resulted in significant revision of those preliminary rules, and the final rules issued in October 2011[14] received much more positive acclaim for having addressed many of the provisions initially felt to be unsatisfactory by health care organizations.[15] Those improvements included removal of downside financial risk, better patient attribution, lowering of reporting metrics from 65 to 33, flexible governance, and removal of CMS Meaningful Use electronic health record (EHR) requirements. Additional safe harbor considerations with respect to antitrust and Internal Revenue Service issues have been well received nationally as well.[16,17]

Baylor Health Care System (BHCS) in Dallas-Fort Worth, Texas, is a nationally recognized health care delivery organization that provides full-range, inpatient, outpatient, rehabilitation, and emergency medical services through 17 owned, leased, or affiliated hospitals. The BHCS physician staff consists of approximately 4500 physicians on its combined medical staffs, of whom almost 600 are employed in HealthTexas Provider Network, an affiliate 5.01a or-

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ganization, owned by BHCS. One of the key strategic goals for BHCS, articulated by Joel Allison, CEO of Baylor, is that by 2015 BHCS would form an ACO.[18]

The BHCS Board of Trustees formed Baylor Quality Alliance (BQA)—a limited liability corporation wholly owned by BHCS hospitals with physicians as "participation members" rather than owners—in April 2011, establishing an initial board of managers and management team. In reviewing the preliminary DHHS rules for ACO formation, the Board did not feel that the organization could meet those requirements, so initial plans were to develop a clinically integrated delivery organization without formal Medicare Shared Savings ACO status. The BQA Board framed and committed the organization to the mission of achieving high-quality care while reducing the overall cost of care for our patients by clinically integrating independent physicians, employed physicians, hospitals, and other health care institutions into an effective alliance. An extensive physician-led committee structure was put into place, and the organization has begun to redesign care processes to benefit the community and achieve these goals. In the first 7 months, more than 750 physician committee hours have been logged to create policies, establish membership criteria, consider payer contracts, and begin the detailed process of creating disease-management, population-management care delivery protocols and pathways. The Table illustrates these committees and their basic functions. When the DHHS final regulations were received in October 2011, the leadership of both BQA and BHCS felt that the rules were manageable and that the opportunities to accomplish shared savings were within the capability of BQA. It was further felt that the CMS Pioneer model was not appropriate for BQA because of our limited prior experience in managing financial risk and the fact that our organization was new and lacked the experience, systems, and technology required for the population-management approach necessary for success under the Pioneer model requirements.

After filing an initial notice of intent of registration with the CMS, BQA learned that patient attribution must be via the tax identification number (tax ID) of the physician.[19] Many of our physicians practice in groups that include physicians that do not practice within BHCS, with the entire group sharing a single tax ID. Thus, attribution by tax ID would capture *all* of that group's patients. Despite conversations with and appeals to the CMS, agency policy does not allow attribution by National Provider Identifier number (NPI) since, in their view, use of the NPI would hamper flexibility for physicians and other health care providers or suppliers to participate in multiple ACOs.[19] This hurdle seems insurmountable to BQA at this time, forcing us to suspend our application. The BQA likewise does not currently hold any non-Medicare ACO contracts. We anticipate the first contract will be between the BHCS Employee Benefit Plan and BQA, starting in January 2013. We are also engaged in discussions with Medicare Advantage plans and several commercial plans, looking primarily at shared savings models and patient-centered medical home fees.

Proceeding with our clinical integrated network strategy, BQA leadership feels strongly that "accountability" for quality, cost, and access are core tenets of membership. Members must agree to pay

TABLE. Baylor Quality Alliance Committee Structure

BQA committee	Committee function
Membership and Standards	Create standards of membership and manage performance of all participants; NCQA-accepted credentialing of physicians and other providers, such as post-acute care providers and facilities
Best Care/Clinical Integration	Multidisciplinary creation and monitoring of quality and efficiency of care paths across continuum of care; chronic disease management; transitional care management
Compliance	Organizational adherence to regulatory requirements; assurance of rights and ethical care for patients served
Finance/Contracting	Monitor financial performance of organization; create and adjudicate reward distribution; approve managed care contracts
Information Technology	Ensure electronic connectivity to support clinical integration and measure both quality and cost performance
Population Management	Profiling of population segments and predictive modeling in order to match delivery and resources according to needs of patients. Particular attention to identifying and bringing resources to highest-need patients

BQA = Baylor Quality Alliance; NCQA = National Committee for Quality Assurance.

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an initial fee, submit quality and cost data, acquire an EHR, and log onto a secure website to view their quality and efficiency data no less than 8 of every 12 months. Moreover, they agree to integrate clinical care, with primary care and specialist physicians jointly treating patients, using agreed-on, evidence-based care paths and protocols created collaboratively by primary care and specialist physicians. The BQA leadership also believes it is essential that every patient have a patient-centered medical home; we will therefore have over 250 primary care physicians who have attained National Committee for Quality Assurance Level 3 Patient-Centered Medical Home status.

A significant challenge in creating coalitions like BQA is finding secure, feasible means to share and report the necessary clinical and performance data. While the BHCS employed–physician group is actively using a shared EHR, many of the independent physicians have different EHR systems. We are therefore linking all participating physicians to a Health Information Exchange, the deployment of which has begun.

Performance management within BQA will depend on good data, fed back to physicians and other health care professionals following analysis to identify gaps in care, unexplained variation, and substandard performance of any member. To complement this feedback in truly achieving high-quality care and cost reductions, we are developing a performance improvement and coaching program that we will use to help substandard performers reach target levels. The BQA physician leaders believe that we are truly reorganizing the way that care is delivered to the benefit of patients, while reducing the overall costs of care.

We began recruiting physicians to BQA in mid-December 2011, and our initial efforts have been successful. Of the 600 physicians in the BHCS employed-physician group, 90% have already joined BQA, individually signing participation agreements accepting accountability. More than 700 specialty physicians have already indicated a desire to join, and, at this writing, town hall meetings have been conducted with physicians throughout BHCS. Although BQA is open to willing physicians at this time, the Board recognizes that we may reach a membership level with adequate capacity to serve the population enrolled, in which case membership would close.

The future of accountable care is unclear. However, solutions to the cost, quality, and access problems must—and will—be found, and the ACO model deserves a fair trial with wholehearted commitment to creating a successful, clinically integrated organization that achieves the Triple Aim. We believe that the CMS should strongly reconsider the physician tax ID attribution method and offer an NPI attribution methodology. Until this flexibility is allowed, BQA (and likely many similar organizations) will be unable to apply for Medicare Shared Savings designation. Nonetheless, at BHCS, we are committed to pursuing our clinically integrated strategy and are organizing ourselves to improve care delivery for the patients we serve in north Texas.

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