Iowa Wellness Plan ACO Readiness Application

The Accountable Care Organization (ACO) Readiness Application must be submitted and approved by Iowa Medicaid Enterprise (IME) prior to IME processing an ACO Enrollment packet. Readiness Applications must be completed, signed, and submitted by email to Mbussel@dhs.state.ia.us. Include with the submitted application, an appendix of all requested documentation and written responses with the appropriate organization's letterhead.

The IME has 30 days to review submitted applications and respond in writing with a decision of acceptance, denial, or request for more information. IME reserves the final right to approve an application based on the applicant's responses to the questions, and ultimate capability to meet the requirements outlined in the ACO agreement, improve patient outcomes, and reduce the total cost of care of a population.

Section 1 – Your Contact Information

ACO Address

Legal Entity Name
Trade Name/DBA (if applicable)
Mailing Address

Organization Contacts

ACO Executive (AUTHORIZED OFFICIAL) REQUIRED	
Last Name	First Name
Title	
Mailing Address	
Phone Number (including area code)	Email Address

Agency Liaison (Primary Contact) REQUIRED	
Last Name	First Name
Title	
Mailing Address	
Phone Number (including area code)	Email Address

Iowa Wellness Plan ACO Readiness Application

Application Contact (Primary) REQUIRED	
Last Name	First Name
Title	
Mailing Address	
Phone Number (including area code)	Email Address

Authorized to Sign REQUIRED	
Last Name	First Name
Title	
Mailing Address	
Phone Number (including area code)	Email Address

Quality Contact (Primary) REQUIRED	
Last Name	First Name
Title	
Mailing Address	
Phone Number (including area code)	Email Address

Section 2 – Tell Us Some General Information About Your ACO

Composition of ACO Participants Eligible to form the ACO (Select all that apply):

- ☐ ACO professionals in a group practice arrangement
- ☐ Critical Access Hospital (CAH) billing under Method II
- ☐ Federally Qualified Health Center (FQHC)
- ☐ Hospital employing ACO professionals
- ☐ Network of individual practices of ACO professionals
- ☐ Partnership or joint venture arrangements between hospitals and ACO professionals
- ☐ Rural Health Clinic (RHC)

ACO Taxpayer Identification Number (TIN): _____

Date of Information

The date on the ACO Certificate of Incorporation or other formation documentation:
_____ *(DD/MM/YYYY)*

Your Business Structure (Select One):

- ☐ Limited Liability Company
- ☐ Partnership
- ☐ Privately-Held Corporation
- ☐ Publicly-Traded Corporation
- ☐ Sole Proprietorship
- ☐ Other (specify) _____

Your Tax Status (Select One):

- ☐ For profit
- ☐ Not-for-profit
- ☐ N/A

Section 3 – Tell Us About Your ACO's Legal Entity

1. Submit a narrative giving us a brief overview of your ACO's history, mission, and organization, including your ACO's affiliations.

2. Is the ACO a recognized legal entity formed under applicable state, federal, or tribal law and authorized to conduct business in Iowa?

   ☐ YES ☐ NO

   If you answered **YES**, you are certifying that your ACO legal entity can establish, report, and ensure provider compliance with health care quality criteria, including quality performance standards.

3. Is the ACO formed among multiple, otherwise independent ACO participants?

   ☐ YES ☐ NO

   Note: If the ACO is formed by a subset of the TINs that participate in an organization such as an integrated health delivery system or independent physician association, we consider the ACO to be formed by multiple independent TINs. Accordingly, these entities must answer YES to this question.

4. If you answered **YES** to question 3, do you certify that the ACO is a legal entity separate from any of the ACO participants and comprised only of ACO participants? If you answered **NO** to question 3 select **N/A**.

   ☐ YES ☐ NO ☐ N/A

5. If you answered **NO** to question 3, the ACO is not required to have a separate legal entity. However, please indicate whether the ACO has chosen to have a legal entity separate from the single ACO participant to allow the addition of ACO participants in the future.

   If you answered **YES** to question 3, select **N/A**.

   ☐ YES ☐ NO ☐ N/A

6. Do you have available all documents (e.g., charters, by-laws, articles of incorporation, etc.) that effectuate the formation and operation of the ACO?

   ☐ YES ☐ NO

7. Submit your ACO's organizational chart showing the flow of responsibility. Include committees and key leadership personnel on each committee.

Section 4 – Tell Us About Your ACO's Leadership and Management

1. Are your operations managed by an executive, officer, manager, general partner, or similar party whose appointment and removal are under the control of the ACO's governing body, and whose leadership team has demonstrated the ability to influence or direct clinical practice to improve efficiency, processes and outcomes?

   ☐ YES ☐ NO

   If you answered **NO**, describe how you manage the operations of the ACO, and how this alternate leadership and management structure is capable of accomplishing the ACO's mission.

2. Are your clinical management and oversight managed by a senior-level medical director who is a physician and one of the ACO providers/suppliers, who is physically present on a regular basis at any clinic, office or other location participating in the ACO, and who is a board-certified physician and licensed in a state in which the ACO operates?

   ☐ YES ☐ NO

   If you answered **NO**, describe the ACO's clinical management and oversight, including how this structure is capable of accomplishing the ACO's mission.

3. Does the ACO have a compliance plan that includes at least the following elements:

   a. A designated compliance official or individual who is not legal counsel to the ACO and reports directly to the ACO's governing body,

   b. Mechanisms for identifying and addressing compliance problems related to the ACO's operations and performance,

   c. A method for employees or contractors of the ACO, ACO participants, ACO providers/suppliers, or for other entities performing functions or services related to ACO activities, to anonymously report suspected problems related to the ACO to the compliance officer,

d. Compliance training for the ACO, ACO participants, and ACO providers/suppliers, and

e. A requirement for the ACO to report probable violations of law to an appropriate law enforcement agency.

☐ YES ☐ NO

Section 5 – Tell Us About Your ACP Participants

ACO Participants

1. You must submit a list of ACO participant Taxpayer Identification Numbers (TINs). If your ACO contains FQHC or RHC participants, you may be required to submit additional ACO provider/supplier information. The ACO participant TINs submitted on this list are the ACO participants that have joined together to form the ACO and have agreed to become accountable for the quality, cost, and overall care of beneficiaries assigned to the ACO and to comply with all requirements of the program. **DO NOT submit any ACO participant TINs that have not signed an ACO Participant Agreement with the ACO.**

Meaningful Commitment

2. Does each ACO participant and each ACO provider/supplier demonstrate a meaningful commitment to the mission of the ACO to ensure the ACO's likely success?

   ☐ YES ☐ NO

ACO Participant Agreement

3. Submit a sample of the agreements you are currently using between the ACO and ACO Participants (Taxpayer Identification Number (TINs), ACO providers/suppliers, other individuals and other entities performing functions or services related to ACO activities. All ACO providers/suppliers (NPIs) that have reassigned their billings to the TIN of an ACO participant must also agree to participate in the ACO and to comply with all applicable laws and regulations?

4. Submit the ACO Participant Agreement Template to identify the location of the following in your agreements:

   a. An explicit requirement that the ACO participant or the ACO provider/supplier will comply with the requirements and conditions of the Program, including, but not limited to, those specified in the participant agreement with the Agency.

   b. The ACO participants' and ACO providers'/suppliers' rights and obligations in and representation by the ACO.

c. How the opportunity to get bonuses or other financial arrangements will encourage ACO participants and ACO providers/suppliers to adhere to the quality assurance and improvement program and evidence-based clinical guidelines.

d. Remedial measures that will apply to ACO participants and ACO providers/suppliers in the event of non-compliance with the requirements of their agreements with the ACO.

Section 6 – Tell Us About Your Data Sharing

1. Do you certify that you are requesting this information as a HIPAA-covered entity or as a business associate of a HIPAA-covered entity and that the requested data reflects the minimum data necessary for the ACO to conduct its own healthcare operations or the healthcare operations of its covered entity ACO participants and ACO providers/suppliers?

   ☐ YES ☐ NO

2. Do you certify that you will ensure privacy and security of data and you intend to use this data:

   a. To evaluate the performance of the ACO participants, and the ACO Providers/supplies,
   b. To conduct quality assessment and improvement activities, and
   c. To conduct population-based activities to improve the health of your assigned member population.

   ☐ YES ☐ NO

Section 7 – Tell Us About Your Clinical Processes and Patient Centeredness

Accountability for Members

1. Does the ACO, its ACO participants, and its ACO providers/suppliers agree to become accountable for the quality, cost, and overall care of Medicaid assigned to the ACO?

   ☐ YES ☐ NO

Providing a Quality Assurance and Improvement Program

2. Do you have a qualified healthcare professional responsible for the ACO's quality assurance and improvement program that encompasses all 4 of the following processes:

   a. Promoting evidence-based medicine
   b. Promoting member engagement
   c. Reporting internally on quality and cost metrics
   d. Coordinating care
   e. Promoting the Iowa Wellness Plan Healthy Behaviors Program

   ☐ YES ☐ NO

Please submit a narrative describing how the ACO will require ACO participants and ACO providers/suppliers to comply with and implement its quality assurance and improvement program including but not limited to the ACO's processes to promote evidence-based medicine, member engagement, coordination of care, and internal reporting on cost and quality. Please include a description of remedial processes and penalties (including the potential for expulsion) that would apply for non-compliance.

Promoting Evidence Based Medicine

3. Submit a narrative describing how the ACO defines, establishes, implements, evaluates, and periodically updates its process to promote evidence-based medicine. Also, describe how the ACO will:

    a. Use evidence-based medicine to cover diagnoses with significant potential for the ACO to achieve quality improvements, while taking into account the circumstances of individual members.

    b. Use the internal assessments of this process to continuously improve the ACO's care practices.

Promoting Member Engagement

4. Submit a narrative describing how the ACO defines, establishes, implements, evaluates, and periodically updates its process to promote patient engagement. Also, describe how the ACO will:

    a. Evaluate the health needs of its assigned member population (including consideration of diversity in its patient population) and develop a plan to address the needs of its population. This plan should include a description of how the ACO partners with community stakeholders to improve the health of its population.

    b. Communicate clinical knowledge/evidence-based medicine to members in a way they can understand.

    c. Engage members in shared decision-making in ways that consider member's unique needs, preferences, values and priorities.

    d. Establish written standards for member access and communication and a process for members to access their medical records.

    e. Use the internal assessments of this process to continuously improve the ACO's care practices.

Internally Reporting on Quality and Cost Metrics

5. Submit a narrative describing how the ACO defines, establishes, implements, evaluates, and periodically updates its process and infrastructure to support internal reporting on quality and cost metrics that lets the ACO monitor, give feedback, and evaluate ACO participant and ACO provider/supplier performance. Also, describe how you use these results to improve care and service over time. Also describe how the ACO will use the internal assessments of this process to continuously improve the ACO's care practices.

Promoting Coordination of Care

6. Submit a narrative describing how the ACO defines, establishes, implements, evaluates, and periodically updates its care coordination processes. Also describe:

    a. The ACO's methods and processes to coordinate care throughout an episode of care and during care transitions, such as discharge from a hospital or transfer of care from a primary care physician to a specialist (both inside and outside the ACO).

    b. The ACO's individualized care program, along with a sample individual care plan, and explain how you use this program to promote improved outcomes for, at a minimum, high-risk and multiple chronic-condition

    c. How individual care plans take into account the community resources available to members.

    d. Additional target populations that would benefit from individualized care plans.

    e. How the ACO will use the internal assessments of this process to continuously improve the ACO's care practices.

Section 8 – Certify Your Application

We will not process your application if you do not complete this entire application and mail in an original signed copy to IME.

I have read the contents of this application. I certify that I am legally authorized to execute this document and to bind the ACO to comply with the applicable laws and regulations of the program. By my signature, I certify that the information contained herein is true, correct, and complete, and I authorize the Iowa Medicaid Enterprise to verify this information. If I become aware that any information in this application is not true, correct, or complete, I agree to notify IME of this fact immediately and to provide the correct and/or complete information.

Signature:	Date: