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Accountable Care Organizations:

Past, Present, and Future

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Accountable Care Organizations:

Past, Present, and Future

About the Authors

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Prior to joining Premier, Damore served as the President/CEO of Mission Health System in North Carolina and Sparrow Health System in Michigan. He also served in leadership positions with the Greenville Hospital System (South Carolina) and the Sisters of Mercy Health Corporation (now Trinity Health). His entire 30-plus-year career has focused on building and developing regional integrated health systems, including integrating comprehensive delivery systems and health plans and building several provider sponsored health plans.

Throughout his career, he has received numerous awards for his successful leadership and is a nationally recognized speaker on the topics of health reform, integrated care, and population health management and has published numerous articles on healthcare management, finance, and delivery.

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Prior to this role, Edwards was the Director of Federal Affairs for the Premier Healthcare Alliance, working with lawmakers and their staff to advocate for Premier's legislative priorities and assist in developing policy positions. Edwards primarily focused on delivery system reforms (ACOs, bundled payments, etc.) and quality outcomes (readmissions and healthcare-associated infections). In addition, Edwards previously worked with national thought leaders, such as Dr. Rick Gilfillan and Lynne Rothney-Kozlak, to develop, implement, and manage the PACT Collaborative.

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Masters has written more than 90 articles on healthcare current issues and is co-author with Steven T. Valentine of the *Health Care Capitation & Risk Contracting Manual* (Thompson Publishing, 1995). He is a frequent speaker at industry conferences, professional associations and other meetings nationwide. In addition, Masters is a designated Advisor for The Governance Institute, and has been a regular speaker with that organization for more than 15 years.

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The Governance Institute

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Case Examples: What Different ACOs Learned and Accomplished

The formation and implementation of Accountable Care Organizations (ACOs) includes the development of both value-based care (VBC) capabilities and new value-based payment (VBP) arrangements. ACOs are designed with the goal of taking responsibility for the health status, quality of care, patient satisfaction, and costs for a defined population. Many ACOs, through agreements with both governmental and private payers, have been able to demonstrate sizable and meaningful improvement in attaining these goals since the inception and diaspora of the model.

The Governance Institute's Spring 2018 white paper, *Accountable Care Organizations: Past, Present, and Future,* provides a background on the ACO model and discusses the experience of Medicare, Medicaid, and commercial payers in implementing the model, lessons learned, expectations for the future of the ACO model, and implications for governing bodies.

To provide a picture of how the various ACO structures described in this white paper have been implemented, the following case studies profile three different organizations that each had a different ACO structure: Medicaid, Medicare, and commercial payer. These organizations shared what their priorities were, how they accomplished their goals, and key lessons learned.

Memorial Healthcare System: Medicaid ACO

Broward Health and Memorial Healthcare System, two public hospital safety-net systems covering Broward County and surrounding areas in South Florida, partnered with a safety-net provider services network organization called Community Care Plan (CCP) to administer its Medicaid ACO in July, 2014 (at the time, CCP was known as South Florida Community Care Network). CCP is a provider service network and serves members enrolled in Medicaid, Children's Medical Services Network, and self-insured employee health plans, including Memorial Healthcare System.

Memorial is a safety-net provider and a public health system under the South Broward County Hospital District and one of the largest public healthcare systems in the U.S. Matt Muhart, Executive Vice President & Chief Administrative Officer at Memorial, considers the safety net to extend beyond the uninsured to the Medicaid community, as they are still underserved despite having government insurance coverage, facing continued problems in Medicaid with access and quality. "When the opportunity came up to move from an administrative role managing care for our population under a non-risk basis to actually bidding on and winning full-risk Medicaid business, it made a lot of sense to me," Muhart explained. "Ultimately, managing the totality of the cost of care and the quality of care through a separate organization made a lot of sense from addressing our role as a safety net provider, improving the health of the community, while recognizing that we don't make money on every Medicaid patient that comes in the door. In fact, we lose money. And so, the best strategy for us was to have Community Care Plan manage that population, keep them healthy, and keep them out of hospitals."

The Memorial/Broward Health Medicaid ACO covers 45,000 lives in what is considered a "full-risk Medicaid product" that consists of 90 percent of the Medicaid business in Broward County (North and South districts). The two health systems invested $5 million each over about five years to build the infrastructure and IT to support the ACO and CCP. The two systems each had a different EMR, so the first task was unifying the EMR platform so that data could be shared across the ACO. "The first six months were all about culture and building infrastructure," said John Benz, President & CEO of CCP. "Employees needed to effectively see the purpose for which we were created and understand their goals and objectives." They were "lucky" in the first six months, according to Benz, and made $6 million during that time while they were still trying to put together the pieces.

Once the culture and infrastructure were in place, the next major investment was in building a data warehouse. Called Horizon, it gathers everything possible from internal and external sources to provide a full picture of every ACO members' health status, risk, disease profile, etc. While this was a significant up-front investment, leaders felt it was necessary in order to make decisions based on real-time information, rather than relying solely on historical claims data.

The next piece was physician alignment and incentivizing physicians based on quality metrics. The physicians are under shared savings, pay-for-performance, and fee-for-service contracts (about 75 percent of the ACO patients are in shared savings and pay-for-performance arrangements, and the rest are fee-for-service). Their performance challenge (where reimbursement was at risk) was set at making above the 50th percentile on national standards for NCQA in 37 different quality measures, a rule put in place in the State of Florida for the Medicaid model. Achieving alignment with physicians takes constant monitoring. "In reality, we handhold our providers," said Benz. The pay-for-performance provider program through CCP assesses physician performance against evidence-based care protocols and usage of clinical guideline recommendations. They provide physicians with customized, individual practice data and aim to close gaps in clinical quality measures so that all physicians are performing at or above threshold.

The ACO also includes both social workers and care managers. Each primary care practice with over 400 members has a dedicated care manager to manage high-risk patients as determined by the practice and CCP through a scoring procedure looking at disease or case mix, pharmacy use, physician and ER visits, and hospitalization rates. Support for these patients include closing gaps in access, a member and physician portal, and an annual "care roadmap" for each member. In addition, there is a home visitation program for patients who have presented to the ER more than three times in a calendar year or have not seen a primary care physician in 18 months. The home care team, involving nurse practitioners and physicians, does a complete physical workup, creates a quality measure scorecard for the patient, and assigns them a primary care physician. They provide education to the patient about dental, visual, and medical benefits; transportation; and any other barriers to receiving care. They follow up to ensure that the patient has seen his or her physician to receive their care roadmap within two months of the home visit. To date, they have seen an 80 percent success rate with this aspect of the model.

The Medicaid ACO is earning four- and five-star ratings from CMS and has the capacity to expand to 200,000 members. Administrative costs have remained low, which has helped their success (CCP spends 91 cents of every Medicaid dollar on direct healthcare services). Net earnings were at about $35 million over 35 months; in 2016, CCP achieved 24 percent above

financial projections. How much and how fast to grow in the future are the current strategic considerations.

At the time the Medicaid ACO was created in 2014, Memorial was already well-positioned to take on a population health model due to its primary care service model that had been in place for a few decades. South Broward Hospital District got into population health in the early 1990s, when the district board decided its job was to accept responsibility for the health of the community. Early efforts focused on the uninsured and low-income population. It was hospital-focused, meaning that most interventions were done from the standpoint of trying to avoid uncompensated care. This included the development of a special primary care delivery system specifically for the uninsured and Medicaid population (commercial and Medicare patients were excluded).

Then, in 2000, Florida Governor Jeb Bush created legislation to create six provider service networks (PSNs) for Medicaid managed care via private, for-profit insurers. These PSN programs included shared savings, administrative arrangements, and the provision of care to the Medicaid population for Broward, Miami-Dade, and Monroe Counties. The South Florida Community Care Network was born, the state's first safety-net hospital-owned provider services network, today known as CCP.

With the passing of the ACA in 2010, there were no primary care physicians in the area willing to take part in exchange product networks, because of their participation in the Medicaid managed care plans through CCP. In Broward County, the ACA exchange plans grew quickly to over 200,000 members, and participating private insurers found that they didn't have enough primary care physicians to carry the network through private avenues. So the insurers approached Memorial's primary care centers to see if they would participate in the networks to give the plans a "home" for their members. Memorial agreed, and at that point, the Memorial primary care centers went from 100 percent Medicaid and indigent to 60 percent Medicaid/indigent and 40 percent private payer, virtually overnight.

Today, these primary care centers have evolved into patient-centered medical homes that are part of a comprehensive primary care provider service network that combines Medicaid and commercial lives in both fee-for-service and shared savings, ACO-type arrangements.

Governance and Leadership Structure, and Keys to Success

Benz reports to both Broward and Memorial system boards and their CEOs on a quarterly basis to share financial and quality results of the Medicaid ACO, as well as quarterly reporting to the hospital district board. CCP itself holds monthly board meetings and has a quality improvement committee that handles everything from patient satisfaction to call center statistics.

In addition to the Medicaid ACO, Memorial has a commercial clinically integrated network (CIN) that includes Memorial employees and is also administered by CCP. Memorial and CCP are working on developing a centralized set of services, including technology, to leverage across each ACO administered/managed by CCP. The ultimate goal is to continue to develop synergies across all populations, and leaders are currently creating a document, called Population Health House, to identify how these synergies can further develop over time.

Benz considers this Medicaid ACO product to be something that other public hospital systems across the country can and should attempt. In fact, CCP has told the Governor of Florida that it would be willing to do a block grant for universal coverage in Broward County because the public hospital districts there already have responsibility for the population. "You can't have population health without management," Benz said. "You have to have a legitimate back-office mindset to solve the long-term issues and take the short-term bumps. It's giving back to your community."

For Memorial, the main keys to success were to ensure that the ACO was clinically led and professionally managed, funnel patients through a strong primary care model, and ensure robust data-sharing to drive improvement throughout the ACO.

Hackensack Meridian Health: Hackensack Alliance Medicare ACO

In 2010, Dr. Peter Gross, CMO at Hackensack Health System in New Jersey, approached Dr. Morey Menacker, a primary care physician leader who currently serves as Vice President of Specialty Care and Care Transitions at Hackensack Meridian Health, with the idea of developing an ACO as a demonstration project in the infant stages of looking at value-based care. They were inspired by the Pioneer ACO project under demonstration at the time by CMS. "Dr. Gross was very forward-thinking," said Dr. Menacker. "My only concern was, if we were going to do it, we needed to do it right." The initial step in "doing it right" was focusing on how to eliminate waste, improve outcomes, and then use that information to benefit the entire hospital network.

Dr. Menacker has helped lead Hackensack Meridian Health's population health strategy since joining the organization in 1988. He has served as the President and CEO of Hackensack-Alliance ACO, Hackensack University Medical Center's MSSP ACO, since its inception in 2012. "We recognized [in 2010] that we were not prepared for the Pioneer ACO program," said Dr. Menacker. "But it gave us a head start to prepare ourselves when the MSSP program became a reality."

The first step to prepare for the MSSP ACO program was to obtain the start-up capital necessary to build the infrastructure. The Hackensack President was willing to think outside the box regarding new types of programs, recognizing that there might not be an ROI with this type of investment, but that if the ACO did generate savings, it would be able to pay back the hospital for the infrastructure loan. So the hospital loaned the ACO the capital to get started, but the ACO was set up under ownership by the Hackensack physician group. "I think that that was a very important step because if this was set up as a hospital-based program, and it was run by the hospital, then the doctors wouldn't feel ownership of really changing the way they practice," said Dr. Menacker. While the ACO gained assurance from the hospital that it wouldn't intervene, a key goal at the outset was to translate ACO successes into standards of practice throughout the organization, so they wouldn't remain "trapped" in the ACO program.

The second step was to limit the program to primary care physicians to manage Medicare patients. "We felt that bringing in specialists would not align incentives because we couldn't guarantee how much savings there would be [due to an inability to control decisions on what and how many procedures]," Dr. Menacker explained. By focusing on primary care doctors who were willing to make changes in their daily practice, they created a PCMH model and sought certification from NCQA. This became the foundation of how the ACO viewed value-based care. They mandated that every practice that joined the ACO become PCMH-certified within one year. Consultants were hired to assist new practices in transforming their processes to make this a reality. The ACO paid for the consultants' fees during this step in the implementation. The practices that participated were not required to have a prior affiliation with Hackensack.

The third step was to research the major issues associated with compliance and outcomes and develop relationships between patients and their medical homes. "When you are dealing with patients over 65 who spend 10 minutes with the doctor discussing a problem, how much of this information does the patient remember by the time they're walking out the door?" Dr. Menacker posited. "That is reported to be somewhere around 50 percent. And how often do people comply with those recommendations before they see the doctor the next time, which may be three months, six months, or a year later? About 25 percent. So we recognized that the biggest hurdle was not that the doctors didn't know what they were doing, or that the patients were not seeing their doctors, but that there was a disconnect once the patients walked out of the office. We had no mechanism to monitor compliance, whether it's compliance with medication, diagnostic tests, or consultative work. So we moved aggressively into a care coordination model."

This was before care coordination was commonplace, so HackensackAlliance created its own playbook. Nurses were trained in care coordination and became certified as outpatient care coordinators through an online program at Duke University or a local program in New Jersey. Care coordinators were embedded into each PCMH, seeing patients in person and then following up via phone. "We were preventing a lot of unnecessary duplication of services, unnecessary emergency room visits, unnecessary hospitalizations, and we were also building a database on these patients at the same time," said Dr. Menacker.

This process did not require significant investments in technology at the outset. ACO leaders realized early on that they would not succeed if they tried to "fix everything" all at once. Instead, they set specific annual goals. The initial goal was minimizing unnecessary diagnostics and ER visits. "These are low-tech interventions," said Dr. Menacker. "We expanded hours in our practices. We changed the message when the practices were closed and created a system so patients can call care coordinators after hours on their cell phones [to determine if their situation required emergency care]." In one example, at 3:30 p.m. on Christmas Eve, a patient's daughter called a care coordinator because her father was slurring his speech. She was concerned that he was having a stroke. The care coordinator took a detailed history and found out the patient was diabetic, but he didn't have any other focal neurologic signs. "The care coordinator talked to the patient's doctor, who was planning on leaving to go home to his family, but was still at the office and was willing to stay," said Dr. Menacker. "The patient was hypoglycemic and they were able to adjust the patient's insulin dose. He was able to spend Christmas Eve and Christmas with his family. We eliminated an unnecessary emergency room visit and an unnecessary hospitalization, just because the patient called the care coordinator." This is one aspect of how the doctor/patient relationship is developed via the PCMHs, and one example of the ACO's initial attempts to create change and demonstrate savings. HackensackAlliance was able to distribute a significant amount of money back to its physicians and also begin to pay off start-up expenses at the end of its first year.

In the second year, the goal was to work on reducing 30-day readmissions. Their research revealed that the main causes of readmissions were medication reconciliation problems and lack of follow-up with primary care in an appropriate amount of time. The ACO mandated follow-up appointments within 72 hours of discharge and patients had the appointment already scheduled for them when they left the hospital. In addition, every patient received a 30-day supply of all medications upon discharge. They were advised to stop taking what they had at home, and to bring everything to their follow-up appointment. If there were duplicates, the physician would have the opportunity to ensure that the patient was taking the right medications and dosages. "We actually inserted Pharm.D's in our hospital who now do all the medication reconciliations for every single patient, after we showed success in decreasing our 30-day readmission rate to less than 10 percent," Dr. Menacker said. This is one example of how the ACO is translating successes to the entire health system.

"The ACO works as a clinical laboratory. You identify what the problem is. You create a workflow to correct the problem or improve it. And then once you show value, you roll it out to the entire organization."

—Dr. Morey Menacker, President & CEO, HackensackAlliance

In another example, they created an app to assist patients with chronic heart failure to remember when to take which medications. The app would generate alarms, and if the alarms were not turned off, the patient's care coordinator would receive a notification. In the initial pilot program with about 25 patients, they decreased average patient hospitalizations from four per year to 0.8.

Recently, the ACO recognized that it needed to address post-acute care issues, as this represented 33 percent of its total cost, but the ACO did not own any post-acute care services. The first question to be answered was whether the patients receiving post-acute care actually needed it, and then develop post-acute practice standards. In order to do this, they developed a checklist to identify patients, upon admission to the hospital, who were at high-risk for requiring post-acute care. It was mandated that a HackensackAlliance physician would monitor all patients who went to sub-acute and post-acute care. In addition, care coordinators would visit post-acute facilities and analyze and work with doctors to minimize lengths of stay. To help with this, the hospital would send physical therapy notes along with the patient to the post-acute facility, demonstrating the patient's status upon discharge and the expected length of stay based on physical therapy.

The HackensackAlliance ACO has regularly been recognized as one of the top Medicare ACOs in the country. In its 2015 performance year, it ranked seventh in the nation for total savings, saving more than $33 million while earning a 95.7 percent overall quality score. Due to its success, the ACO was approached two years ago by commercial insurers interested in partnering. "With commercial carriers, a significant number of these patients are young and healthy," Dr. Menacker explained. "It's difficult to create significant savings out of minimizing waste and improving efficiencies when most of the patient utilization is limited to annual wellness visits. However, there are still a lot of things that can be done. And we've been relatively

The HackensackAlliance ACO

successful with our commercial payers. But we're moving into a new environment and made a clear decision that the future of healthcare and healthcare financing is going to depend upon an integrated clinical model. So we've made a commitment as an organization that this is our goal."

HackensackAlliance has now contracted with commercial payers and created a clinically integrated network, which currently has over 3,000 doctors, with a goal of increasing to 5,000 doctors by the end of 2018 (via a combination of employed physicians and independent medical staff physicians).

Governance and Leadership Structure, and Keys to Success

As HackensackAlliance is part of the MSSP ACO program, CMS has specific requirements for the governance structure of these ACOs. The board must be made up of 75 percent of ACO-participating physicians. The ACO board also includes members of the community and hospital administration. The ACO board reports progress to the Hackensack Meridian Health board on a regular basis.

"From a leadership standpoint, it's got to be about vision," said Menacker. "You have to have not only the right vision, but to be able to verbalize and demonstrate it. I think that is a vital part of this entire process."

The keys to success at Hackensack include the focus on primary care in the initial stages, the development of a roadmap for steps to success, and the intent at the outset to ensure that benefits to ACO patients could be implemented throughout the health system.

Baystate Health and Baycare®: Commercial ACO

Baystate Health, located in Springfield, Massachusetts, and its physician-hospital organization, Baycare Health Partners (Baycare®), have been committed to a movement to value-based care since the mid-2000s. When founded in 1994, Baycare was primarily focused on arranging fee-for-service managed care contracts. In the early 2000s, they began their clinically integrated journey to improve the quality, safety, and efficiency of care delivered to their patients.

In 2009, Blue Cross Blue Shield of Massachusetts announced the first value-based contract in Massachusetts, the Alternative Quality Contract (AQC), which is a value-based payment model with two-sided risk and quality metrics built on a fee-for-service model. Two things accelerated entering the AQC contract, according to Dr. Stephen Sweet, CEO of Baycare. First, they saw that the primary care doctors were not happy in the fee-for-service, RVU value-driven system. They were tired and increasingly burned out trying to keep improving productivity every year. Second, a physician from a competing provider organization that was closely aligned with another local medical center was trying to recruit all of the major primary care practices in the area to enter into the Blue Cross AQC through its contract, which posed a competitive threat to Baystate Health and Baycare. In addition, the State of Massachusetts had embarked upon a major effort towards value-based care with its own state-wide insurance program. So Baycare and its board realized that value-based care with provider risk was where the market was headed, and that it needed to become involved in the Blue Cross AQC.

In 2010, Baycare entered into the Blue Cross AQC, a commercial ACO product with 15,000 members with the primary care practices employed by Baystate as well as the other major independent primary care practices—all of whom are members of Baycare. In the beginning, this was a subset of Baycare acting as a pilot with the intent to extend the opportunity to all Baycare providers. Recognizing that it would be difficult to treat only 15,000 patients differently than the rest of the population, Baystate's goal was to expand the ACO model as soon as possible to other commercial payer and Medicare patients. To do this, Baycare expanded its participation

in additional VBP agreements over time with other payers including Health New England (Baystate's health plan), UniCare/GIC, Cigna, and Tufts Health Plan. This approach was designed to provide a critical mass of patients under these models to truly gain the attention of clinicians.

During the initial year of the agreements, they began working with eight physician practices who were culturally ready to accept risk and pilot the value-based agreements. Initially, it took several months of education to create the burning platform to convince the practices to begin to transition to a value-based model, as there were concerns related to the financial impact. With that said, they have been extremely successful over the years, and participation has continued to grow. After the first results were released, they received a significant amount of interest from other parties. During the first year of the agreements, Baycare was able to earn over $3.3 million dollars in additional payments. Over the six years of cumulative performance in these models, it has earned over $56 million in additional payments above fee-for-service and maintained strong quality scores.

Since the ACO's inception, Baycare has focused on five key population health strategies to mitigate risk and manage performance. They include better management of the following:

- Post-acute care:
  - » Decreasing inappropriate length of stay
  - » Coordinating emergency room transfers
  - » Reducing rehospitalizations
- Acute care:
  - » Decreasing unnecessary emergency room visits
  - » Decreasing avoidable inpatient admissions and readmissions
- Costly care:
  - » Focusing on appropriate utilization of sites of care
  - » Utilizing less expensive sites of care when appropriate
- Accurate coding:
  - » Ensuring complete and accurate documentation and diagnosis coding to better identify complex patients in need of additional care
- Specialty engagement:
  - » Enhancing collaboration with specialists in areas such as enhanced access, reduced out-of-area utilization, and bundled payment models
- Care management:
  - » Implementation of a team-based model across the continuum

Governance and Leadership Structure, and Keys to Success

The Baycare Health Partners ACO board of 23 members is comprised of seven primary care clinicians, nine specialists, and seven representatives from Baystate Health (including one community advocate independent of the health system). With super majority quorum and voting requirements such that any of these three key stakeholder groups has veto power, they believe that this structure fosters buy-in from all three parties, since there is a need to bring all parties together to reach consensus in implementing value-based care capabilities. Their keys to success included building relationships with primary care practices, a narrow focus on the five population health strategies listed above while allowing the flexibility to rapidly adjust the tactics supporting their execution, strong ACO leadership, an engaged board, and aligned contract terms.