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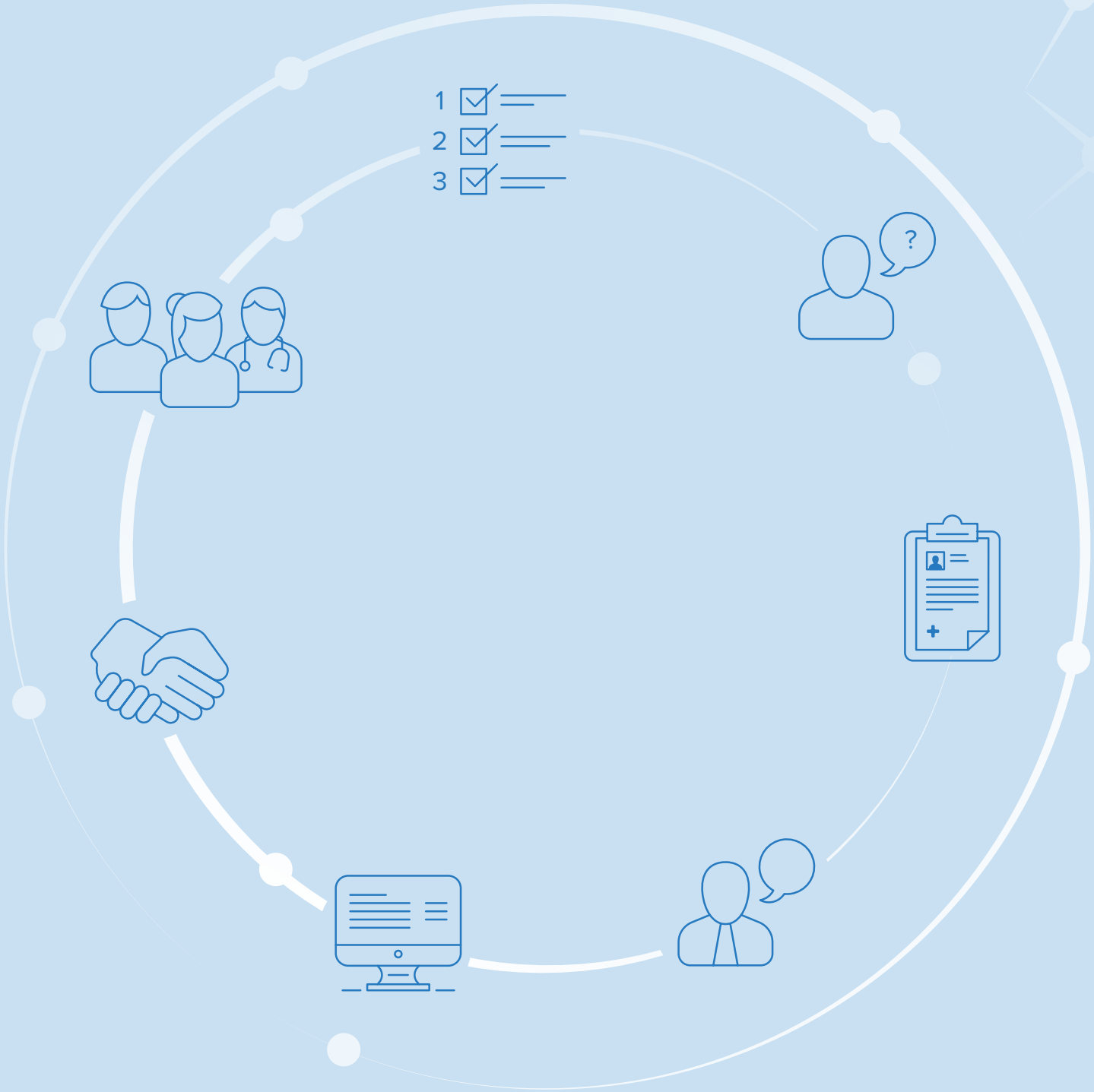
ACO ASSESSMENT TOOLKIT

APPENDIX II. SAMPLE ACO REVIEW REPORT

JUNE 2017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Appendix II. Sample ACO Review Report

On behalf of its Members, the *Business Group* collaborated with *Health Plan* to interview leadership from *Provider Organization* contracted for the *Health Plan*'s ACO program. The ACO contract for self-funded and insured (PPO, HMO) members was effective *Month, Year*. Purchasers are interested in better understanding the types of services that are being provided through the ACO provider organizations with which they contract and/or for which they pay a Per Member fee for attributed patients. This process review will assist employers in exploring opportunities to promote ACO enrollment, develop complementary provider organization partnerships, understand operational strengths and identify opportunities for improvement. For some employers, their geographic footprint might lead to opportunities to coordinate provider organization services with workplace programs such as onsite employer clinics and wellness initiatives.

The goals of the process reviews are to understand:

- Systems the *Provider Organization* has in place managing overall population health, coordinating care, and supporting medically complex patients with high costs and high needs;
- Best practice and success factors for the *Provider Organization* in managing quality and financial risk for a PPO population;
- How services may differ from the care members were previously receiving prior to the establishment of the ACO contract;
- How effective is the ACO-health plan partnership? What's different for *Health Plan* enrollees vs. any other population the Medical Groups are managing?
- Roadmap for incorporating not-yet-in-place best in class ACO processes, including patient-reported outcome measures, physician-specific and practice-level benchmarking, robust point-of-care decision support, etc.

What follows is a high-level summary of the interview with *Provider Organization*. The discussion guide outlined in Appendix I was designed to be an informational interview structured around key provider organization processes and operations, and not a program audit. This preliminary summary report includes observations [and comparative results, if applicable].

Provider Organization Name, Location, Date

Narrative

(Include a short summary description and distinguishing elements of each domain. Example and numbers included here are for illustrative purposes). Where applicable, discuss status and/or progress towards Best Practices.

Leadership, Governance, Organization and Experience

Group employs 125 physicians through its foundation model and contracts with an additional 250 through an Independent Practice Association (IPA) structure. About 65% of the ACO's inpatient population is treated by *Hospital*, with whom the *Provider Organization* has a data sharing arrangement. Governance includes primary care, specialty and hospital representation, quality management and care coordination director, with input from purchasers and consumers. Senior leadership, led by Dr. Brenda Jones, is committed to this group's transformation to an ACO as evidenced by their experience direct contracting with Joe's Tires Company and interest in more direct contracting relationships. Currently, 22% of the group's patient population is attributed or enrolled in a health plan or direct contract ACO arrangement.

Group holds commercial ACO contracts with *Health Plan*[s]. Plan support includes [*monthly*] eligibility and claims data reporting, admission and service authorization notification, and performance benchmarking. *Group* providers infrastructure support, including Electronic Medical Records (EMR), staff training and practice redesign. *Group* also participates in the [*Medicare Next Generation ACO*] model and accepts risk for financial performance under Track {#}.

Member Identification and Engagement

Members are attributed to *Group* based on health plan attribution to primary care physicians (PCPs) based on claims analysis. Under a limited number of benefit designs, members are also attributed based on primary care physician selection, representing 5% of commercial ACO. Members attributed by health plans are flagged in the EMR, which is used by 100% of employed physicians and 20% of independently contracted physicians. IPA physicians receive a [*monthly*] list of attributed members and are notified about care management interactions with *Group* health coaches and staff. At-risk or high-need patients are identified through risk assessment and physician referral. Members with poorly managed chronic conditions or medically complex needs are contacted via [telephone, letter and/or physician referral]. Efforts extended to enroll those targeted in an opt-in care management/ coaching program have a reach rate of 75% with an overall enrollment success rate of 37%. Additionally, other attributed members are managed using software [*name*] to identify gaps in preventive care and outreach via US mail and email when available.

Provider Engagement, Support, and Feedback

Group is both a Foundation and an IPA model, with 60% of its PCPs employed through its Foundation and 40% contracted through its IPA. IPA-based PCPs are required to enter into an opt-in agreement with the ACO wherein they agree to share medical record information, refer to specialists and hospitals working the ACO, and acknowledge care coordination interactions with the member. Among specialists, 85% are contracted through the IPA. The overall ratio of PCPs to specialists is [1:1.8]. Group provides quality measurement, utilization, and financial performance feedback and benchmarking at the individual physician level and practice level through quarterly reports. Employed physicians have access to ad hoc performance dashboards through an online portal.

Care coordination interactions are entered into the EMR, [with/without] PCP notification. For high-risk members, the frequency and content of care coordination department huddles are also documented. Behavioral health services are integrated to the extent possible, with the health plan providing an eligibility flag for attributed individuals with mental health services that are carved out.

For IPA-based physicians, PCPs are notified about care coordination interactions via email [or fax]. PCPs provide acknowledgement of case review notes or recommended follow-ups. Care coordinators may obtain expedited same-day appointments for ACO members. PCPs may also refer attributed members for care coordination outreach. Care managers may be embedded in primary care practices or may provide patient support through primary care or specialty referral to the ACO.

[Hospital] provides real-time Emergency Department and inpatient admission notification to the ACO; ACO notifies hospital of elective admissions authorized by [*Group* and/or *Health Plan*]. ACO offers clinical, operational and administrative support to participating providers.

Group meets individually with PCPs to review provider-specific feedback reports regarding variation in quality and efficiency, including specialty utilization (referral cost), drug optimization (generic use rate, substitution) select modifiable services such as advanced imaging, emergency department and/or hospital use rate (especially avoidable ED or inpatient admissions rate).

Care Management and Population Health

Members with chronic conditions and/or behavioral health needs are proactively identified through risk stratification software. *[Name*] is applied to the last 12 months of claims [and EMR] data to identify the top 20% in terms of prospective risk, illness burden and/or future cost, who are then assigned to the care coordination team's outreach list. Patient gaps in care are prioritized based on clinical significance. Care management may include intake of periodic patient assessment tools, outreach and interventions to address gaps in care and recommended preventive services, referrals to specialists, community resources and services, frequency and documentation of patient contact.

Address whether care coordinators address psychosocial needs and environmental barriers to self-care and health risk reduction. Discuss how behavioral health services are integrated.

Discuss how care transitions, such as a hospital discharge or transfer of specialty care, are managed.

Discuss how use of non-preferred physicians and/or hospitals is addressed and whether admissions to non-preferred hospitals are repatriated to the ACO's primary hospital[s].

Quality Measurement and Improvement

Group uses quality, utilization and financial measures to monitor overall performance of the ACO. Key performance indicators include [*list: total cost of care, clinical outcomes, patient experience*]. Indicate whether the ACO relies primarily on traditional clinical process measures

or if it has a documented roadmap to capture clinical outcomes, as well as to incorporate patient-reported outcomes.

Performance measures are reported [*quarterly*] to participating providers, with metrics and methodology documented and transparent to physicians [and hospitals]. PCPs are given actionable information such as patient lists with identified gaps in care or prescription drug management opportunities. The ACO provides staff training and practice management support to improve workflow. Collaborative learning and sharing of best practices are disseminated through [*quarterly*] management sessions.

Provide description for how care coordinators are trained, including any ongoing training and/or recertification.

Networking, Contracting, Management and Financial Model

The ACO manages a comprehensive network of providers, including sufficient ambulatory, inpatient and ancillary services to optimize access and the site-of-care. Beyond its primary hospital relationship, the *Group*'s admissions are distributed among [*number*] regional hospitals. The ACO has on-site care coordinators at [*number*] of hospitals, and relies on health plan notification for [25%] of its hospital admissions and emergency department visits. The ACO offers options for telehealth and other means of virtual access. High performance specialty providers and preferred inpatient, outpatient surgical and ancillary providers are identified for referring providers.

The ACO accepts financial risk based on [*total cost of care, targeted global budget, managing to targeted inpatient and emergency department utilization levels*], inclusive/exclusive of prescription drug costs. Hospital payments are [*budgeted separately, part of the targeted global budge*t], for which the ACO [*has potential downside risk up to X%/is not at risk*]. Contracts include threshold quality performance metrics and [*upside only, upside and downside*] financial risk. ACO passes through 20% of performance payments to its primary care and specialty providers. Employed physicians have a fixed salary and performance bonus structure of up to 20%; IPA physicians are compensated primarily on a fee-for-service basis.

Indicate the extent to which ACO uses alternative payment models to align incentives among providers, including portion of payments under such models. Examples may include bundled or episode-based payments, capitation or reference pricing. Indicate if hospital[s] participate in risk-sharing with aligned performance incentives.

Provide description for how information is shared between the health plan and provider organization to understand quality and efficiency performance, methodology for shared savings and/or risk calculation, distribution and timing of performance payments, including how any care coordination fee is utilized.

Prescription Drug Management and Optimization

The ACO manages prescription drug management by tracking formulary adherence, generic prescribing efficiency rate, and site of service for specialty drugs. The ACO management team includes a pharmacist to support polypharmacy review and case coordination with care managers. The pharmacist interacts with ACO providers to optimize prescription drug management. Key quality, cost and utilization measures include chronic medication possession rates, generic dispensing rates and adherence to step therapy protocols that promote use of high-value medications.

Describe the extent to which site of care is managed for specialty drugs and infusion therapy. Discuss use of alternative payment models and or reference pricing to manage drug costs. If applicable, address the portion of ACO commercial membership who may be subject to a prescription drug carve-out benefit.

Health IT, Data Integration, and Reporting

For the employed physicians and IPA providers on the EMR platform, the system provides ready access to care coordination provided through the ACO staff. Additionally, the clinical decision support system provides timely information at the point of care to guide recommended diagnostic services, optimal drug prescribing (and potential drug interactions), specialty referrals, and treatment decision support. Real-time communication between treating providers and care coordinators to help inform decisions about a patient's care, reduce potential duplication of service, and support caregiver engagement.

Describe how IPA providers not on the EMR platform exchange data and information with the ACO consistent with sections above.

The ACO conducts data analytics that include risk stratification and predictive modeling particularly high-cost high-need patients, gaps in care, adherence to evidence-based medicine and care pathways, provider-level utilization and cost variation.

Indicate periodicity and how information is conveyed to providers via push communications or direct provider access; if latter, indicate the extent to which ACO monitors provider use of the IT platform.

Participation in community or other health information exchange networks reduces duplication of services, and supports portable clinical information and comparative effectiveness research.

Provide description for how the ACO program performance is monitored, including how Health Plan data is utilized, software systems, how the metrics are reported back to the Health Plan, etc.

Other Highlights

Provide description for any other program elements to highlight, including opportunities for engagement with the business coalition and community collaboration. Summarize major strategies and direction of the ACO, such as growth plans or change in financial risk-bearing arrangements. Other topics may include administrative efficiency, staff levels, staff optimization to maximal skill/licensure.

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