Smooth Shift from Medicare ACO to New ACO with Freed Input

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It was time: after several successful years of participating in a Medicare accountable care organization (ACO), one of California's highest-ranked health care systems planned to exit and start its own ACO. While the Medicare ACO had proven beneficial to all concerned, the health care system noted that it was showing diminishing returns and didn't offer the flexibility the health system desired. The health system's administrators wanted to apply their Medicare ACO learnings and processes to an ACO of their own design, tailored to their needs.

But where to begin, considering creating a new ACO program would be an entirely new endeavor for this health system? And could this task be completed by year-end, to coincide with the start of the health system's fiscal year and renewal of its primary care physician (PCP) contracts?

For experience and expediency, the health system turned to Freed Associates for help in planning, designing, building and implementing its planned new ACO program. Time was of the essence. It was still early in the year, but less than six months remained before the end of September, when structure and wording of PCP's annual contracts would be due for legal and compliance finalization.

Goal

Methodically and sequentially, Freed helped the health care system identify and work through each of the main goals of the new ACO program implementation:

1. Planning and design – quickly and efficiently collecting input from key stakeholders throughout the organization and building a satisfactory new program
2. Stakeholder input and review – crafting plans for a new ACO program and gathering all pertinent shareholder input
3. Planning and implementation – designating key timing and organizational metrics and implementing the new ACO program within prescribed time limits

Strategy

For input and assistance with overseeing the design of the new ACO program, Freed relied on a client-assembled, highly engaged work group consisting of the system's leaders in risk/contracting, quality, and care coordination, as well as from physicians leading the system's inpatient and medical groups, two at-large physician representatives, and the system's chief legal/compliance representative.

Very quickly, Freed realized that one of the greatest challenges in creating the new ACO would come from collecting, assimilating, and coordinating the often disparate input of all of the functional areas represented by work group members. While collectively, all work group participants agreed on the need for the new ACO by year-end, individually, they frequently had strong but differing views on the ACO's structure and guidelines.

Freed leveraged weekly workgroups, for dialogue and key decision-making, but more often worked through non-formal channels to move the project forward without delay. For example, if two or more work group members expressed widely divergent viewpoints on a key ACO component, they were instructed to independently take this dialogue offline, reach consensus, and report back to the master work group with their final decisions.

Tactics

With less than six months to pull together and create a new ACO program for the health care system, Freed's lead wasted little time moving the workgroup forward. Each work group member was tasked with supplying his/her expertise and input in at least one if not all three of the new ACO's primary categories:

1. **Education/training** – Establishing expectations for PCP education and training around the system's new ACO program
2. **Care coordination** – Setting up metrics (including frequency) for PCPs to work in conjunction with care coordinators to meet or exceed newly created baseline ACO standards
3. **Quality component** – Creating a new set of ACO quality standards for PCPs to follow

The work group established a new fiscal year budget and funding for the ACO program, including the potential PCP bonus pool, based on PCP fulfillment of each of the above three categories. The group also created plans for a governance structure for the new ACO program, including establishing a new organizational role for program oversight.

When establishing quality components, it was critical for the work group to gain buy-in and acceptance from each of the participating physicians. While the system's quality and care representatives advocated for stringent quality standards for the new ACO, the group eventually collectively determined that more rigorous standards could be reserved for future years, and that the first year of the new ACO would serve as a foundational baseline for future programmatic tweaks and changes.

Results

Freed helped the health system design, create and roll out its new ACO program within the system's initial timeline, and within time to meet legal/compliance requirements for review and finalization of annual PCP contracts.

Conclusion

Members of the health system's work group universally agreed that completion of the system's new ACO program would not have been possible without Freed's input, particularly in navigating and facilitating the often contradictory points of view that inevitably arose during PCP program design dialogue.

