Your Customized ACO Playbook

Results-Driven Insights, Tools and Guidance to Develop and Manage Accountable Care Organizations
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The Playbook Advantage

Navigating the Path to Accountable Care is Easier with a Roadmap
By the Numbers: Payers are Transitioning and Providers Must, Too.

The transformation from volume- to value-based care is creating more than an opportunity for innovative hospitals, physician groups and payers to embrace the accountable care model – it’s actually creating an imperative.

The Accountable Care Organization concept is one that is evolving, but generally, an ACO can be defined as a set of healthcare providers—including primary care physicians, specialists, and hospitals—that work together collaboratively and accept collective accountability for the cost and quality of care delivered to a population of patients.
Potential Risks – and Rewards – are Great.

The move to accountable care can make a profound impact on patient health and healthcare costs in America. For instance, one primary care network in St. Louis, MO, that serves approximately 5,600 Medicare Advantage members annually was able to control their medical and administrative loss ratios so well that they were able to pay their providers more than the standard reimbursement would have been and make a profit.

If best practices are not pursued, value-based reimbursement models can severely disrupt processes and strain cash flow. Specifically, networks can fail when organizations:

- Lack a strong administrative infrastructure foundation – including a driving vision, organizational governance, technological infrastructure and financial strategy.
- Fail to sufficiently develop and engage a clinically integrated network of primary care and specialty physicians, along with high-quality, low-cost facilities.
- Are unable to identify and effectively pursue the clinical and operational changes necessary to deliver results.
- Do not develop comprehensive care coordination and management capabilities.
- Lack appropriate tools and processes for data management, analytics and reporting.
- Waste valuable time and resources taking on all elements of the transition to value-based reimbursement in-house.
The Move to Value-based Reimbursement is Accelerating – Ready or Not.

And healthcare providers recognize this.

According to recent research conducted by McKesson:

- **66%** OF Payers currently use one or more prevalent value-based reimbursement models, and that number is on the rise.

- **50%** OF Healthcare Providers have at least begun discussions about how to become an Accountable Care Organization (ACO) or other form of Clinical Integrated Network (CIN).

- **35%** OF Healthcare Providers believe that value-based models will deliver positive financial impact to their organizations.

Transition Risks and How to Avoid Them.

Clearly, developing and implementing an ACO requires the careful coordination of multiple elements and dozens of discrete tasks. And the risks are many, including:

- **Risks of financial failure**
- **Risk of clinical failure**
- **Risks associated with applying for and obtaining appropriate credentialing**
- **Risks associated with assuring regulatory compliance**
- **Risks associated with how the competitive landscape in your market may either support or impede your success**

Slightly more than half of the 114 organizations that became ACOs in 2012 were unable to reduce healthcare spending below targets during their first 12 months of operations.¹ With this in mind, it’s no wonder many healthcare providers anticipate some challenges in implementing value-based payment models.

Any organization would have to invest considerable dollars and spend months – if not years – on the necessary organizational, legal and information technology infrastructure before scheduling the first clinical appointment.

Playbook Overview

An Invaluable Resource for ACO Development, Management and Growth
An Invaluable Resource for ACO Development, Management and Growth.

Your customized ACO Playbook by McKesson is designed to support physicians, hospitals, health systems and payers involved in developing ACOs in four important ways:

1. **As a Guide to help ACO leadership address all appropriate structural, operational and clinical issues in an organized, relevant way.**

2. **As a Repository for key documentation, contracts and agreements.**

3. **As a Set of Metrics against which to measure progress and achievement of goals.**

4. **As a “Living Document,” customized according to specific organizational and situational requirements, able to be adjusted dynamically as circumstances evolve and change.**

Your customized ACO Playbook includes the steps to establish the appropriate legal structure, governing board, information technology infrastructure, business analytics, and care coordination team for your organization.

The Playbook also describes the implementation steps required to complete a Medicare Shared Savings Program (MSSP) application and provides a gain/risk share model to help you estimate the benefit from participating in both MSSP and commercial value-based reimbursement contracts.
Table of Contents Preview:

* A Comprehensive, Interactive Guide to Support Your ACO
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The ACO Playbook provides deep, comprehensive guidance in an interactive, electronic format. This makes it easy to securely access information to help you develop and manage everything from your infrastructure, policies and procedures, to your specific documentation, contracts and agreements. It also includes modeling applications to enable you to use information you already know to project likely expenses and revenues.

1. General Reference Information
2. Project Documents
3. Financial Models
4. Integration/Implementation Planning
5. Operations Team Onboarding
6. Strategy & Business Plan Development

Definitions and Acronym Glossary
Project Specific Reference Information
Key Contacts
Organizational Charts
Articles of Incorporation
IRS Form CP-575 or IRS Letter 147C
Provider List
Governing Board Structure / Org Chart
Governing Board Committee Structure / Org Chart
Payer Contract List
MSSP ACO ID Confirmation
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Master Services Agreement
Statement of Work
MSSP Participation Agreement with CMS
MSSP Participant Agreements
ACO Participating Provider Agreements
MSSP Application
Governing Board Bylaws
Payer Contract Copies
Executive Director Weekly Operations Updates
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Executive Summary
Summary and Monthly P&L
Staffing Schedule
Current Year Budget
Gain/Risk-Share Models
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- Executive Summary Playbook
- Stakeholder Engagement
- McKesson ACO Leadership Team Recruitment
- Leadership Orientation
- Office Set Up/Equipment Provisioning
- Strategy/Development/Payer Contracting
- Physician Engagement/Network Development
- Business Intelligence/Analytics
- Practice Transformation
- Care Coordination & Utilization Management
- Technology Implementation
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ACO Leadership Team Boot Camp

Compliance

Finance

Legal

Human Resources

Announcement of ACO Operations Team

Market Introductions
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Current State Assessment of ACO & Business Plan Strategy
ACO Goals/Strategy
Mission/Vision/Values Development
Legal Entity Development
  Governing Board/Leadership Development
  Governing Board Committee Development
Current Payer Contract Assessment & Strategic Planning
Incentive Program Development & Administration
Risk Stratification
Financial Performance Reporting & Monitoring
Clinical Performance Reporting & Monitoring
Technology Assessment & Strategy Development
Marketing Assessment & Strategy Development
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7 Network Development & Physician Engagement
8 Business Analytics & Reporting
9 Clinical Practice Transformation
10 Care Coordination and Utilization Management
11 Technology

Current State Assessment – Physician Alignment

Governance/Operations

Physician Recruitment

Physician Onboarding

Physician Communication/Engagement Plan
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Phases:

- **Phase I - ACO Specific Project Planning & Engagement Start-Up Activities**
  - Clinical Practice Transformation Implementation Plan
  - Project Calendar & ACO Leadership Communication/Reporting Plan & Process
  - Identification of Practice Cohorts

- **Phase II - Comprehensive Individual Practice Assessment for Cohort**
  - Data Collection - Clinical Transformation Survey
  - Onsite Practice Observations/Interviews
  - Onsite Education on Transformation, ACO Measures & Their Role in Clinical Quality Improvement Activities
  - Practice Specific Action Plans
  - Clinician & Practice Staff Introductory Webinars

- **Phase III - Transformation Implementation/Practice Coaching**
  - Monthly Onsite HTW QIC Practice Coaching Visits
  - Quarterly Co-facilitation of Physician Clinical Advisory Group Meetings
  - Monthly ACO Leadership Meetings with HTW QIC and Program Manager
  - Quarterly Written Progress Reports
  - Quarterly Project Manager Teleconference with ACO Operations Leaders & McKesson ACO Services’ Leadership

- **Phase IV - Performance Improvement/Performance Management**
  - Regional ACO-Wide Learning Collaboratives
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- **Business Analytics & Reporting**
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- **Care Coordination and Utilization Management**
- **Technology**

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- Care Management Plan Development
- Collaborative Relationship Development
- Tracking and Coordination
- Coordination of Care Transitions
- Medication Management
- Care Coordination Dashboard Reporting
- Implementation of Evidence-Based Guidelines
- Preventive Care
- Patient Self Management
- Utilization Management Audit Preparation
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Assess Current Technology Needs of ACO and ACO Participants

Identification of Technology Solutions

Development of Technology Implementation Plan

Implementation of Selected Technology Platform

7 Network Development & Physician Engagement

8 Business Analytics & Reporting

9 Clinical Practice Transformation

10 Care Coordination and Utilization Management

11 Technology
A Playbook Built on

Proven Success Factors
Proven Success Factors.

Your customized ACO Playbook by McKesson is based on proven drivers of value-based success:

The Playbook contains valuable tools, templates, and deliverables. Most importantly, each element is also backed by access to the knowledge and expertise of McKesson executive management. These industry leaders are experienced in successfully negotiating value-based contracts and developing ACO and other forms of clinical integrated networks.

Users of the Playbook will have the capabilities to confidently implement the prescribed processes, supported by knowledgeable experts who have successfully done it before. While many organizations have expertise related to one or more of these drivers of success, most lack the experience to address and manage all of them without additional support.
## ACO Four Pillars

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**How the Playbook supports**

- **Strategic Management and Analytics:**

- **Network Development & Physician Engagement:**

- **Practice Transformation:**

- **Care Coordination:**

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**Data Management, Analytics and Reporting Tools**

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Glossary

of Reimbursement Models
# Glossary of Reimbursement Models

Accountable care as a reimbursement model has been defined in both broad and narrow terms. The most narrow and original definition as deemed by the Centers for Medicare and Medicaid is that ACOs are groups of doctors, hospitals, and other healthcare providers who come together voluntarily to give coordinated high quality care to the Medicare patients they serve.

Given below are additional reimbursement models starting with the most prevalent with fee for service to the more advanced along the continuum to value based care.

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Under the typical fee-for-service model, physicians and hospitals are paid on a per service or unit basis. The majority of providers still operate today under some form of fee-for-service reimbursement. The primary concern with straight fee-for-service is that the incentive is to drive utilization without a direct correlation to quality.

The fee-for-service model requires less integration and information technology (IT) infrastructure than do other more advanced models. Pay for Performance (P4P) can be closely associated with fee-for-service; however, the model has distinct differences. In most cases, the model requires the abilities to establish clinical quality benchmarks, as well as to collect, measure, and report results. P4P models are fundamental stepping stones to more advanced forms of value-based care.

The P4P model is not perfect. Incentives may be too small to change physician behavior, or the patient population being affected is too small to institutionalize change. It also remains essentially a FFS model with respect to “rewards,” with providers receiving higher payments in return for rendering more service.
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The bundled payment/episode-of-care model provides a single negotiated payment for all services for a specified procedure or condition, such as pregnancy and birth, knee and hip replacement surgery, and certain cardiac procedures. The model bases provider payment amounts on the costs of adhering to clinical standards of care, risk stratification, and complication allowances. It also incentivizes provider performance based on a comprehensive score card.

Under an episode-of-care payment system, providers automatically benefit from any savings they generate by improving efficiency within episodes. Under a comprehensive-care payment system, providers can also benefit from the savings they achieve by preventing unnecessary episodes of care. The payer, meanwhile, saves money by paying a provider less money per episode or per patient than it has in the past. Moreover, the payer knows up front how much it will be spending, rather than having to wait to see whether any savings will be achieved.
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In some cases combined with fee-for-service, P4P, bundled payments, global payments, or capitation, shared savings programs reward providers that reduce total healthcare spending on their patients below an expected level set by the payer. The provider is then entitled to a share of the savings. The idea is that the payer spends less on a patient’s treatment than it would have otherwise spent, and the provider gets more revenue than it otherwise would have expected.

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Shared risk models could be described as the “next-level” of risk arrangements, under which providers receive performance-based incentives to share cost savings combined with disincentives to share the excess costs of healthcare delivery. This model is based on an agreed upon budget with a payer, and calls for the provider to cover a portion of costs if savings targets are not achieved; this portion could be a percentage of the premium (e.g., 30% of the overall premium flows to provider) or a set amount (e.g., 50/50 sharing of excess costs). As expected, there is a relationship between risk and reward. Because under this model providers take on more risk, essentially upside and downside, most often the opportunity for upside financial gain is larger.
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Under a capitated payment model, a provider organization, or group of organizations, receive from the payer a set payment per patient for specified medical services. In this way, the provider takes on 100% of the insurance risk for the covered patient and services. These payments are usually in the form of a monthly per-patient-fee. These fees are determined by actuarial analysis of historic costs of the patient population to be covered by the capitated model. These fees are adjusted to reflect the “acuity” or “level of risk” associated with the patient population. Then the provider organization or group of organizations must determine how to divide up the single capitated payment. More often than not, this fund disbursement is done using a combination of incentives and fee-for-service agreements.
Accountable Care Services

As powerful and comprehensive as your customized ACO Playbook by McKesson is, its real value is the experience and expertise of the entire McKesson team of accountable care professionals. For more than 15 years, we have successfully helped providers effectively manage by providing the organizational and care foundation to ignite better business performance.

We offer the accountable care management and technology necessary to help you improve financial and clinical performance throughout the journey from volume- to value-based care. And our team supports practices and organizations in their efforts to successfully obtain and execute payer agreements containing value-based reimbursement.

End result: we help ACOs and other clinical integrated networks achieve maximum financial benefits while minimizing risks and delivering the best possible care.
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