Recommendations to the Green Mountain Care Board:
Accountable Care Organization (ACO) Oversight
Damore Health Advisors LLC
December 2021

1. BACKGROUND

In Fall 2021, the Green Mountain Care Board (GMCB) engaged Damore Health Advisors LLC ("Damore Health Advisors") to support its accountable care organization (ACO) oversight processes through a subcontract with Bailit Health. Damore Health Advisors has provided expert consultation to support assessing OneCare Vermont's (OneCare or OCV) performance on two core competencies (Population Health Management and Managing with Data) and to provide recommendations to GMCB on ACO performance, as well as suggested improvements that GMCB staff could make to its ACO guidance, budget review, and monitoring and performance improvement processes.

Damore Health Advisors President and CEO Joe Damore has significant experience as a health system CEO and as a consultant supporting ACOs and health systems in becoming high performing organizations. Damore has served as Vice President of Strategy, Innovation, and Population Health at Premier Consulting Solutions, responsible for assisting physician groups, hospitals and health systems, health plans, and integrated health systems in implementing population health management arrangements, including ACOs. His team of 80 consultants provided collaborative and consulting services to numerous healthcare organizations in areas such as strategic business planning, clinical integration, new value-based payer arrangements, quality and financial improvement, and in implementing population health management core capabilities. Prior to joining Premier, Damore served for nearly two decades as the President/CEO of Mission Health System in North Carolina and Sparrow Health System in Michigan. He also served in leadership positions with Greenville Hospital System (now Prisma Health) in South Carolina, and the Sisters of Mercy Health Corporation (now Trinity Health). Damore's career of more than 30 years 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. Damore is a nationally recognized speaker on the topics of health reform, integrated care, and population health management, and has published numerous articles on health care management, finance, and delivery.

2. INTRODUCTION

The goal of this analysis is to provide recommendations to GMCB for further improvement of the process to provide required oversight of OneCare Vermont as an ACO serving the enrollees of the state of Vermont. The ultimate goal is to meet the goals of the enabling legislation creating the GMCB to improve health of Vermonters and moderate the growth of health care expenditures, within the statutory authority granted by the legislature (see 18 V.S.A. § 9371; § 9382).

The report contains three sections:

- The first section introduces benchmarking as a concept, discusses its uses in managing an ACO or health system, and identifies the specific need for the development of a benchmarking program to support a more effective continuous performance improvement program and attain improved results for individuals attributed to OneCare.
- The second section contains the recommendations for GMCB as it relates to its oversight of OCV and other ACOs.
- The third section addresses the core capabilities that successful ACOs build and implement, building on the core competency framework presented to GMCB by Bailit Health on May 12, 2021.

3. BENCHMARKING AS A TOOL FOR PERFORMANCE IMPROVEMENT

The development of national and regional benchmarking comparisons is a critical tool for managing the cost and quality of care for a population. It is a fundamental building block to: 1) developing a more effective performance improvement program and thus improved performance; 2) sharpening an ACO's focus on the priority areas that will result in the most significant return on investment (ROI) in terms of both cost and quality; 3) identifying best practices; 4) presenting specific opportunities to implement best practices for ACO providers that have been effective in ensuring success for other ACOs; and 5) further embedding an operational culture of continuous improvement in performance. Implementing an effective benchmarking tool is a major opportunity for OneCare to implement a more data-driven management approach and identify and spread best practices across the state.

The development of benchmarking comparisons should be built for each individual major payer lines of business (Medicare, Medicaid, and Commercial), aligned where feasible and appropriate. In addition, the benchmarking metrics should be developed in each of these five key areas for each payer: 1) utilization, 2) cost per capita, 3) patient satisfaction/engagement, 4) quality, and 5) evidence-based clinical appropriateness.

Exhibit 1 (see "Medicare Dashboards") is a set of sample metrics for consideration that can be used by OCV for the Medicare ACO population for both comparativeness purposes and as a key tool in identifying the greatest opportunities for performance improvement on both a quarterly and annual basis. Medicare is a candidate to be the first payer to benchmark since benchmarking datasets for Medicare ACO performance are readily available, and because Medicare has the highest total cost of care (TCOC) on both a per capita basis and as a percentage of ACO revenue.

In the future, similar benchmarking dashboards could be developed using tailored metrics for the Medicaid and Commercial ACO populations based on the unique attributes of those populations. The state of Vermont or a specialized Medicaid consulting firm may be able to provide Medicaid dashboard

metrics. An alternative could be to use Medicaid Managed Care comparative data as Medicaid ACO benchmarking may be difficult to obtain. A set of Medicaid dashboards can be developed to reflect the unique factors and the incidence and prevalence of specific conditions for the Medicaid ACO population, such as high-risk deliveries, pediatrics, developmental disabilities, and behavioral health. OCV could consider developing a similar set of commercial dashboards in collaboration with Vermont Blue Cross Blue Shield of Vermont and MVP Health Care based on the unique conditions of the commercial ACO population, such as childbirth, cancer care, and chronic conditions like diabetes and heart care. The State should request commercial payers to share dashboard data and best practices from the national Blue Cross Blue Shield Association (BCBSA) ACO database and other regional or national data, where appropriate.

Also, additional data mining capabilities and dashboards should be built to permit a "drill down" by both individual provider or group practice and by region (pod) or Hospital Service Area (HSA). This will provide individual providers and each HSA with information concerning national best practices and provide focused areas of performance improvement for providers that will provide patients with the greatest benefit and improve OCV performance results. This process can be used as a part of OCV's business intelligence tool and support its commitment to continuous improvement. Other statewide ACOs such as Bon Secours Mercy Health in Ohio (BSMH) and Highmark/Allegheny Health Network in Pennsylvania have developed regional pods to permit the "drill down" of provider data to a level that still provides statistical significance; Vermont could consider grouping HSAs or hospitals for this purpose.[1]

4. RECOMMENDATIONS FOR GMCB TO LEVERAGE ACO REGULATION TO SUPPORT A HIGH-PERFORMING HEALTH SYSTEM

The recommendations presented below center on the advanced use of data to strengthen both OCV's performance improvement program and GMCB's regulatory oversight. Developing and using benchmarking dashboards will help focus on key ACO performance outcomes such as improving the quality of care provided and efficiently managing costs.

a. **Benchmarking:** GMCB should require OCV to implement a reputable benchmarking system for each payer population starting with the Medicare population. This would include OCV reporting benchmarking and financial results to GMCB on a quarterly basis. Medicare benchmarking tools are available from multiple sources, including Milliman, Premier's Population Health Management Collaborative, and the NAACOS Institute for Accountable Care. Premier's benchmarking product includes access to best practices from 70 ACOs with over two million Medicare beneficiaries. Benchmarking systems can be purchased for an annual fee of less than $90,000 per year that would include best practices data and the

[1] A 2015 analysis for the GMCB by Truven Health Analytics and Brandeis University suggested five regions: Region 1: Burlington, Middlebury, and St. Albans; Region 2: Barre and Morrisville; Region 3: St. Johnsbury, Newport; Region 4: Lebanon/White River Junction, Randolph, Brattleboro, and Springfield; Region 5: Rutland and Bennington. Vermont could also elect to use Dartmouth Atlas Hospital Referral Regions.

identification of specific ACOs that are performing at the best practice level (top decile) in specific areas. Based upon 10 years of experience with these ACO benchmarking programs, the ROI of this investment should easily exceed 8:1 for OCV through increased shared savings.

GMCB should approach BCBSVT to provide similar comparative benchmarking data to complete the content of the dashboards in the five areas for commercial payers from the national BCBSA data and best practices. The metrics should include the areas of most prevalent areas of services such as childbirth, pediatrics, cancer, heart disease, diabetes, etc.

Similarly, the GMCB should make a similar request to the Department of Vermont Health Access for benchmarking data to complete the five Medicaid benchmarking charts. Additionally, Vermont may belong to the National Association of Medicaid Directors which could serve as a resource for national data and best practices. Other sources of Medicaid data include the Consumer Assessment of Healthcare Providers and Systems (CAHPS), the Health Services Advisory Group, or a Medicaid specialized consulting firm. It may be a challenge to obtain only ACO data, but Medicaid Managed Care data could serve as a proxy for the ACO comparative data.

b. **Quality and Performance Improvement:** GMCB should require the integration of benchmarking results into the development of the OCV annual performance improvement plan. An ROI analysis of major opportunities should occur to ensure that OCV is including the areas of greatest opportunities in the annual quality and performance improvement plan. The ROI analysis should include quality, satisfaction, and health equity criteria in addition to utilization and cost criteria.

c. **Quarterly Performance Reporting:** GMCB should require OCV to provide at least quarterly performance reports with specific mutually agreeable targets. The reports should include financial performance and benchmarking reports by payer in the areas of utilization, total cost of care, quality, satisfaction, and clinical appropriateness. Criteria could be included to determine when follow-up action plans are required. For example, any area with a variance greater than 20 percent or a variance to target of 10 percent for two quarters in a row would require an action plan due to GMCB within 30 days. The goal of this approach is to provide greater focus and accountability on the major areas for performance improvement. By focusing on the areas of greatest opportunity (including ROI), this will provide additional cost savings to invest resources in other needed areas.

d. **Risk Management/Mitigation:** GMCB should require OCV to present in their annual financial plan their top 3-5 areas of risk and the detailed action plans to mitigate each of these risk factors. Examples could be a significant COVID-19 breakout or a significant shortage of staff.

5. FURTHER ENHANCEMENTS TO ACO CORE CAPABILITIES

This section of the report addresses the core capabilities that successful ACOs build and implement. It also provides recommendations for OneCare based on Damore Health Advisors' observations of its management and performance, gathered from a review of OneCare's FY22 budget submission, hearing, and responses to questions. These core capabilities expand on core competencies that were presented by Bailit Health at the May 12, 2021 GMCB meeting (see Core Competencies of High Performing ACOs, Bailit Health, May 12, 2021), with additions drawn from Damore Health Advisors' experience working with over 70 ACOs across the country for the past 11 years.

Some of the core capabilities and related recommendations listed below may interact or overlap with work currently performed by other Vermont health system actors, for example, the Blueprint for Health; however, the need for the core capability remains, so they remain included here.

a. Governance and Management

i. OCV should implement a reputable benchmarking system for each payer population starting with the Medicare population (see Section 3, Benchmarking as a Tool for Performance Improvement). Examples of Medicare benchmarking systems include Milliman's benchmarking system, the National Association of ACOs Institute for Accountable Care, and the Premier Population Health Management Collaborative benchmarking tool. The Premier product is the most mature and would likely offer the greatest potential ROI to OneCare because of the availability of best practices of top performers by specific metric. The cost for each of these products would be slightly less than $90,000 per year but more than likely provide at least an eight-fold ROI.

ii. OCV should commit to further becoming a high performing ACO by taking responsibility for TCOC, appropriate utilization based upon evidence-based healthcare standards (i.e., Choosing Wisely, CMS Care Compare), quality based on national benchmarks and best practices, patient and provider satisfaction and engagement, and health parity. This additional commitment must be to standardize quality, cost-effective care across the entire state for all attributed lives. OCV has stated in response to GMCB questions that "OneCare is not a healthcare provider and does not have direct access to provider EHRs, which limits the ability to measure clinical appropriateness of care in the manner reflected in the question. As such, OneCare does not deploy a clinical appropriateness tool at this time." (see Response to Round 1 questions, Q12, 11/5/21.) This is a major gap and an area that ACOs should pursue to achieve quality, cost-effective care. There are publicly available measures for hospitals on the CMS Care Compare website, and Choosing Wisely provides evidence-based clinical appropriateness criteria developed by the physician specialties societies (i.e., the American Academy of Cardiology), at no cost. Many ACOs have adopted numerous criteria from Choosing Wisely.

iii. OCV states that it is an ACO and, therefore, should take accountability for the care provided to its enrolled populations. The commitment to measuring clinical appropriateness should be re-enforced by governance and executive management as a fundamental principle of the organization..
iv. OCV should integrate the results of national and regional benchmarking into its strategic planning and performance improvement processes throughout the organization. OCV comparative global metrics should be used to identify specific areas that require further investigation. Provider and HSA-specific comparisons to the best practice metrics and processes and median benchmarking data should be used to “drill down” to identify specific opportunities for operational improvement.
v. OCV should integrate a program evaluation process into its annual strategic and operational planning processes to measure program effectiveness and to identify programs for modification or elimination based on data and actual program effectiveness.
vi. OCV should integrate benchmarking and performance improvement goals based on national benchmarking and best practices into its annual Board and executive management goals.
vii. OCV should review the typical ACO functions (see Exhibit 2, “ACO Functional Areas”) to determine current resource allocations and additional shared services with ACO members, and identify functions that require either additional investment or reduced investment of resources to better position OCV to be a more effective and successful ACO. This may require significant collaboration with the Blueprint for Health and Department of Vermont Health Access.
viii. OCV should evaluate its Board of Managers composition to further evolve towards a competency-based governance model. OCV should identify specific areas of expertise that are needed on the Board such as nursing, population health information technology (IT), and population health management. The Board should also consider increasing the number of primary care providers to make the ACO more primary care-led and less hospital-focused and ensuring gender and ethnic parity on the Board.
ix. OCV should ensure the Board of Managers develops and implements a plan to ensure all enrollees have access to quality, cost-effective care consistently across the state for contracted populations. Where local capacity may not exist, the use of telemedicine, physician extenders, and transportation services could be provided.
x. OCV should develop a Board of Managers-endorsed plan to become one of the nation’s high performing ACOs (see Exhibit 3, “HP ACO Attributes”) by adopting a set of principles and developing and implementing a metric-driven three-to-five-year plan to implement the actions that would lead OCV to being recognized as one of the nation’s high performing ACOs. This would be an ambitious plan but would provide an inspiring and motivating vision for the OCV Board, leaders, employees, and providers. This plan should be shared with GMCB.

b. Provider Engagement & Network Management

i. OCV should make available to providers cost per capita, quality, utilization, satisfaction, and clinical appropriateness data on their patients and comparisons to best practices within OCV and nationally. OCV should provide primary care providers with access to specialists' performance data to assist in making patient referral decisions to specialists who demonstrate value-based care. Several large or other statewide ACOs (such as BSMH in Ohio) have developed regional networks or ACO pods to measure performance and build accountability on a regional basis.

ii. OCV should develop and share with primary care providers specialist performance metrics by specialist to permit a preferred referral network based on quality, cost, satisfaction, utilization, and clinical appropriateness data and reward specialists who demonstrate high value. A Medicare "shadow bundle" program for services such as total joint replacement and heart failure have been successful in engaging and rewarding high value specialists based on metrics. A "shadow bundle" program establishes a target spend for a specific procedure or episode of care using definitive criteria such as Medicare bundled payment program definitions. If the physician can deliver the services at a lower rate and meet the quality and satisfaction metrics, the physician would be paid an added payment from the shared savings. This program can be a successful effort to engage specialists in value-based care and better align payment.

iii. OCV should develop and implement a three-year plan to transition a greater percentage of provider payment to value-based payment (or alternative payment models) rather than fee-for-service (FFS), such as primary care capitation or a shadow bundle program to create alignment with the OCV Board goals and value-based payment contracts.

iv. OCV should implement an operational tool to measure primary care practices' implementation of team-based advanced primary care, which may include the use of group visits, integration of behavioral health services, and use of other professionals for delivering care in areas such as depression. OneCare should create a payment model to reward ACO primary care providers who implement these team-based advanced functions. OneCare should undertake these activities in consultation with the Blueprint for Health.

v. OCV should develop and implement measurable performance expectations for preferred post-acute care providers that offer services such as weekend skilled nursing facility admissions and hospital EHR access.

vi. OCV should develop and implement a scalable plan to provide care management services for the high-risk, rising risk, and populations with one or more chronically ill conditions, such as patients with asthma, diabetes, COPD, heart failure, hypertension, and chronical depression. OCV should review the ROI for each of these care management programs. The use of remote monitoring and artificial intelligence-based models will assist in improving the ROI for care management. Care managers should continue to integrate the social determinants of health into

the program and collaborate with community service organizations. The OCV goal should be to create consistent care processes and care management team member roles across OCV for all regions and attributed lives. OCV can likely utilize existing frameworks for care management and care coordination developed by the Blueprint for Health and the State Innovation Models Initiative grant, but should seek to achieve program fidelity across the state in partnership with the Blueprint for Health.

vii. OCV should implement a plan to ensure continuity of care occurs across the continuum in a consistent manner across the state for enrollees and create incentives and processes to ensure care is delivered at the lowest cost, most appropriate location such as the home or outpatient centers. For example, many patients across the country are still being admitted to hospitals for rehydration when the lower cost and more appropriate location may be an outpatient infusion center or home care. The Centers for Medicare & Medicaid Services (CMS) has recently begun providing a waiver to over 150 hospitals and health systems to provide the "acute hospital in the home" program. This permits health systems to be paid for Medicare services delivered in the home that formally required hospitalization.

viii. As a future step, OCV should more meaningfully engage specialists in its network via payment models specific to specialists (e.g., the use of "shadow bundles"[2] to reward high-performing specialists) to permit a preferred referral network based on quality, cost, satisfaction, utilization, and clinical appropriateness data. To support this, OCV should develop statewide specialty councils to build clinical pathways and specialist performance criteria by area of specialty, such as cardiology, gastroenterology, and orthopedics. OCV should seek to do this in a way that creates strong performance incentives for both hospital-based and independent specialists.

c. Patient Engagement

i. OCV should design opportunities for patients to be more involved in their patient care decisions, such as requiring providers to provide patients with open access scheduling, individualized care plans, and alternative treatment options.

ii. OCV should develop additional opportunities for patients to be involved in program design through advisory councils, participation in clinical service line planning, among others.

iii. OCV should develop an enrollee and community education plan that includes community education-focused Public Service Announcements (PSA) promoting the

[2] A Medicare "shadow bundle" program for services such as total joint replacement and heart failure have been successful in engaging and rewarding high value specialists based on metrics. A "shadow bundle" program establishes a target spend for a specific procedure or episode of care using definitive criteria such as Medicare bundled payment program definitions. If the physician can deliver the services at a lower rate and meet the quality and satisfaction metrics, the physician would be paid an added payment from the shared savings. This program can successfully engage specialists in value-based care and better align payment.

advantages to enrollees of an ACO model, as compared to FFS. The PSAs could also include suggestions emphasizing the value to the patient of having a primary care provider relationship and other value-based care principles. This messaging would take health literacy into consideration, ensuring verbiage is in layman's terms, and would provide examples of the successes of OCV in lowering the rate of increased costs, improving quality, enhancing satisfaction (such as showing Vermont's CMS Care Compare data against national benchmarks), utilization and clinical appropriate areas (such as lowering ED visits for minor conditions by relocating these visits to lower cost, more appropriate settings, and more timely care). OCV should consider educational forums by HSA. Other programs could focus on concepts such as "Know your Numbers" which would encourage enrollees to know their basic clinical numbers such as blood pressure, blood sugar and heart rate.

OCV may want to consider having a credible national ACO expert such as Dr. Rick Gilfillan (former director of CMMI and CEO of Trinity Health) or Dr. Don Berwick (former Director of CMS) or other similar experts co-present at regional or HSA forums rather than OCV presenting alone, to present a more objective approach. Also, several national organizations have produced quality videos on the benefits of ACOs and value-based care that are available. If not already complete, OCV should implement a community perception survey and share the raw results and action plan with GMCB.

d. Population Health Management

i. OCV should develop and implement a set of metrics to identify the best performing value-based care post-acute care providers.
ii. OCV should develop statewide specialty councils to build clinical pathways and specialist performance criteria by area of specialty, such as cardiology, gastroenterology, and orthopedics.
iii. OCV should implement a statewide primary care council to develop and guide the implementation of a primary care provider value-based payment model for all enrollees.
iv. OCV should implement an evidence-based clinical appropriateness tool for primary care providers, specialists, and hospitals such as Stanson Health or others. CMS Care Compare provides several basic metrics for hospitals and physicians to measure clinical appropriateness. OCV should publish results of the CMS Care Compare for all the hospitals in the participating in OCV at least annually and recognize and reward those that are performing better than the national and state benchmarks.
v. OCV should develop and implement a plan to begin to measure pharmaceutical compliance using tools such as third-party medication dispensers for complex patients and patients with memory loss issues. This could initially be implemented as a pilot at University of Vermont Medical Center.

vi. OCV should develop and implement a set of value-based payment guidelines to create alignment with value-based care principles and to create consistency in payer payment models and provider payment models.

e. Data Management

i. OCV should develop an annual Population Health Information Technology (PHIT) strategic and operating plan and priority setting process that involves key provider groups such as primary care providers, care management, specialists, and IT leadership.
ii. OCV should use benchmarking data by payer population to identify best practices and the greatest opportunities for continuous performance improvement.
iii. OCV should distribute regular reports to providers on their individual performance (including benchmarks) with data on utilization, cost of care, quality, satisfaction, evidence based clinical appropriateness, and health equity.

6. CONCLUSION

OCV is a large, statewide ACO servicing Medicare, Medicaid, and commercial enrollees in the state of Vermont. OCV has produced numerous positive results in its brief history and expressed a commitment to continuous improvement. This report provides an approach to benchmarking dashboards that OCV can implement to further implement this philosophy of continuous improvement to better serve its enrollees. It also identifies opportunities for GMCB to use its regulatory levers to push toward this same goal. Together, this strategy will help both organizations move towards a more data-driven approach to strengthen Vermont ACO performance.

Exhibit 1: Medicare Benchmarking Dashboards

- **Utilization**
- **Total Cost of Care**
- **Quality**
- **Satisfaction/engagement**
- **Evidence Based Clinical Appropriateness**

Medicare Utilization Dashboard (Source DHA LLC)

	Q1	Q2	Q3	Q4	YTD	National Avg.	Top Decile
Admissions/1000							
ED visits/1000							
Hosp. days/1000							
Primary care visits/1000							
Specialty Visits/1000							
% AWV							
Hosp. discharge/home h							
Hosp. discharge/SNF							
SNF days/1000							
Part B Rx/PBPM							
Amb. care sensitive adm./1000							
Preference sensitive adm./1000							
Outpt. Perf. Sensi. admissions/1000							
% Aged non-dual							

Medicare Per Capita Cost Dashboard (Source DHA LLC)

	Q1	Q2	Q3	Q4	YTD	National Avg.	Top Decile
Total Cost of Care PBPM							
Total inpatient cost of Care PBPM							
Post acute cost of care PBPM							
Primary care costs PBPM							
Specialty Physician services cost PBPM							
Outpatient Surgery cost PBPM							
Total Part B Rx cost PBPM							
% use of generic Rx							

Medicare Quality Dashboard (Source: CMS Care Compare)

	Q1	Q2	Q3	Q4	YTD	National Avg.	Top Decile
Actual/Expected Mortality rate						1.0	
All readmissions within 90 days						15.5%	
Serious complication rate						1.00	
Death rate from heart attacks						12.3%	
Death rate from stroke						13.5%	
Rate of readmission of heart failure pats.						21.9%	
% adult patients w/ influenza vaccine						81%	
% pats. tested positive for alcohol/drug referred for treatment						62%	
Pats who left ED before being seen						2%	
% deaths occurring in hospitals							

Medicare Satisfaction/Engagement Dashboard (Source CMS Care Compare/DHA LLC)

	Q1	Q2	Q3	Q4	YTD	National Avg.	Top Decile
% Patient sat. score of 9 or 10						72%	
% Would recommend (Yes or No)						71%	
Primary Care visit in last 12 months							
Specialist visit in past 12 months							
% of chronic disease Pats. active in program							
% understand their Rx						63%	
Pats who STRONGLY AGREE understood their care at discharge						52%	
Patient stated dr always communicated well						81%	
Patients reported always received help as soon as they wanted						67%	

Medicare Evidence Based Clinical Appropriateness Dashboard (Source: CMS Care Compare)

	Q1	Q2	Q3	Q4	YTD	National Avg.	Top Decile
Pats receiving app, recommendation for F/U for colonoscopy screen						91%	
% of ED chest pain patients got clotting Rx within 30”						52%	
% of workers rec. influenza vaccine						86%	
% of mothers w/deliveries sched. Early w/o med. necess.						3% (lower better)	
% of low back pain outpts had MRI before PT						38.5% (lower better)	
% of outpt CTs of the abdomen that were double scans						1.9 % (lower better)	
% of outpts w/cardiac stress test before low-risk outpt. surgery						4.1% (lower better)	

Exhibit 2: ACO Functional Areas

Financial	Clinical	Operational	Pop. Health IT	Other Services
• Payer Contracting	• Quality/Performance Improvement	• Operational processes	• EHR Integration	• Governance
• Payer Relations/Strategies	• Team-Based Advanced Primary care	• Member relations	• HIE Connectivity	• Compliance
• Data Analytics	• Clinical Appropriateness	• Enrollment	• Risk stratification/analytics	• Legal
• Actuarial Services	• EB clinical care plans/pathways	• Patient satisfaction	• Predictive modeling	• Marketing/PR
• Accounting	• Care management/chronic disease management	• Patient engagement/communication	• Decision support	• Policy
• Benchmarking/metrics	• Provider engagement	• Community services (SDOH)	• Telemedicine	• Strategy
• Provider compensation models	• Behavioral health management	• Network development/management	• PHIT Strategies/ priorities	• HR/Cultural transformation
• Claims analytics	• End of life care	• Post acute network management	• Disease registries	
• Risk management	• Continuity of care/Transitions of care		• Patient Portals	
• Financial planning	• Pharmacy management			
• Financial /Benchmark Performance reporting				

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Building a High Performing ACO

Exhibit 3

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Attributes of a mature, high-performing Accountable Care Organization (ACO)

- **A commitment to continuous learning, performance improvement, and benchmarking.**
- **A focus on the application and updating of evidence-based care processes with applications based on the latest research.**
- **Ability to capture, measure, and benchmark key value-based care metrics in the areas of cost (per episode of care and per capita), utilization, quality, satisfaction, and clinical appropriateness; and demonstrated capability to utilize this data to improve performance through benchmarking and other tools.**
- **Ability to utilize employers and other payers' performance data (cost, quality, satisfaction, and utilization) to transform care delivery.**
- **Willingness to transparently share performance data to consumers and payers.**
- **Design and implementation of a compensation system for physicians and other providers which includes value-based care metrics (rather than only volume-based such as RVU system) and align incentives with value-based care principles where appropriate.**

Attributes of a mature, high-performing Accountable Care Organization (ACO)

- **Adoption by the ACO of performance incentives with willingness to accept upside and downside risk in a step-wise fashion over time.**
- **Implementation of an effective patient experience/engagement program that results in above benchmark metrics.**
- **Effective programs to create continuity of care across the continuum including a care management program for chronically ill populations and high-risk/high-cost, and rising risk patients, connecting providers through an integrated electronic patient record system, the use of technology to move care to the lowest cost appropriate location, and a network of providers who are committed to these high-performance principles.**
- **A population health data and reporting infrastructure including a patient portal and utilization of standard data tools.**
- **Ability to demonstrate a model for health, wellness, and chronic disease management success.**
- **A demonstrated committed to measuring and improving health equity.**