

You Can't Pick Your Family, But You Can Pick Your Friends: Choosing Wisely When Building Strategic ACO Collaborations

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April 4, 2014

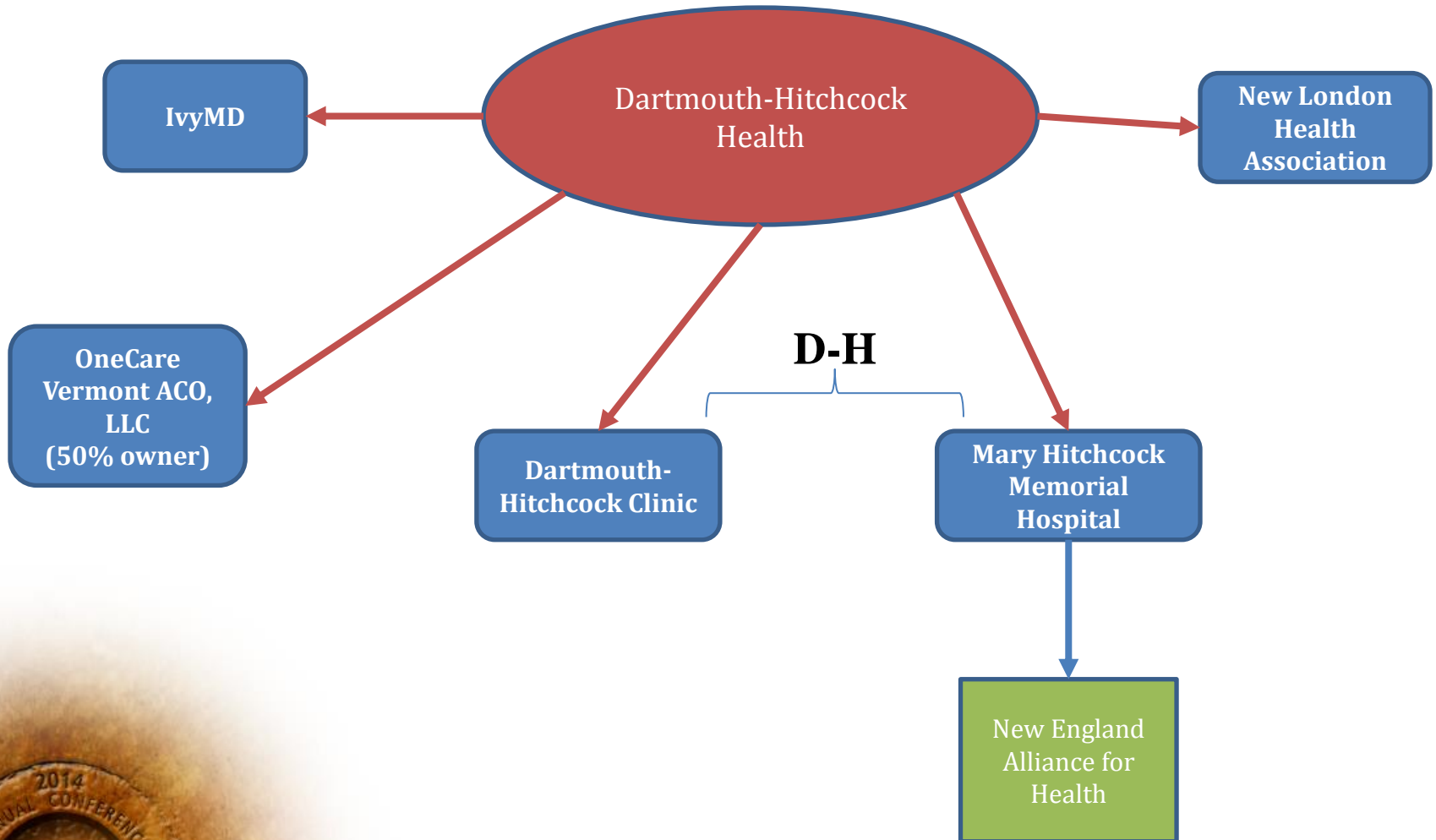


Presentation Learning Objectives

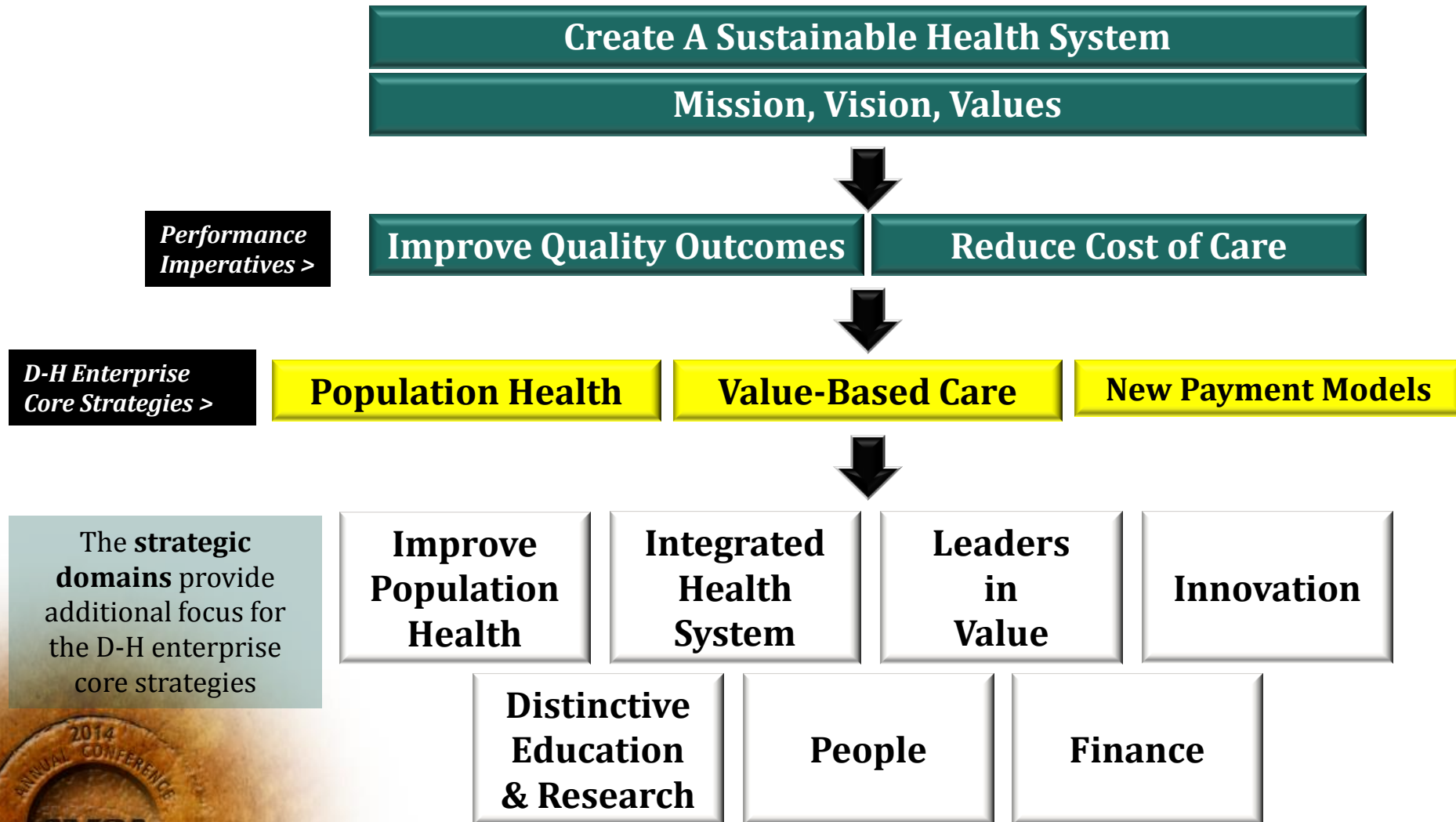
- Use key criteria to identify potential partners for collaboration
 - ACO model participation
 - Joint Venture with health plan and other providers
- Create internal discipline to adhere to key criteria
- Develop and utilize a due diligence checklist to gather financial, administrative, and operational data needed to satisfy ACO fiduciary responsibility
- Utilize readiness assessment tools to understand a potential partner's care coordination/management philosophies, patient-centered medical home capabilities, ability to collect and report on required quality measures, and overall state of readiness to successfully participate in an ACO



Who is Dartmouth-Hitchcock Health?



7 Strategic Domains Under 3 Enterprise Core Strategies



Creating A Sustainable Health System



GEISEL
SCHOOL OF
MEDICINE
AT DARTMOUTH



THAYER SCHOOL OF
ENGINEERING
AT DARTMOUTH



THE DARTMOUTH INSTITUTE
FOR HEALTH POLICY & CLINICAL PRACTICE



Tuck School of Business
at Dartmouth



Boston Children's Hospital



Population Health

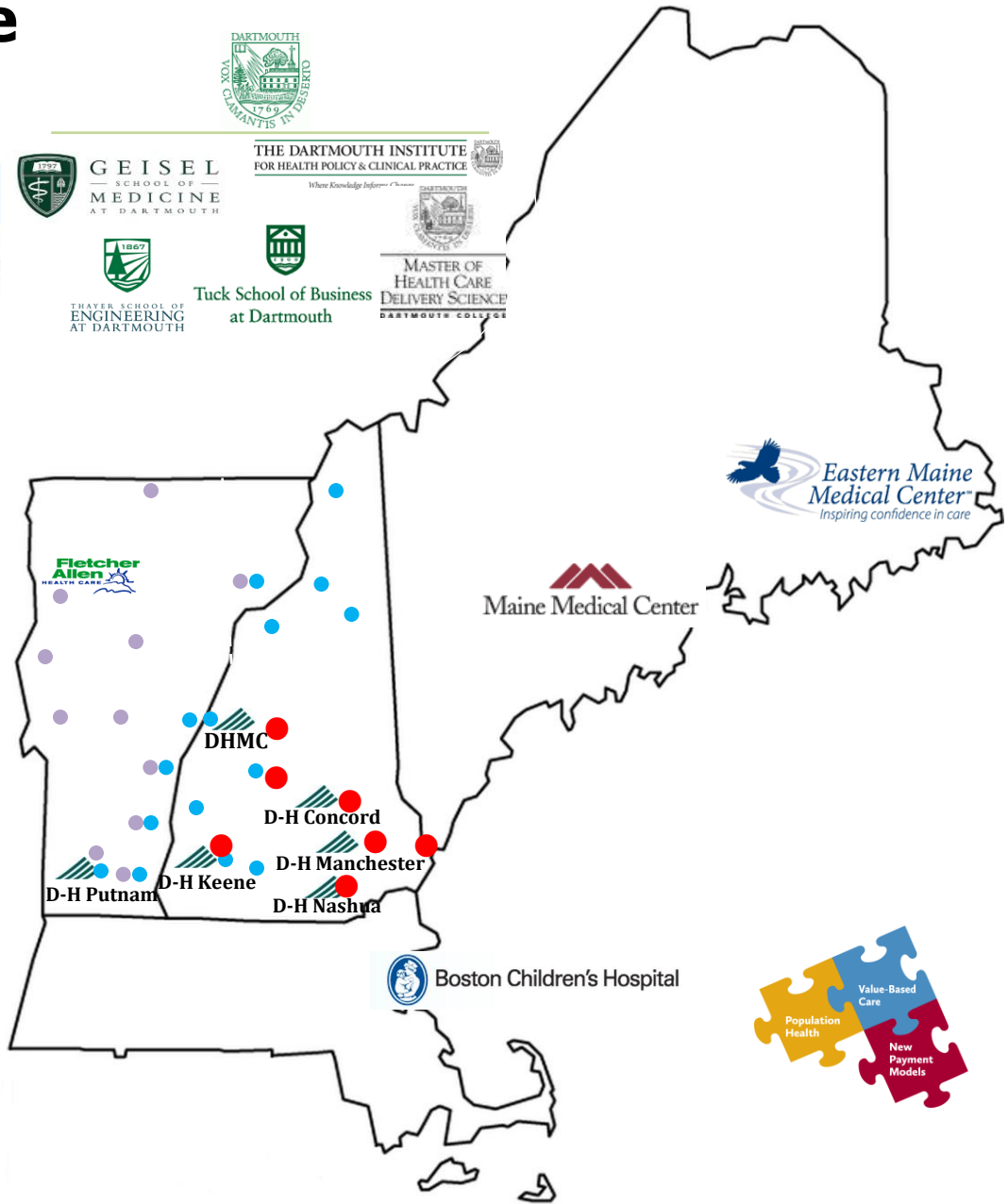
- New England Alliance for Health (NEAH)
- Boston Children's
- So. NH & Seacoast region

Value Based Care

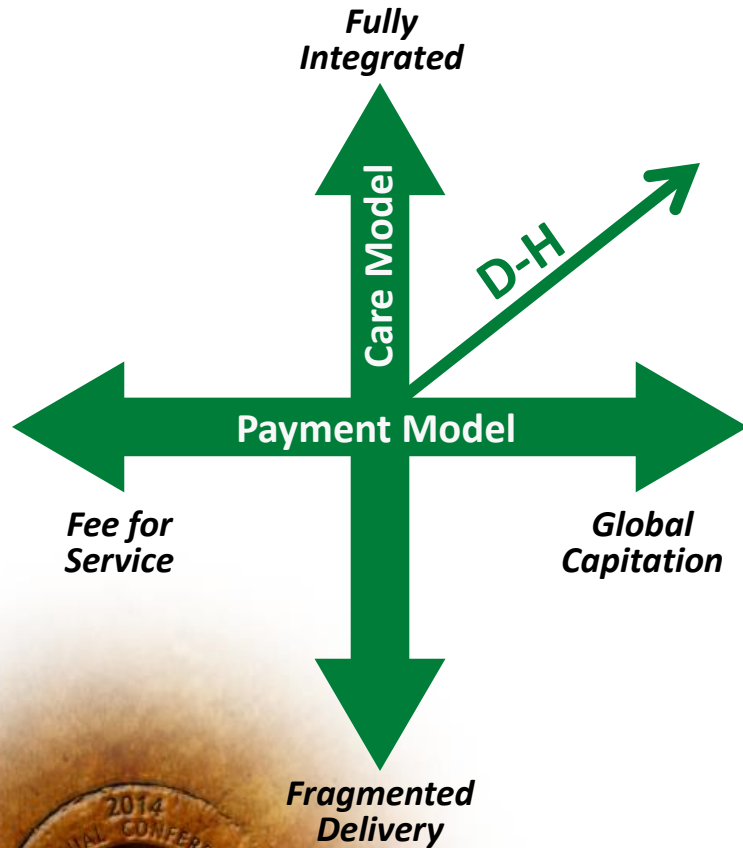
- High Value Healthcare Collaborative (HVHC)
- Mayo Clinic Network
- Northern New England Accountable Care Collaborative (NNEACC)
- Dartmouth College
- Industry Partners

New Payment Models

- DHH AllWell Pioneer ACO
- OneCare VT ACO
- ElevateHealth (partnership of DHH, Elliot Health Systems, and Harvard Pilgrim Health Care)



End-State Goals – Where Are We Heading?



- Provide care and wellness services to 2+ million people
- Measurably improve population health
- Implement value-based care processes across D-H
- Participate to the fullest extent possible in payment models that recognize the value of care delivered
- Develop an integrated Northern New England healthcare network
- Refine and expand an integrated Northern New England support and management services infrastructure
- Enable more care and wellness to be delivered at community level and at home
- Align D-H workforce with enterprise strategies/objectives
- Align research and education to support achievement of a sustainable health system
- Establish innovative partnerships with government and industry that improve care and wellness
- ***D-H recognized as a national leader in creating value and implementing a sustainable health system***

How to Get Where We're Heading

- **Option #1: Merge with or acquire other providers/health systems**
 - Rural nature of NH marketplace, federal anti-trust laws/regulations, and lack of state action immunity laws/regulations make this challenging
- **Option #2: Formerly affiliate with other providers/health systems**
 - Limited potential; See Barriers to Option #1
- **Option #3: Buy or build own health plan**
 - Capital intensive; not core competency
- **Option #4: Strategic collaborations with other providers/health systems and health plans**
 - Until such time as the federal and state regulatory environment changes, viewed as only real viable solution to enable D-H to achieve our end-state goals



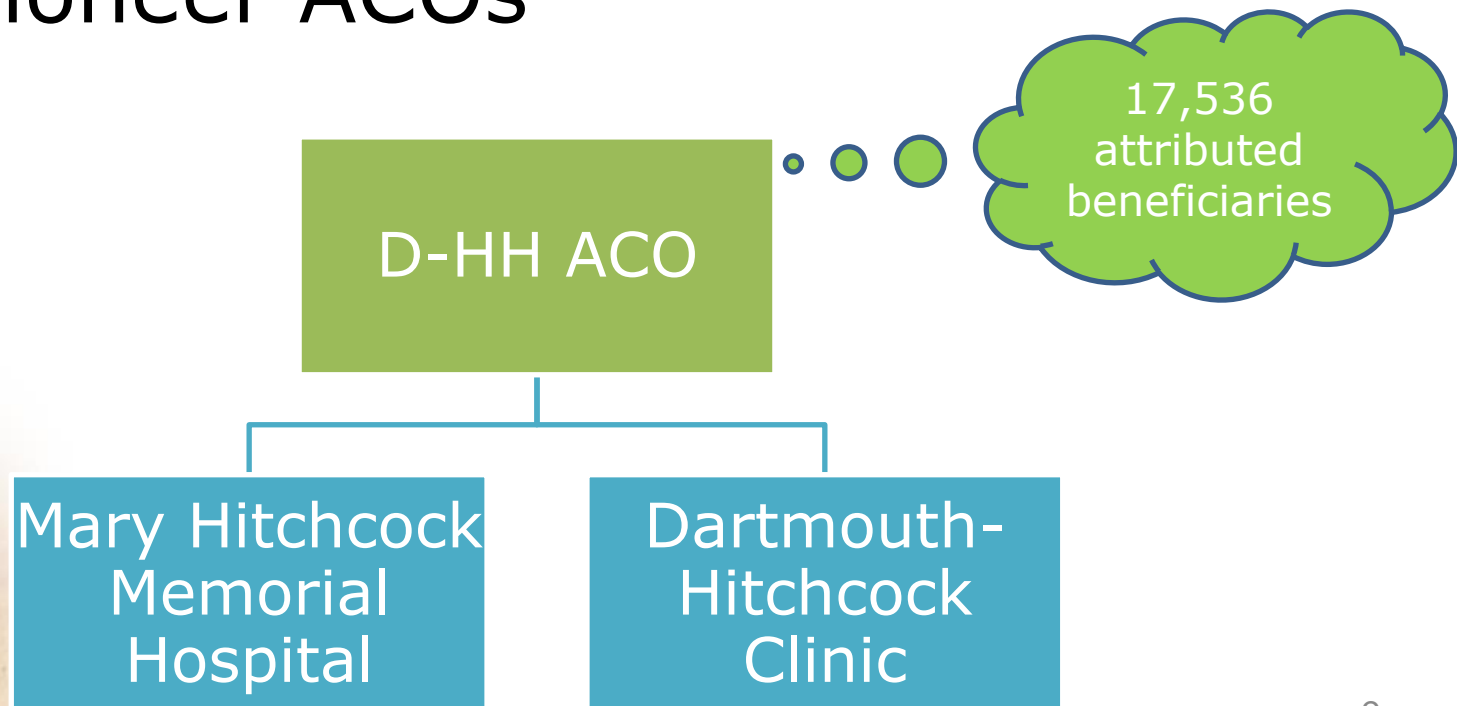
Two Examples of Deploying Option #4

- Dartmouth-Hitchcock Health Pioneer ACO Model expansion
- ElevateHealth Joint Venture, a partnership of Harvard Pilgrim Health Care, Dartmouth-Hitchcock, and Elliot Health System



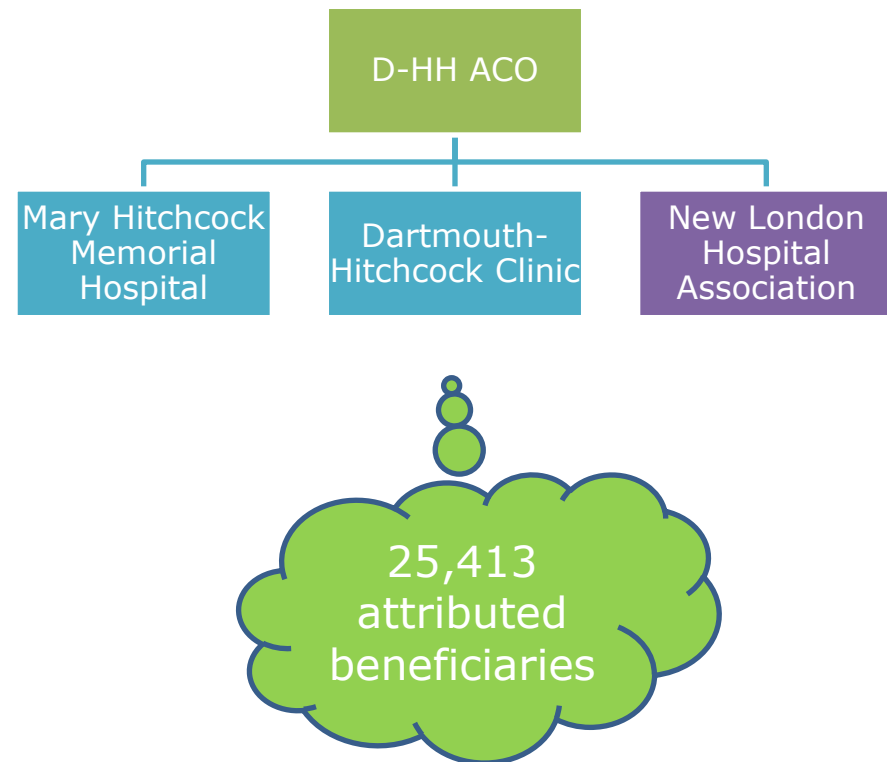
NEW PAYMENT MODEL: Dartmouth-Hitchcock Health Pioneer ACO (2012)

- Through competitive application process, D-HH became one of thirty-two Pioneer ACOs



Dartmouth-Hitchcock Health Pioneer ACO: 2013

- Expanded ACO participation by adding one Critical Access Hospital and its employed physicians
- Criteria for adding NLHA:
 - D-H & NHLA affiliation discussions were underway; ACO inclusion would foster continued clinical integration
 - NLHA's Chief Medical Officer was a former D-H physician who had championed accountable care, shared-decision making, evidence-based medicine, and shared the same care coordination philosophy
 - NLHA's patients generally used D-H for specialty care



ACO Expansion for 2014

- D-H determined that it needed to expand Pioneer ACO participants beyond D-H and NLHA
 - Why?
 - To move closer to achieving our vision of creating a sustainable health system with the healthiest population possible
 - To lead the transformation of health care in our region and to set the standard for the nation
 - How?
 - Create rigor and structure to the expansion identification, selection, and implementation process
 - Adequately assess business risk to D-H and its ACO because of changes in composition of ACO provider participation



D-HH Pioneer ACO Expansion Process

- Created internal workgroup that included senior leadership
 - Workgroup Purpose:
 - Identify preferred platform to develop/expand Medicare ACO in New Hampshire
 - Identify potential new participants that could include one or more PPS hospitals and/or CAH hospitals
 - Develop criteria and other factors to assist in expansion decision(s)
 - Develop due diligence timeline and project team assignments
 - Recommend financial terms & participation agreements to be offered to selected potential participants



D-H 2014 Participation Criteria for PPS Hospitals

Employs primary care providers; private practice providers excluded from participation offering

Stable administrative and clinical leadership teams

Willing & able to adopt/implement D-H Care Coordination principles

Able to collect, report, and exchange clinical & administrative data in a timely way

Financially able to assume downside risk

Able to secure any necessary Board of Trustee approvals by June 2013

Participates in D-H due diligence process under "fast-track" time frame

Able to supply TIN/NPI roster in prescribed format by July 1, 2013



D-H 2014 Participation Criteria for Critical Access Hospitals

Employs $\geq 50\%$ of primary care providers in its community

Accepts phase-in of downside risk in second year of participation

Willing & able to adopt/implement D-H Care Coordination principles

NH-based NEAH member with stable administrative and clinical leadership teams

If quality targets are met, then eligible for 50% of potential share of cost savings in return for no exposure to downside risk in 1st year of participation

Able to secure any necessary Board of Trustee approvals by June 2013

Participates in D-H due diligence process under "fast-track" time frame

Able to supply TIN/NPI roster in prescribed format by July 1, 2013



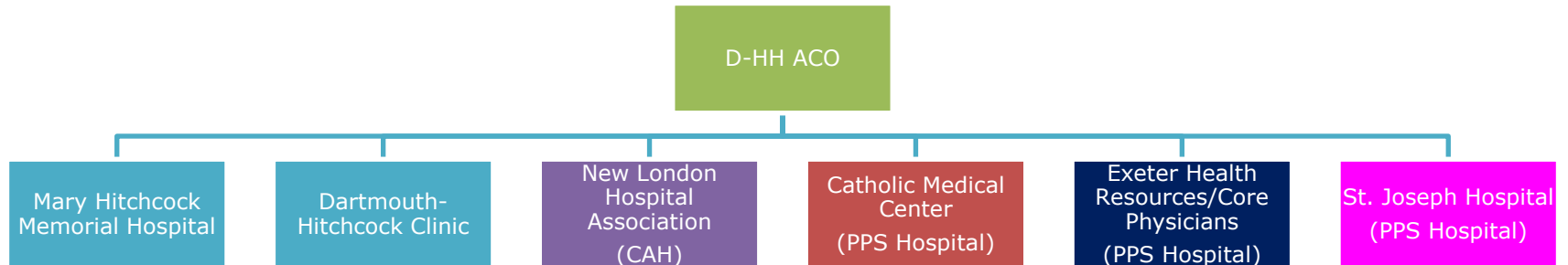
D-H 2014 Pioneer ACO Expansion

Due Diligence Focus Areas

- **Financial Condition**
 - Assessment of ability to assume financial downside risk
- **Outcomes-based Commercial Contracts**
 - Percentage of commercial contracts that are outcomes-based now; what percentage is expected to be by end of 2015?
- **Employer-sponsored health benefit plan funding mechanism**
 - Self-funded or fully insured?
- **Clinical Care**
 - Assessment of willingness and ability to adopt D-HH Pioneer ACO Care Principles/Care Coordination philosophy
- **Compliance**
 - Willingness to comply with terms and conditions of the D-HH Pioneer ACO Participation Agreement



Dartmouth-Hitchcock Health Pioneer ACO: 2014

A green, cloud-like graphic with a blue outline and a small green stem with two circles at the top.

46,700
attributed
beneficiaries



Gaining Entry to New Capabilities in Order to Design Next Generation Payment Models

- In the summer of 2012, D-H began exploring how it could partner with health insurers as the next iteration of transitioning to value-based care
- Being directly involved in insurance would address a number of disadvantages imposed by shared risk models:
 - Better potential economics through access to full premium upfront, keeping a full share of any savings retained by the carrier, as well as benefiting from savings related to reduced administrative redundancies
 - Better control of the benefit design (patient incentives, education, and communications to align with value-based care), and ability to focus the network on like-minded providers
 - Acceleration of the adoption of value-based care models by sharing the value created thru new care models with consumers, employers, and communities in the form of reduced premiums (thereby pushing other insurers to adopt similar value-based models in order to effectively compete in the NH market place)



What form would Partnering with a health plan take?

- **Buying**
 - Not seen as a viable option. Few insurers of feasible size and required market position were available and those that were did not have best-in-class capabilities
- **Renting**
 - Offered a broader array of options but potential plans either lacked best-in-class capabilities, a New Hampshire beachhead to build from, or a genuine commitment o value-based care
- **Partnering**
 - Offered best combination of low cost entry, access to best-in-class capabilities, and opportunities to share in the management of the business with an experienced set of executives



Criteria for “Partnering” with a health plan

- Plan Partner had to have:
 - Long history of trust and collaboration between D-H and plan partner
 - Be a non-profit entity
 - Existing network and strategic commitment to the NH marketplace
 - Shared philosophy and commitment to a value-based approach
 - Shared aspirations that the venture would change and grow over time



Designing the Joint Venture: Who's in it?

- Harvard Pilgrim Health Care (HPHC) and D-H agreed to enter into a joint venture that would incorporate a new value-based model
- Midway through the design process, HPHC and D-H decided that the joint venture model might be strengthened with the addition of other provider partners
 - A network organization of five NH-based health systems to join the venture as a partner but declined
 - However, one member of this network organization, Elliot Health Systems, agreed to collaborate and become a JV partner outside of its network organization membership
 - This addition slowed down the process but we believe ultimately made it a better product



Designing the Joint Venture: What is it?

- Joint venture design began in summer of 2012 and progressed through summer of 2013
 - Retained outside consultant as lead project manager to ensure JV design and development occurred within established timeframes
 - Year-long process allowed all three parties to develop relationships and trust necessary for success; allowed the parties to better understand the culture and perspectives of each other as we learned to work together toward a shared vision



Designing the Joint Venture:

What is it?

- In the fall of 2013, ElevateHealth was launched: a suite of commercial insurance products initially aimed at the small employer group market in NH; may expand to other market segments in 2015
 - Benefit design includes a narrow provider network comprised of providers who share joint venture partners' philosophy and commitment to value-based care
 - Care model differentiators:
 - Concentrate the care among high-value providers with continual reinforcement and support for coordination of care;
 - Consolidate and integrate to the "best of breed" among population health and care coordination approaches used by participating providers and HPHC
 - Put population health activity and accountability as close to the point of care as possible; and
 - Continual innovation to take advantage of the integration across HPHC and participating providers
 - Patient liaisons to help members make connections into a participating health system and aid them through care episodes

• HPHC, Elliot Health Systems, and D-H share equally in financial success/failure of ElevateHealth

Lessons Learned So Far

- Collaboration is hard despite shared vision, aspirations, and enthusiasm
- Candor, respect and trust are fundamental
- Inter-personal relationships are key
- Communications and managing expectations are essential
- Success depends on buy-in across organizations and within organizations



Questions?

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