

# BAY AREA ACCOUNTABLE CARE NETWORK



University of California  
San Francisco



## CHIEF MEDICAL OFFICER

Bay Area, California

### Position Specification

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## I. ORGANIZATIONAL OVERVIEW

### Vision and Charter

The Bay Area Accountable Care Network (the Network) is bringing together leading providers in the region to form an innovative *system of care* that provides its members with the benefits of population health, while delivering the personalization, convenience and expertise of premier independent providers. John Muir Health and UCSF will provide the initial capital for the Network; additional participants may include Dignity Health, Hill Physicians, Muir Medical Group IPA and other hospital and provider group partners.

Through a federated model, the Network will provide patients the convenience of easy access to a broad, highly regarded network of providers; the ability to choose their doctor; and a personalized, evidence-driven approach to care built on a trusting relationship between each patient and their own care team. Through active care management across this broad network, the Network will generate value to patients in the form of high quality care, and savings to providers and partners, including payers and the employers and employees they serve. The Network will become a true Bay Area system of care – one that delivers a level of expertise and personalization of care that other integrated delivery systems will be challenged to meet.



#### **Bay Area Accountable Care Network Statement of Purpose:**

“We are leading health care providers and institutions in the San Francisco Bay Area, working together to form a high value health system for the benefit of patients, employers, and payers. We will achieve our objectives by linking our organizations together to seamlessly integrate care across a broad, robust network of providers. We are committed to delivering high quality care, adopting evidence-based medicine, and spreading innovative practices to generate value to patients and purchasers. We will deliver products at price points that will enable us to directly compete with other networks and be attractive to purchasers and consumers. Together, we will collaborate with select health plan partners who share our vision of offering high value healthcare products with joint accountability for the cost, quality and exceptional patient experience of the care we provide.”

## Guiding Principles

The Network participants will commit to partnering together to leverage our collective and complementary strengths to create a regional *system of care* that offers the advantages of cost and care management, while maintaining a personalized approach to health. Specifically, the participants will:

1. **Be Member-Centric & Population Health-Focused:** Physicians will guide the care of members using evidence-based guidelines, and will leverage population health capabilities to promote preventive care and management of chronic conditions. They will partner with other providers to ensure that patients receive the right care at the right place at the right time, that the care is coordinated across inpatient, outpatient, post-acute and virtual settings, and that information travels seamlessly across those settings. The network must offer a consistent, high-quality and member/family-centered care experience regardless of where members receive care in the network.
2. **Create Greater Value:** The network must be able to offer products at or at times below Kaiser prices; maintain and grow share by leveraging and rapidly spreading collective strengths, best practices and innovation to differentiate the Network from other networks. It must be able to do so in a way that is easy and appealing to members. The Network's distinctive reputation should thus be rooted in our high quality, user-friendly, and cost-effective care.
3. **Work with Plans and Payers as Partners:** The network must work with a variety of plans and payers as partners.
4. **Build a Degree of Interdependence and Shared Purpose:** Network Institutions will maintain their independent identities while establishing integration of services along three dimensions:
  - a. **Clinical:** Spreading best practices that lead to more clinically appropriate utilization and cost reductions, committing to clinical standards and creating a culture of performance improvement
  - b. **Operational:** Leveraging shared infrastructure; becoming operationally coherent and "crowd-sourcing" to identify and rapidly spread best practices without becoming bureaucratic, while maintaining some local control of delegated functions
  - c. **Technical:** Supporting information exchange and robust analytics on a broad base
5. **Achieve Financial Alignment:** Network institutions will be bound together through shared risk arrangements such that financial models and incentives are aligned with clinical, operational, technical and financial objectives.
6. **Be Nimble & Execute:** The network will act collectively, quickly and decisively.
7. **Embrace Transparency:** Network institutions will commit to meeting ACO performance and quality objectives and reporting performance on agreed upon indicators both internally and externally, through published reports.

8. **Innovate & Differentiate:** The network will differentiate itself through innovation, rapidly identifying and spreading better practices, supporting consumerism as it relates to cost, quality, and service, adopting leading cancer therapies, genomic medicine and other areas across a large network in ways the competition cannot.

### **Formation and Structure**

The Network will be structured as a C-Corporation that will hold a restricted Knox-Keene license. The Network will initially provide services for employees and dependents of various participants and develop Commercial HMO, Commercial PPO and Medicare Advantage products in partnership with select health plans. The corporation will enroll beneficiaries residing in the county core Bay Area market (Alameda, Contra Costa, Marin, San Francisco, San Mateo, and Santa Clara) starting in January 2016 and may also include Sonoma and Napa counties depending upon the initial network adequacy. The Network owners will consider expanding into other product areas and geographies over time.

Knox-Keene licensure will enable the Network to deliver single-signature contracting for members and take on full-risk contracts with health plans through the corporation that specify savings arrangements, patient experience, quality and care management standards. Products will be priced in such a way as to retain existing and attract new members and deliver value to employers, employees, and Medicare Advantage beneficiaries looking for high quality alternatives to existing options. In the longer term, the Network expects its products to be priced on the lower end of options on the market.

The Network will have up to an 11 person Board of Directors, which will serve as the fiduciary board for the corporation. UCSF and John Muir Health, as the initial investors in the Corporation, will select six members of the Board. The Board will have a balance of physician, hospital and shareholder representation. The Network will also have a large Operating Committee consisting of representatives from Founding and Collaborating Providers (see definitions below). The Operating Committee will be advisory in nature, and its members will not have any fiduciary responsibilities with respect to the Network. Parameters for decision making will be articulated in the corporation's articles and bylaws and in a Shareholders Agreement.

The Network will accommodate three levels of provider participation: Owners, who will capitalize the corporation and oversee major strategic decisions (Founding Providers); Providers who will partner in managing risk for the Network population and have opportunities to participate on the Operating Committee and in shared savings distributions (Collaborating Providers); and providers who will enter into contracts with the corporation to provide continuum services or fill gaps in the network (Contracted Providers).

The Network will instantiate the following governance committees with representation from Owners and Provider Partners:

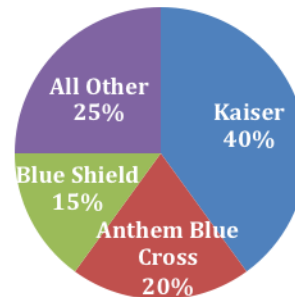
- *Clinical Services Committee/Care Management Council*: Sets care management standards and benchmarks, defines a set of initiatives that the ACO physicians and hospitals can launch and coordinate to deliver value, find savings and reduce unnecessary utilization.
- *Finance Committee*: Develops shared savings allocation and payment methodologies.
- *IT Committee*: Defines data exchange/use requirements and standards. Evaluates recommended investments.

The Network PARTICIPANT TYPE & EXPECTATIONS	Founding Providers	Collaborating Providers	Contracted Providers
The Network members by type of participation	<ul style="list-style-type: none"> <li>• UCSF and John Muir Health, Others TBD</li> </ul>	Non-owner Hospitals and medical groups in the geographies the Network is aiming to serve.	TBD, e.g. <ul style="list-style-type: none"> <li>• <i>post-acute care providers</i></li> </ul>
Capitalize the Network	X		
Determine board representation	X		
Approve additional shareholders	X		
Select new Contracted Providers, Active Participants and Owners	X		
Participate in Committees to define/refine the Network’s operating principles & performance expectations. Committees to include: <ul style="list-style-type: none"> <li>• Clinical Services*</li> <li>• Finance*</li> <li>• IT*</li> </ul> <i>*Note: Committees are advisory in nature.</i>	X	X	
Be individually and collectively accountable for the cost and quality of care they provide, including utilization of services – both in and out of network	X	X	
Recommend and introduce continuum providers to the Network to aid in developing a preferred provider network for continuum services	X	X	
Accept a reciprocal (“best price”) pricing arrangement for care delivered for network members not attributed to the dyad	X	X	
Accept agreed-upon pricing arrangement, including “best price”	<i>N/A (see item above)</i>	<i>N/A (see item above)</i>	X
Participate in cross-network health information exchange & care management programs to support the seamless delivery of care to patients	X	X	X
Meet the Network-defined standards of clinical care delivery, including access and quality targets	X	X	X
Adhere to mutually agreed upon guidelines for escalating concerns about the Network operations	X	X	X
Not engage in collusive or other anti-competitive behaviors that would threaten the integrity of the Network	X	X	X

## Market Context and Strategy

The Affordable Care Act resulted in important shifts in the payer and provider landscape in Northern California – including the emergence of ACO and narrow network health insurance products. The estimated market size for Commercial & Medicare products in the six core Bay Area counties is sizeable: 3.7 million insured lives – though highly concentrated with a few health plans. The broader ten-county Bay Area has a population of 7.8m people, of which 6.8m are estimated to have been insured in 2014.

**California Private Insurance Landscape**  
(Health Plan Market Share, 2011)



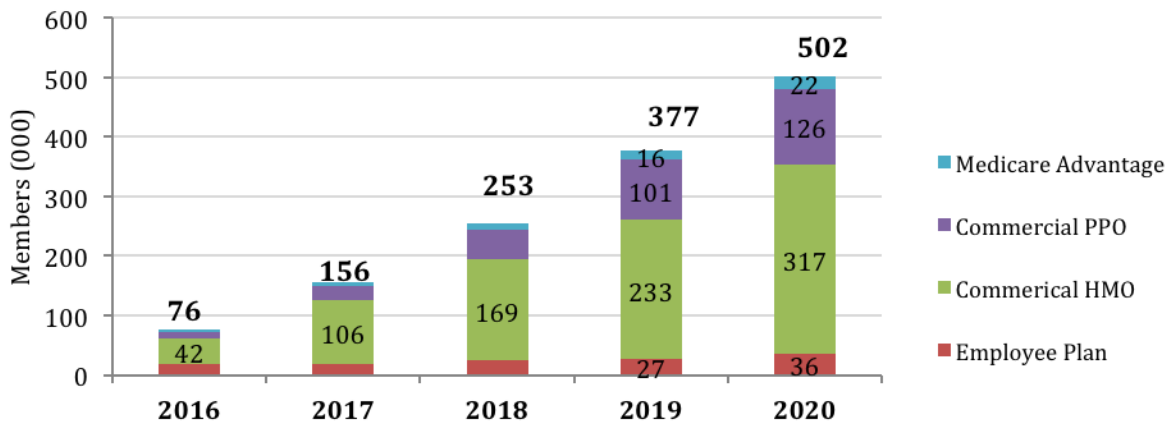
Kaiser has 40% of the California private insurance market share. That said, the CalPERS and Blue & Gold ACO experiences are evidence of an appetite for non-Kaiser health care options at affordable prices.

The Network plans to partner with health plans that already have strong relationships and brands in the market, which will be leveraged to drive enrollment and compete more effectively against Kaiser, Sutter, and Stanford. Initial discussions have been held with Blue Shield of California, Anthem, and HealthNet. Due to the strategy of partnering with and not competing with select health plans, the Network will not conduct direct-to-employer contracting for the foreseeable future. Founding Providers expect to partner with select health plans on a non-exclusive basis to co-develop and co-market products.

To thrive under a shared risk model, participant organizations will need to develop or expand existing care delivery redesign efforts that reduce the total cost of care. The Network will need to play an active role in defining cost, quality and performance targets – and incentivizing their achievement through the design of shared savings arrangements – so as to ensure that network resources are used in a cost-effective manner, and care is directed to the lowest cost setting, without jeopardizing quality.

Research shows that the regional healthcare market is sensitive with respect to price, and that patients value choice, personalization of care, and level of expertise that is provided by independent physicians. Building a reputation in personalized care, while adopting the population health and consumer-friendly aspects of Kaiser’s care model, will help differentiate the Network from current options.

The Network will enroll members into employee, HMO, PPO and Medicare Advantage products beginning in 2016. Initial enrollment will be primarily derived from ACO Providers’ existing employees and patient populations, with 5% of the ACO’s membership derived from new patients in 2016 with a progressive increase to 25% in 2020. Enrollment for year-end 2016 is estimated to be 75,000 members, and projected to grow to 500,000 members in 2020.



## II. POSITION SUMMARY

Title: Chief Medical Officer, Bay Area Accountable Care Network

Reports to: Joel Criste, Chief Executive Officer, Bay Area Accountable Care Network

The CMO, Bay Area Accountable Care Network will be accountable for the development, implementation, and ongoing management of the clinical programs and clinical infrastructure of the newly created Bay Area Accountable Care Network. He/she, working in partnership with the Network Care Management Council and key medical leaders, will successfully lead/manage the care management/care continuum and clinical programs involving a network of leading integrated health systems that takes full risk from health plans, effectively carries out population management, and provides a high-quality, affordable option in the market. He/she will play a key role in the development, oversight, and implementation of medical strategies and plans for the Corporation.

Overall categories under the responsibility of the CMO include:

- Medical / Care Management
  - Working with the Care Management Council and with key medical leaders in each of the partners, develop a Bay-Area wide integrated health system with superior care management/quality metrics and care transition, management of hospital and provider costs and reduced cost trends
- Network
  - Working with the CEO, develop strong, productive relationships between the Network provider organizations and with health plans
- Health Information Technology
  - Working with the partners, develop systems that support the care management process including electronic health record, interoperability, analytics, innovative health technologies, consumer accessibility and functionality
- Compliance
  - CMS, HHS, DOJ, FTC and Department of Managed Healthcare



### III. DUTIES AND RESPONSIBILITIES

Additional duties and responsibilities of the CMO include:

- Evaluate the care management and clinical programs across the network and how services are delivered. Identify best practices and areas for improvement among network participants;
- Oversee and collaboratively implement identified best practices in care management and clinical services across the network – for both the sickest patients and those that are healthy and seeking a seamless process. Effectively communicate the value proposition for sharing and implementation of clinical best practices;
- Be the clinical “face” of the organization. Foster and maintain open and effective relationships with key stakeholders including physician executives, administrators, and Boards of current and potential participants including hospitals, medical groups, and health plans, as well as relevant regulatory bodies;
- Enable collaborative, productive relationships between providers that empower the delivery of coordinated and accountable care to patients;
- Develop clinical programs in coordination with a shared savings model that achieves cost-efficient care and enables the Network to successfully compete in a price-sensitive healthcare market;
- Successfully develop the clinical infrastructure and clinical capabilities of the Network to enable rapid scaling while maintaining an efficient organizational structure;
- Achieve targeted levels of clinical integration between the Network members to empower efficient care coordination and ensure regulatory compliance;
- Implement the use of evidence-based protocols and decision support tools to align treatment with the patient’s needs;
- Advance the use of health information technology that enables coordination of care, patient access, and supports quality, including increasing:
  - The availability of a comprehensive patient record across the entire system of care, and the ability to communicate electronically and rapidly within the care team;
  - Consumer-friendly access for patients, such as the ability to view test results and order/renew prescriptions online, and easy access to primary care physicians and specialty consult expertise when needed, including through multiple media;
  - Potential partnership development with companies developing innovative health tools and applications;
- Lead with a patient-centric mindset, with priority on providing the high-quality, affordable option in the market;
- Instill a focus on transparency in quality reporting;

- Working with the CEO, the Board, and partners build an organization that delivers on the vision of truly accountable care.

#### **IV. GOALS AND OBJECTIVES**

Within the first 18-24 months, the successful CMO of the Bay Area Accountable Care Network will have:

- Successfully evaluated the care management/care coordination and clinical programs across the network and their strengths and weaknesses;
- Built and maintained strong, trusting, and effective working relationships with the CEO, Board, key medical leaders in each of the partners, participating and potential provider members, and relevant health plans; strengthened physician-hospital relationships and trust among partners;
- Identified clinical best practices in areas of top priority for the network, including end-of-life, emergency room avoidance, preventive service, long-term care, discharge planning, post-acute care strategies and care transition;
- Developed a strategy for and begun the collaborative implementation of care management standards across the network;
- Developed a reputation as a trusted, sincere and transparent leader who can execute, is a problem solver, and drive initiatives to completion;
- Created a scalable clinical infrastructure to support the addition of one health plan contract within the first 12 months and two health plan contracts within 24 months, with a 24-month target of 100k lives;
- Developed a post-acute care strategy that enables the Network to achieve its acute care utilization targets, including developing a network-wide coordinated referral plan that utilizes and builds internal capabilities as well as developing potential shared-risk arrangements with external providers that meet the Corporation's standards;
- Built an organization characterized by successful care management, innovation, and productive relationships between participating providers and with health plans;
- Innovative utilization of coordinated care models and health technology to elevate the patient's experience of care to a new level in a tech-savvy, price-sensitive, and sophisticated consumer market;
- Instill a focus on transparency in quality reporting;
- Developed and implemented evidence-based protocols and decision support tools to align treatment with the patient's needs;
- Significantly enhanced the integration of care delivery provided by the Network providers.

## V. CANDIDATE QUALIFICATIONS

The successful physician executive will be a results-oriented leader with at least seven years or more of increasing responsibility in a leadership role for one or more healthcare organizations (health plans, IPAs, ACOs, etc.) implementing the innovative payment, care management, data system, and culture change reforms needed to succeed in an accountable care marketplace. He/she ideally will have experience running a care management program and experience in a Knox-Keene licensed entity. The successful candidate will possess experience in California, or in a similarly mature managed care market characterized by capitated or other risk sharing contracts, involving hospitals and medical groups/IPAs. MD degree required.

Characteristics/experience of the ideal candidate include:

- Experience overseeing the key clinical drivers of success for the Network, including medical management, case management, quality, capitation/risk arrangements, hospital cost management and LOS, network development, and regulatory relations;
- Familiarity with other areas important for the success of the Network, such as electronic medical records, analytics, care transition and discharge planning, and physician compensation models;
- Familiarity with modern techniques/approaches of population care management activities and how to embed them into workflows at the point of service.
- Experience with both commercial and Medicare covered lives, including Stars ratings;
- A highly skilled relationship builder who is sincere and transparent. Someone who is flexible, collaborative, a good listener and has excellent verbal and written communication skills;
- Demonstrated success and experience in relating to and working with multiple constituencies including providers (academic and community), payers, management services organizations and Boards. Ideally, the person would have practiced medicine for a number of years;
- Works well with healthcare providers and has a strong understanding of processes of integrated health systems, including the financial dynamics of both acute-care facilities and physician organizations
- Comfortable working in a small (but well capitalized) organization with limited resources;
- Creativity and innovation; the ability to succeed in a dynamic landscape and handle ambiguity;
- Someone who delegates appropriately and effectively; can lead through influence to obtain necessary resources;
- Ability to build strong relationships and communicate effectively with multiple constituents in different sectors;

## **VI. PROCEDURE FOR CANDIDACY**

Meyer Consulting has been exclusively retained to conduct this search. Applications, referrals, and inquiries should be directed to the Network's search consultants, Mike Meyer and Ryan Hubbs, via email at [baacnCMO@meyerconsultinginc.com](mailto:baacnCMO@meyerconsultinginc.com). We can be reached by phone at 602/321.0753 (Meyer) or 347/284.0160 (Hubbs). All communication will be treated with full professional confidentiality.