
**Payment Models Workgroup
Accountable Care Organization Taskforce**

ACO Issue Brief



*Partnering for Electronic Delivery
of Information in Healthcare*

Fundamentals of Accountable Care Organizations

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Workgroup for Electronic Data Interchange

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Fundamentals of Accountable Care Organizations

I. Introduction

The healthcare system in the U.S. is in the midst of transitioning away from the traditional fee-for-service (FFS) model and evolving towards a more integrated, patient-centered paradigm focused on value - rather than volume - of care. In the wake of the Affordable Care Act (ACA), healthcare stakeholders are actively implementing alternative payment models such as accountable care organizations (ACOs) to improve quality and health outcomes while reducing the cost of care. To monitor the changing landscape, WEDI convenes the multi-stakeholder [Payment Models Workgroup](#) to create a framework of the core attributes of new payment models, to identify key barriers and best practices, and to provide guidance on technologies that support implementation, improve sustainability and mitigate barriers.

This paper briefly describes the basic structure, operation and activities of ACOs, while outlining some of the key issues and questions that the Workgroup will tackle. WEDI encourages organizations to participate in an ongoing [survey](#) of ACOs to help monitor progress and evaluate common practices, challenges and opportunities. In follow-up to this brief, the Workgroup intends to develop additional papers that provide further perspective and overview of issues encountered, such as contracting and quality measurement and alignment.

II. Landscape of Accountable Care

In striving to correct the shortcomings of FFS models, ACOs often seek to achieve the “triple aim” of improving quality, lowering costs and enriching the patient experience through stronger care integration. Typically, an ACO is formed when a group of providers collectively agrees to be responsible for financial and quality outcomes of a defined patient population. In taking on at least some of the risk traditionally borne by health plans, ACO providers are incented to proactively manage patient conditions, coordinate services, adhere to evidence-based protocols and monitor outcomes across the care continuum. In the past five years, ACOs have grown from several dozen pilots to 750 initiatives in various stages of operation that directly cover more than 23 million Americans, and indirectly impact the care of millions of others.¹ As they develop and mature, ACOs are taking diverse approaches to network structure, governance, risk management and technology infrastructure. Figure 1 shows some of their common tenets below.

Figure 1: Model of Accountable Care



¹ Leavitt Partners, <http://www.leavittpartners.com>

Fundamentals of Accountable Care Organizations**III. Organization, Risk and Financial Management Structure**

The structure of an ACO impacts how care is delivered, managed and reimbursed, as well as the technology that should be adopted to support services. There are several key characteristics that distinguish ACO maturity: the degree of integration, centralization of oversight and level of risk taken on by the entity. The most common contracting approach to establish an ACO has been through the Medicare Shared Savings Program (MSSP) under the Centers for Medicare & Medicaid Services (CMS). Today, CMS contracts with over 400 ACOs in the MSSP.² Similar models have also emerged through commercial health plans and state Medicaid programs. Governance varies among ACOs, most of which are led by a hospital, provider, provider group or integrated delivery system, and some of which are partnered or loosely affiliated with a health plan to gain infrastructure. In an effort to provide more continuity of care and range of services within network, ACOs may expand beyond primary care to vertically or horizontally integrate services (e.g. emergency, specialty, long-term, post-acute, home health, behavioral or rural healthcare). As ACOs mature, they may also form community partnerships to tackle key social determinants of health that can contribute to improving overall outcomes.

There are several common approaches to bearing risk, each of which distributes varying levels of incentive payments and penalties based on performance benchmarks. In the public sector, CMS currently offers three MSSP tracks - Track 1 (one-side, no risk), Track 2 (two-sided, limited downside risk), and Track 3 (increased two-sided risk). The shared savings model of Track 1 is the most common, and rewards ACOs for meeting predetermined measures of quality and spending through payments as a bonus portion of overall savings earned. Because it does not require organizations to assume downside risk for losses or overages during the term of agreement, most MSSP ACOs typically initiate contracting with CMS through Track 1 while they experiment with approaches to successfully take on more risk. Tracks 2 and 3 are intended to ease ACOs into downside risk-sharing and global risk-bearing over time by providing greater return on shared savings – but they also incur greater losses as a result of negative performance.³ To date, implementation and sustainability of two-sided models have been difficult for providers to achieve. CMS initially piloted two-sided risk with 32 organizations through the Pioneer ACO model before later incorporating elements of shared savings and losses into the third track of MSSP. However, since its initiation, more than a third of Pioneer ACO organizations have dropped out of the program. Nonetheless, it was recently announced that CMS will pilot the Next Generation ACO (NGACO) model in 2016 with approximately 15-20 ACOs.⁴ NGACOs will take on higher levels of shared savings and losses, and have greater flexibility in structuring reimbursement arrangements. In the private sector, it is estimated that there are approximately 330 ACOs that contract with private organizations, although it is difficult to evaluate given the lack of public visibility.¹ While similar in structural characteristics to CMS ACOs, private companies may establish more complex payment and risk models that incorporate bundled payments or partial/global capitation rates in addition to variations of the shared savings models discussed above.

² U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Shared Savings Programs <http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram>

³ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Finalized Changes to MSSP Regulations <https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-06-04.html>

⁴ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Innovation Center <http://innovation.cms.gov/initiatives/Next-Generation-ACO-Model>

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Questions for Future Consideration: How do the organizational, financial and risk structures of an ACO impact the needs and requirements for data access, exchange and analysis? How do core technology components change as ACOs scale?

IV. Population Health Management

Unlike the traditional delivery of acute or episodic care, the accountability structure of an ACO requires providers to be responsible for the health, cost and care of patients at both an individual and population level across the continuum of care. Population health management (PHM) requires providers to adopt a more holistic, patient-centered approach comprised of health prevention, intervention, chronic care management and wellness strategies that are targeted to specific patient groups. Effective PHM can help target and prioritize resources towards those in greatest need, reduce disparities and streamline evidence-based guidelines of care. However, PHM is extremely resource-intensive and requires dedicated personnel and technology solutions that can optimize care management, coordination and reporting. ACOs often redesign care delivery, workflow and processes around a care team of physicians, nurses and care coordinators that can work together to prevent gaps and variation in care. Additionally, ACOs depend upon a core health IT infrastructure and analytic solution(s) to support the range of activities and outcomes that must be monitored on an ongoing basis. At an individual patient level, care managers may use data collected to profile and model patient behavior or preferences, provide more personalized disease management, patient engagement and/or communication, and achieve optimal adherence, compliance and outcomes. At the population level, data can be aggregated to identify and stratify patients based on risk profiles associated with high costs, high utilization or poor health outcomes (e.g. chronic conditions such as asthma, diabetes or heart disease) to find those that would benefit most from targeted prevention, treatment and care management strategies.

Questions for Future Consideration: What are the key characteristics of a PHM program? What data and technology are required to perform activities?

V. Health Information Technology Infrastructure

Successful financial, clinical, population health and risk management of an ACO is dependent upon a strong health information technology (health IT) infrastructure and an ability to exchange health data across disparate systems and settings. The more complex and interconnected that an ACO network becomes, the more dependent the entity becomes on health IT to efficiently access accurate, granular information to inform decisions, coordinate care transitions, monitor patient health and target services at an individual and/or population level. Accordingly, ACOs often invest in a foundational set of health IT components to help optimize information flow and manage the quality and cost of care. After implementing an electronic health record (EHR) system, ACOs typically layer additional infrastructure components to gradually support risk management, patient engagement and communication, quality measurement and improvement, revenue cycle management, clinical documentation and data analytics. Depending upon the capabilities and size of an ACO and the degree to which patients seek care within or outside the network, some ACOs may also participate in a Health Information Exchange (HIE) network at a private, regional, and/or state level. By participating in a network that facilitates exchange of accurate patient records among affiliated and non-affiliated organizations, ACOs can better

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monitor and coordinate care.^{5,6} As ACOs grow and mature, emerging needs and gaps may be further addressed with more advanced technical capabilities. Such capabilities include business intelligence, secure messaging, clinical decision support systems, network and referral management solutions, telemedicine, software for revenue cycle management, risk stratification systems, PHM, customer relationship management (CRM), and analytics. Nonetheless, these capabilities are all fundamentally dependent upon interoperable data exchange to be effective. Regardless of their participation with an HIE, most ACOs are not currently able to seamlessly push or pull complete patient health data in an accessible and timely manner – and until they are able to do so, many organizations will find themselves fundamentally handicapped in their ability to meet operational objectives.

Questions for Future Consideration: What are key components of a robust IT infrastructure for ACOs, and do they have sufficient ROI? How do components change with scale? When should ACOs build in-house versus implement best-of-breed or enterprise systems? How are ACOs leveraging telemedicine and mobile health? When should ACOs participate in public versus private HIE initiatives? Where is the industry in readiness for interoperability overall?

VI. Data Measurement, Reporting, and Analytics

ACOs are faced with complex operational, clinical and financial decisions. In order to manage the minutiae of disparate care activities and operations, ACOs require access to data at multiple levels. Ultimately, ACOs will achieve greater success by grounding decisions around hard evidence and data-driven analytics rather than intuition from experience. Many ACOs collect information through electronic data streams from different sources (e.g. EHR, demographic, clinical, claims and laboratory) to build a composite portrait of patient health, analyze performance based on retrospective trends, understand costs of care and ultimately recommend actions or strategies in anticipation of predicted events. Population data can be used to fine-tune evidence-based clinical decision support and protocols, identify gaps and inefficiencies that should be addressed, and prioritize care and resources accordingly. While reporting requirements may vary, ACOs often develop a population dashboard system that can filter business and clinical intelligence into actionable items for care teams. ACOs also need financial and operational data to inform agreements, administer contracting, evaluate performance and manage the complexities of risk-based payment and penalties among participating providers. For ACOs to compete and thrive in today's world, they must adopt technologies fully capable of executing complex, multivariate analysis that can yield actionable results for improvements in quality, costs and service.

Questions for Future Consideration: What are the pain points for data measurement, collection, exchange, and analysis? What are critical analytic capabilities during the ACO lifecycle (e.g. operational vs. mature phases)? Are there established business cases for predictive or prescriptive analytics?

VII. Acknowledgements

⁵ U.S. Department of Health and Human Services, Office of National Coordinator of HIT, ONC Health IT Certification Program, <http://www.healthit.gov/policy-researchers-implementers/about-onc-health-it-certification-program>

⁶ U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, EHR Incentive Programs, <http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/ehrincentiveprograms/>

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