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Choosing the Right Performance Management System for your ACO

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Measurement of performance against cost and quality benchmarks represents a defining principle of Accountable Care Organizations (ACOs). However, in order to successfully improve population health and patient satisfaction while controlling costs—in other words, to achieve the Triple Aim—ACOs require more than performance measurement.

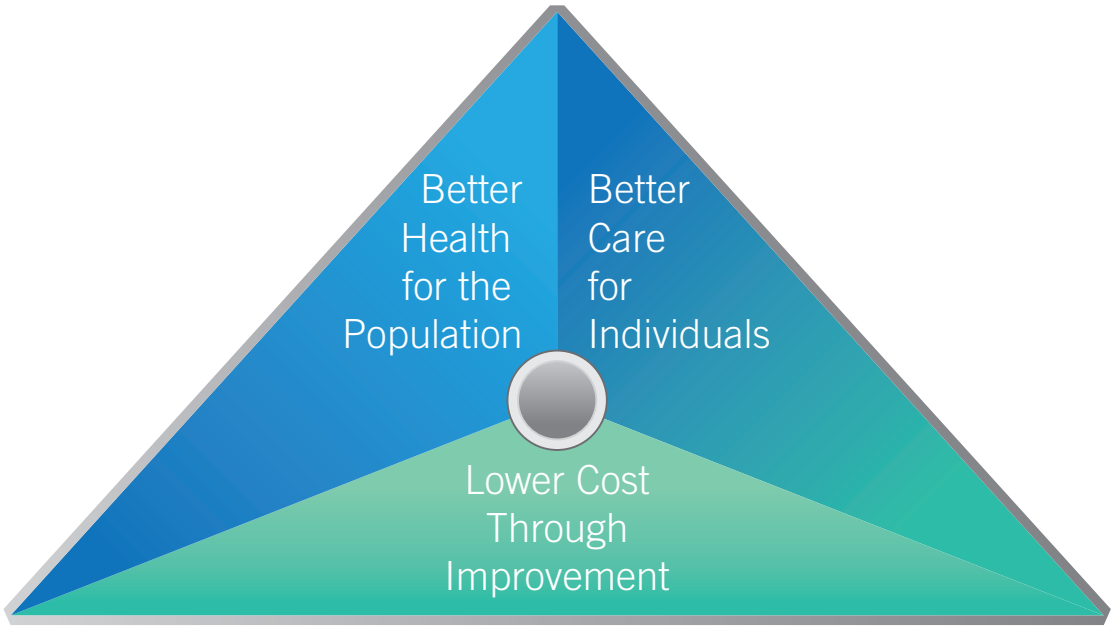
An effective performance management system for ACOs would bring together all available data on their patient population from disparate sources, synthesize it into a coherent picture of population health and service cost/quality, and make it available to stakeholders from executives to providers where and when they need it in time to affect outcomes.

Looking ahead, such a system would be able to scale to accommodate ACO growth and consolidation, as well as future pay-for-performance and value-based payment initiatives from Medicare, Medicaid, and other payers.

The ACO: A Framework for Achieving the Triple Aim

The Centers for Medicare and Medicaid Services define accountable care organizations (ACOs) as groups of doctors, hospitals, and other health care providers who come together voluntarily to give coordinated high quality care to their Medicare patients.[1]

While multiple ACO models exist (three for Medicare alone[2]), they share a common and threefold goal: improving patients' experience of care, improving population health, and reducing per-capita healthcare expenditures—the Triple Aim.



Elliot S. Fisher, the originator of the ACO concept[3], described with his coauthors three essential characteristics of accountable care organizations:

1. Provider-led organizations with a strong base of primary care that are collectively accountable for quality and total per capita costs across the full continuum of care for a population of patients.

2. Payments linked to quality improvements that also reduce overall costs.

3. Reliable and progressively more sophisticated performance measurement, to support improvement and provide confidence that savings are achieved through improvements in care.[4]

Current ACO models reflect these core principles: patients are attributed to primary care providers within a given ACO, which assumes responsibility for achieving cost and quality improvement benchmarks for that patient population, and receives as an incentive payment a portion of cost savings realized if the benchmarks are met.

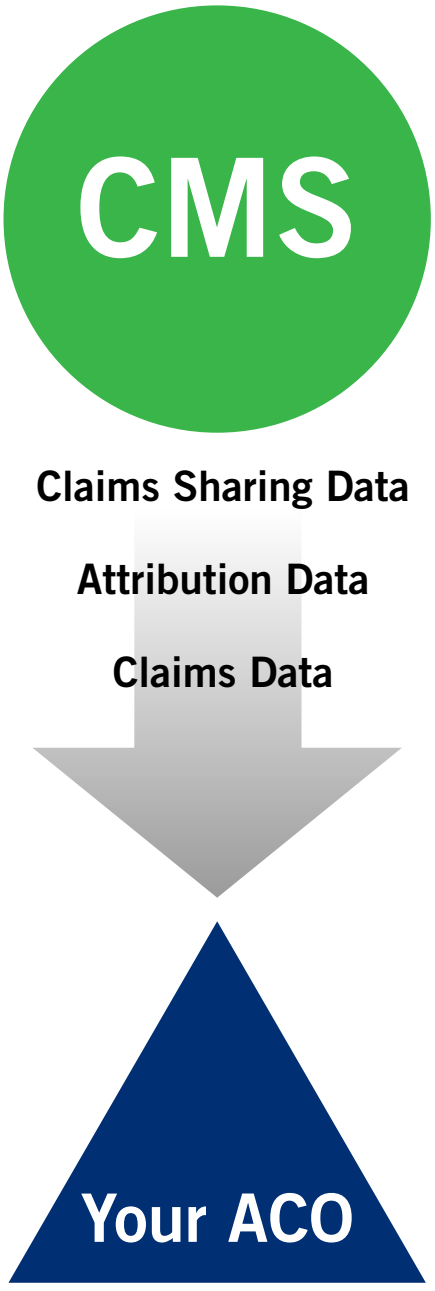
Measurement is Not Enough

Under the current models, CMS provides ACOs with a number of different types of data from which to derive quality and cost performance metrics: paid healthcare claims, ACO benchmark data, beneficiary demographics, chronic conditions (HCC scores), and attribution.

In addition to these, providers within the ACO contribute HCAHPS survey data and potentially clinical data from EMR/EHR systems. From these data sources, ACOs calculate the quality metrics (PQRS/GPRO) by which CMS evaluates their performance.

Herein lies the central problem of the ACO. Performance measurement as conceived under current program models simply does not occur frequently enough to afford ACOs actionable insight into areas where improvement is needed. PQRS/GPRO reporting occurs on an annual basis, as does final attribution of patient populations—meaning that even some of the data necessary for metric calculation is provided only once per year. An ACO can be fully compliant with CMS reporting requirements yet, due to the age and infrequency of performance measurement, perpetually "chasing the needle" rather than proactively "moving the needle" in the right direction. This reporting lag, in fact, puts ACOs at a very real risk of failure.

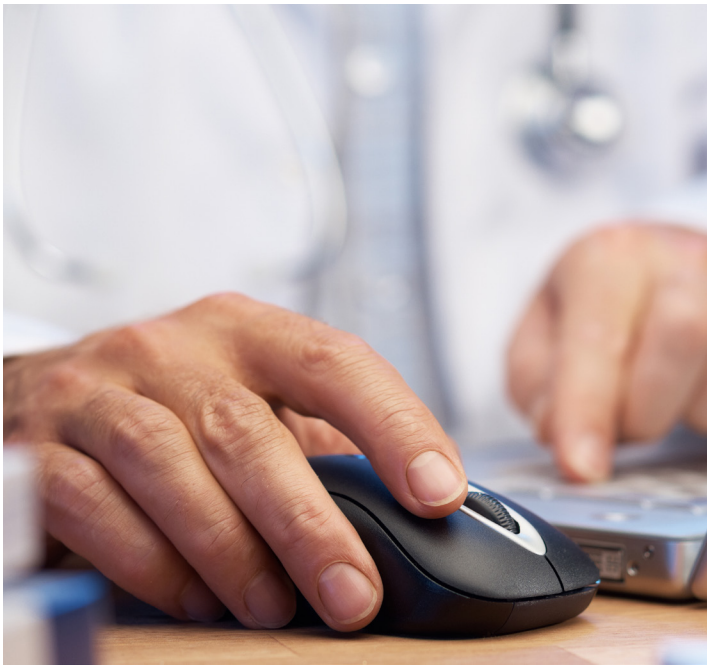
In order to make meaningful progress toward achieving the Triple Aim (and the gain-sharing promised by ACO programs), ACOs must move beyond CMS reporting requirements and perform deeper analytics. They require the ability to proactively survey their attributed population and determine which beneficiaries are at risk of de-attribution, which patients with chronic conditions require greater attention to avoid high-cost hospitalizations and treatments, and where early intervention is appropriate to preempt future problems. ACOs need the ability to perform continuous surveillance in support of timely and precise action to eliminate problems and expand opportunities for improvement.



Attributes of an Effective Performance Management System for ACOs

In order to put data into the hands of providers and executives in time to proactively affect outcomes, ACOs need more than a performance measurement system—they require a comprehensive performance management system.

An effective performance management system would bring together all available data on the patient population from the disparate sources, synthesize it into a coherent picture of population health and service cost/quality, and make it available to stakeholders where, when, and in the format in which they need it.



To accomplish this, the ideal performance management system would have the following attributes:

Synergy

The data ACOs and their providers need to measure and improve their performance comes from many different sources: CMS, EMRs, survey data, and more. None of these data sources on their own is sufficient to provide the answers. To unlock the value of these data, they must be brought together into a comprehensive, cohesive picture of beneficiaries, the providers serving them, the services rendered and their costs, and outcomes. Taking this a step further, these data can and must be used to continuously calculate the quality metrics against which CMS evaluates ACOs, providing an always up-to-date and reliable picture of where the ACO stands at any given point in time.

Self-service

At the point of care, providers do not have time to call for help or request a new report or analysis; they need the ability to ask questions and get answers on their own. An effective performance management solution will provide powerful data visualization and interrogation capabilities with the simplicity of a point-and-click user experience. Each user will have easy access to all possible information relevant to every decision. And since most ACOs and their member practices do not have extensive IT staff, a system offering a turnkey deployment and low maintenance overhead offers the quickest and greatest possible return on investment.

Speed

Providers and ACO executives need to be able to ask questions, get answers, and ask the next question without waiting for queries to run or reports to generate. A sophisticated analytical database engine behind the scenes will reduce the investigative process to just seconds, making information available in time to impact results.

Specificity of information

While global "scorecards" or reports have their place, providers at the point of care do not need aggregate or summary data—they require the ability to determine a specific patient's discrete needs in detail. The ideal performance management system will facilitate this by preserving the finest grained detail in the data, down to the line item, and making it available from anywhere it makes sense—without predefined hierarchies or drill paths that must be followed to obtain the desired information, but at the same time providing intuitive starting points for common inquiries.

Looking Ahead: Scalability to Future Needs

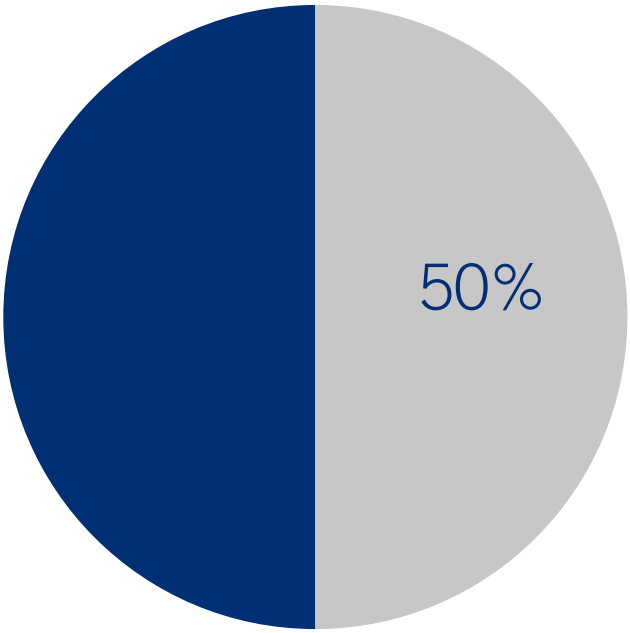
In addition to the attributes outlined above, scalability should comprise a primary consideration for an ACO performance management system. The ideal system will be scalable both horizontally (to accommodate growth in the ACO through organic expansion or mergers/acquisitions) and vertically (to support future ACO initiatives from CMS as well as other payers).

Economies of scale, as well as other market dynamics, dictate the inexorable reality of ACO growth, both by organic expansion to new providers as well as mergers and acquisitions with other ACOs. The performance management solution selected by an ACO should have the ability to accommodate the increased data volumes, as well as disparate data types brought by new entities.

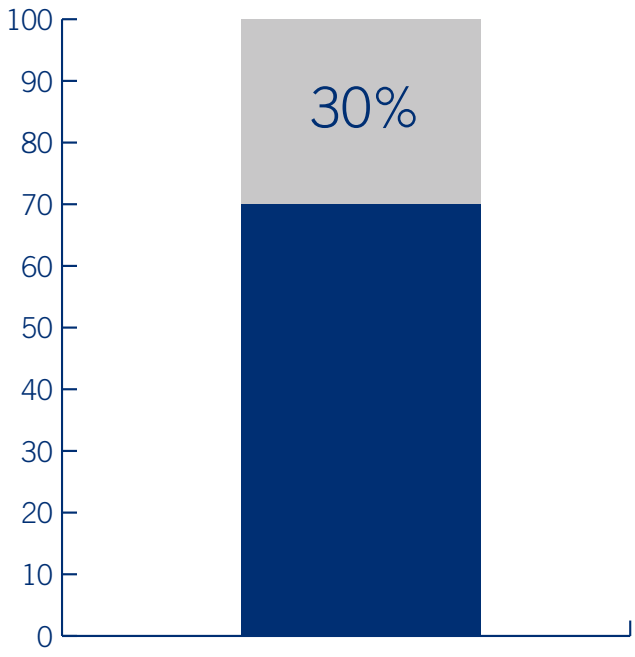
Likewise, changes and expansions in the ACO programmatic framework are inevitable. In just six years since the enactment of the Affordable Care Act, CMS has established three different types of ACOs as well as frequent changes to the set of PQRS measures by which ACOs are evaluated.

The Department of Health and Human Services (HHS) announced in January 2015 their intention to tie 30 percent of fee-for-service Medicare payments to value-based alternative payment models (including ACOs) by the end of 2016, a figure set to rise to 50 percent by the end of 2018.[5]

Meanwhile, as CMS and the states turn their attention to the disproportionate healthcare needs and costs of the "dual eligibles" (beneficiaries enrolled in both Medicare and Medicaid), initiatives such as health homes will further multiply population health and care coordination reporting and measurement standards.



"The Department of Health and Human Services (HHS) aims to tie 50% of fee-for-service Medicare payments to value-based alternative payment models (including ACOs). "



"As of January 2015, Medicare accounts for less than a third of covered lives in ACOs. "

Beyond Medicare, as delivery system reforms percolate through the healthcare ecosystem, other types of ACOs (such as Medicaid and private payer) have already begun to arise—each with their own metrics and reporting requirements.

Delivery System Reform Incentive Payment programs, a type of Medicaid Section 1115 waiver demonstration that have been established in several states, require the formation of regional provider cooperatives that share many of the attributes of ACOs: population attribution, pay-for-performance, and specific performance measurement and reporting requirements. And while Medicare and Medicaid provide perhaps the best-known examples of ACOs, a recent study indicates that 132 different payers had signed ACO contracts as of January 2015 and that Medicare beneficiaries now comprise under one-third of the total covered lives in ACOs.[6]

ACOs will need the flexibility to incorporate these new measurement and reporting schemes, as well as concomitant increases in data volumes, into their performance management systems without compromising speed or specificity of data.

ACOs are here to stay. Political platform promises to repeal or replace the Affordable Care Act notwithstanding, ACOs make financial sense as an approach to controlling unsustainable growth in healthcare costs. Whether the specific mechanisms in the future are known as ACOs or by another name, the fact remains that the transformation from volume-based, fee-for-service reimbursement to pay-for-performance and value-based purchasing is inevitable.

As such arrangements become increasingly ubiquitous, the need for ever more sophisticated performance management technologies to support success within them will likewise continue to grow. As ACOs coalesce and expand, prudence dictates that they carefully consider the adoption of systems that will provide the capability to leverage healthcare data at all levels of the organization to effect the quality and value improvements that yield a healthier population, happier patients, and financial success and stability for providers.

[1] "Accountable Care Organizations." Available online: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html (Retrieved July 31, 2015).

[2] Pioneer, Medicare Shared Savings Program (MSSP), Next Generation MSSP

[3] Kip Sullivan, "The History and Definition of the 'Accountable Care Organization.'" Physicians for a National Health Program California, October 2010. Available online: http://pnhpcalifornia.org/2010/10/the-history-and-definition-of-the-"accountable-care-organization" (Retrieved July 31, 2015).

[4] Mark McClellan, Aaron N. McKethan, Julie L. Lewis, Joachim Roski, and Elliott S. Fisher. "A National Strategy to Put Accountable Care into Practice." *Health Affairs* 29:5, May 2010, 982-990. Available online: http://content.healthaffairs.org/content/29/5/982.full (Retrieved July 31, 2015).

[5] "Better, Smarter, Healthier: In historic announcement, HHS sets clear goals and timeline for shifting Medicare reimbursements from volume to value." HHS Press Release, January 26, 2015. Available online: http://www.hhs.gov/news/press/2015pres/01/20150126a.html (retrieved August 11, 2015).

[6] Muhlestein D. "Growth and dispersion of accountable care organizations in 2015." *Health Affairs* (Millwood). March 31, 2015. Available online: http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/ (Retrieved August 11, 2015).