



Accountable Care Organizations



Financial Network of the Future

# HIMSS G7 Advisory Report:

## *The Intersection Between Accountable Care Organizations & the Financial Network of the Future*

### About this Advisory Report

The Intersection between Accountable Care Organizations and the Financial Network of the Future is the result of the first meeting of the HIMSS G7 in October 2010. This report is not a position statement from HIMSS, but instead, HIMSS G7 members developed these provocative positions around issues healthcare leaders must address and resolve.

Contact [jcasillas@himss.org](mailto:jcasillas@himss.org) for more information on the HIMSS G7 or HIMSS G7 sponsorship.



HIMSS G7 Sponsor

KAISER PERMANENTE®

Collaborator



**IFC**  
International  
Finance  
Corporation  
World Bank Group

### What is an Accountable Care Organization (ACO)?

The HIMSS G7 participants believe that an Accountable Care Organization is a concept offered to address the resource utilization, payment and accountability misalignments currently in place within our health care system. Essentially, the participants state that an ACO is set of organizations that collectively meet defined requirements and take on financial risk and rewards for maintaining the health of a population.

The principles behind ACOs have evolved through many years and some believe ACOs are the latest concept in capitated care. The ACO model arose from understanding variation within Healthcare accomplished by the Dartmouth Atlas organization along with the Centers for Medicare and Medicaid (CMS), per research at Vanderbilt Center for Better Health. The model is intended to address the misalignments between payment for services,

resource utilization, and care outcomes. Within fee-for-service, care providers are paid for the services they render, not for example, how effectively people are returned to health utilizing appropriate resources, or the health status of an identified population. FFS is believed to contribute to a portion of the variability in care and the spiraling costs within the US health care system.

As currently envisioned in the health reform bill, the ACO model builds on the lessons learned from past attempts to change how the healthcare industry is organized and how financial risks and rewards are distributed. Because ACO's are written into the Patient Protection and Affordable Care Act (PPACA), the sense from the perspective of the Vanderbilt Center for Better Health is that many care organizations and their affiliates are working to develop models that satisfy the criteria. This is a significant difference from other "ideas" mentioned within PPACA legislation. PPACA calls for the creation of an ACO program administered by Centers for Medicare and Medicaid Services (CMS) by Jan 1, 2012, and also outlines the criteria CMS must incorporate in its regulations pertaining to CMS-oriented ACOs.

### Legislated CMS ACO Criteria

- Defines a legal structure capable of receiving funds and distributing shared savings, which could require waivers and safe harbors to ensure compliance with Stark and anti-kickback laws,
- Engages a group of Primary Care Providers (PCPs) capable of caring for at least 5,000 individuals,
- Requires providers to participate in the ACO for at least three years,
- Implements operational clinical and administrative systems to provide support throughout the organization,
- Operates processes for evidence-based care, reporting quality measures, and care coordination,
- Meets the Secretary of Health & Human Services' definition of patient-centeredness criteria.

### HIMSS G7 ACO Straw Model ACO

To drive a sufficient level of detail to provide meaningful dialog, the HIMSS G7 participants constructed a straw-model health-reform-statute ACO for their conversations. The characteristics participants settled on for are as follows:

- A legal entity,
- Serves a population within Medicare where members are assigned by their behavior,
- Utilizes a reimbursement type payment model, and
- Involves active health care coordination.

There are many who may eligible to form ACOs, including hospitals, physician group practices, networks of individual practices, and partnerships between hospitals and other health care professionals. The legislation has allowed greater flexibility for organizations to form ACO's than other models. Some of this flexibility may be modified as CMS determines what works and what does not for its Medicare beneficiaries.

The ACO model, as outlined by Congress, allows more flexibility in how different providers want to organize to provide care for their populations than do individual private sector ACOs. This is different than how HMO or IPAs work, and is an effort on the part of Congress to allow CMS to define an organization structure that delivers the best results for Medicare beneficiaries across the care continuum.

Because ACOs are included in the health reform law, the Leadership Forum walked through a process that began by looking at where the Pain-Points and Opportunities exists for HIMSS G7 Stakeholders who will be affected by the creation of ACOs.

The seven stakeholders of the HIMSS G7 believe some of the benefits that could be obtained from an efficient healthcare financial network are:

- **Providers** could gain a “smart network” that uses remittance data to reconcile books and fuel business intelligence.
- **Employers** could offer effective tools that help employees to improve health and lifestyle.
- **Health plans** could find new ways to team with banks and reduce operating costs.
- **Banks** could open up a whole new paradigm for investment, relationships and fee-based programs.
- **Government** could gain a new view of public health issues that could impact policy.
- **Consumers** could find useful tools that merge health-wealth information into compelling programs that help families.
- **Technology** firms could find new distribution channels, new business models and unlikely strategic partners.

## Perceived Threats and Opportunities of HIMSS G7 Stakeholders

Although not comprehensive, the resulting summary list of Pain Points and Opportunities by stakeholder from our first HIMSS G7 meeting include:

| Perceived Threats to Progress  | Perceived Opportunities to Progress  |
|--|--|
| <ul style="list-style-type: none"> <li>- Banks reliance on “others” technology infrastructure.</li> <li>- Barriers to entry for new technology.</li> <li>- Disintermediation of banks role.</li> <li>- Impact of “to be defined” regulations on technology.</li> <li>- Increasing integration between provider and payers.</li> <li>- Increasing provider responsibility for financial risk.</li> <li>- Increasing reporting complexity for payers and providers.</li> <li>- Payer and provider loss of control.</li> <li>- Perceived unwillingness to collaborate on industry standards.</li> <li>- Provider confusion around incentives and disincentives.</li> <li>- Risk of reducing provider revenue stream.</li> <li>- Technology standards insufficient to address requirements.</li> </ul> | <ul style="list-style-type: none"> <li>+ Banks have opportunity to lead solution development.</li> <li>+ Banks to serve in HIPAA/clearing house role.</li> <li>+ Building provider brands.</li> <li>+ Cost savings across all Stakeholders.</li> <li>+ Consumer Driven Health market and ACO model synergies.</li> <li>+ Extending technology infrastructure.</li> <li>+ Gain sharing for providers and payers in cost neutral way.</li> <li>+ Improving personalized data aggregation and presentation.</li> <li>+ Leverage current banking infrastructure.</li> <li>+ New revenue opportunities as ACO model emerges.</li> <li>+ Payer ability to reduce administrative overhead.</li> <li>+ Provider models for delivering care.</li> <li>+ Reuse proven models for securing patient identify.</li> </ul> |

## Three Key Intersections

After considerable discussion, participants were able to developed recommendations that were categorized into three primary areas, all of which would leverage accepted strengths of financial organizations, namely:

1. **Integrator:** aiding organizations to support integration of multiple systems that provide technical and financial functions,
2. **Data Analysis:** providing trusted third party data analysis that links financial information with clinical data and performance,
3. **Payments hub or clearinghouse:** facilitate payments to the healthcare stakeholders.

## Integrator: Supporting ACO Integration of Multiple Systems

Participants defined that integration of multiple systems is likely a prerequisite for any successful ACO, and will require the ability to integrate information from across multiple systems (administrative, clinical, financial...). This integration is necessary to appropriately aggregate information to optimally direct individuals within a population to receive care from the best possible provider for their needs.

Components of ACO integration identified by the team included:

- **Understanding of an Individuals, and a Population's Needs:** This is an ability to understand the health of the population, or a population member at any given time.
- **Scheduling Care Across the ACO member systems:** This is about being able to understand when care resources are available, and allowing patients, clinicians or others to reliably schedule an individual's care.
- **Coordinating Care Across Multiple Venues:** This is an ability to organize care across multiple settings according to pre-defined agreements to help an individual return to sustaining health as quickly as possible in the most cost-effective manner.
- **Accessing Appropriate Resources:** This is about being able to obtain care that meets an individual's context (Clinical Need, Urgency, Quality, Cost, Cultural) and cost-effectiveness.
- **Improving the Revenue Cycle:** This is the ability for an organization to accurately bill for services provided, collect payments, and distribute revenue at the appropriate points during care.
- **Source of funds:** An ACO is a legal entity, and will require multiple sources of different kinds of funds to meet the needs of Cash Flow, Credit Lines, Capital etc.

The group also engaged in an active discussion around core requirements of a bank entering this area, specifically, integration with healthcare financial systems. By definition, "medical banking" offers a two-pronged or threaded strategy that facilitates a bank's entry into healthcare in coordination with a healthcare financial systems vendor in order to offer the required services. While not all of the required services require integration between banking and healthcare financial systems vendors, risks of market entry for many of the services could be mitigated using a medical banking approach.

As with all conceptual modeling, participants were forced to make assumptions. The "bank as integrator" concept for ACOs assumes:

- Strong reliance on healthcare financial systems vendors to leverage one or more of the following: existing EDI trading relationships, required industry knowledge to include healthcare-specific legal and compliance issues, marketing know-how, product positioning and other areas. Conversely, the healthcare financial systems vendor is dependent on the same areas within the bank to extend market reach and expand product functionality.
- New channels of distribution for banks and their new healthcare financial system vendor-partners with the potential to scale supporting technology services much more effectively than has been done in the past
- Mutual knowledge transfer that improves both banking services for healthcare and healthcare financial systems vendor services for healthcare
- Tightly coupled technical integration, in the form of an "inter-organizational system", between two or more partners (such as a bank and a healthcare financial systems vendor) such that the services offered are mutually supported by two or more partners in the "extended enterprise" without which the service could not be offered. For our purposes, the extended enterprise may be defined as a business venture undertaken by two or more entities that meet the technical and financial requirements of the ACO healthcare delivery model.
- Some of the required ACO functions will not require integration with a healthcare financial systems vendor.

Additionally, participants asked the question: “Why would an ACO choose a bank to drive integration?” The fundamental answer is that banks, and other financial services organizations, have different core capabilities that could drive different aspects of the Integrator needs previously discussed.

Ultimately, participants identified the likely initial top integration capabilities as:

- Source for Funds Settlement,
- Online Consumer Health Presence,
- Data Transmission Network, (sending data across bank secure networks and the SWIFT network), and
- Patient Payment Support.

## Data Analysis: Trusted Third Party Data Analysis

Participants in this group answered the key question, “What are the analytical capabilities that banks and financial systems can bring to an ACO?”

- **Identity Management:** There will be a need for identity management services as patients move about the ACO provider network. Participants believe that the strong identity management solutions financial institutions use as their consumers move about the community and use the financial network, means banks could offer increased accuracy to the ACO systems.
- **Financial Assessment at the Point-of-Service:** As payment shifts more to the individual’s responsibility (e.g. from employer insurance to personal Health Savings Account (HSA), Credit Card, or Debit Card) providers will want to understand individuals’ ability to pay before services are rendered.
- **Financial Outcomes:** The need to ascertain cost basis, and other analyses, so organizations can understand if service lines are financially viable. This is a challenge today, outside of an ACO context. Helping ACO organizations understand their costs will be paramount when hospitals and physician practices are going at risk together in an ACO.
- **Fraud and Abuse:** The ability to essentially create real-time systems that could identify fraudulent behavior among providers and patients. The multiple different kinds of fraud could be reviewed within seconds based on current best practices using financial systems that have built-in intelligence around Medicare’s Correct Coding Initiative (CCI), Local Medical Review Policies (LMRPs), and many of the financial algorithms and procedures that are used to detect potential instance of fraud and abuse in real time.
- **Managing Cash Flow:** Every organization has to manage its cash flow, and ACOs will be no different, but will likely be more complex.
- **Consumer Card Systems:** Consumer Card systems are used in many industries to help drive consumer behavior. In an ACO, consumers could be awarded points on a card based on the number of days they stay within control of their diabetes, for example.
- **Multi-Account Analysis:** ACO participants may have multiple healthcare accounts, like an HSA, Flexible Spending Account (FSA), or others. The financial infrastructure could be used to support which accounts are best for payments to come from (“multi-purse” processing)
- **Participant Communication:** The infrastructure of the future will likely have superior capabilities for consumers to access more detailed information through a specialized online banking portal about what they purchase and more.

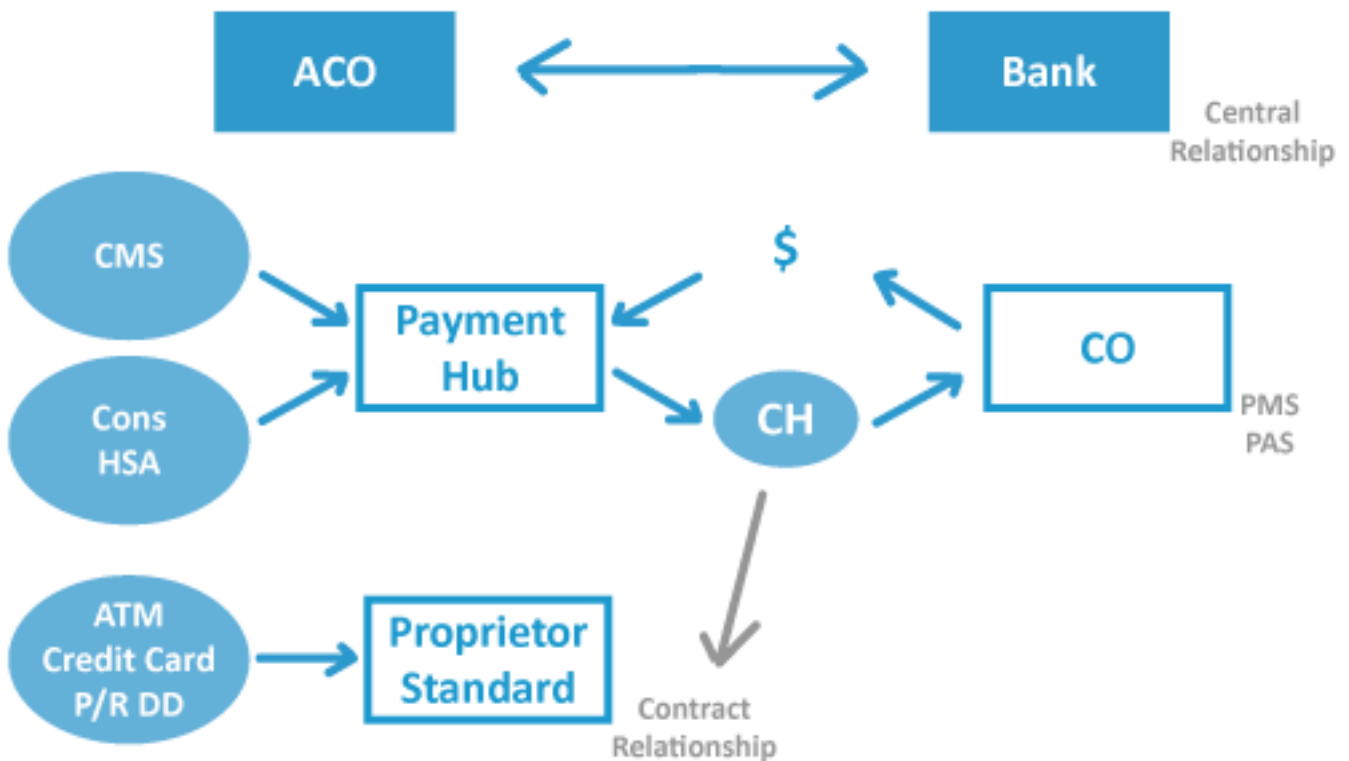
## Facilitate Payments Through a Hub Model

Processing payments is one area where the financial network of the future will play a key role within the ACO model. Participant's identified a number of areas where an ACO could utilize the strengths of a hub payment system. One of the participants drafted the model below to depict payment flows.

Through a contractual arrangement between the bank and ACO, payments from CMS and/or the consumer's account-based plan (such as an HSA), enter a "payment hub" maintained by the bank, pass through a clearinghouse that secures personal health information, and are then credited to the appropriate bank accounts. In this model, the assumption is that the ACO is receiving a lump sum payment, along with data that identifies what the payment is for and who was involved in the care (somewhat akin to eligibility information).

The payment hub would have the capability to receive funds and care information, parse it and send it through to the ACO. It does so using standards so the remittance information updates the accounting system automatically and the funds flowing through to appropriate bank accounts are in addition, automatically reconciled. In this way the appropriate checks and balances follow the flow of money throughout the ACO system. To enable this type of program, especially remittance information updates, will require either an EDI trading partnership relationship with an ACO that is the primary contractor and/or tight EDI linkage with healthcare financial systems that the ACO uses to automate patient accounting tasks.

Additional opportunities include streamlining the back end processes that must occur beyond cash posting and reconciliation with bank accounts, through EDI or technical integration with practice management and/or patient accounting systems. The EDI standards that would be used are already implemented in the HIPAA regulations.



Standards and file formats are important in this kind of a hub. Participants assert that such a hub can be accomplished today with little need for additional new regulations.

Beyond payment and remittance processing, the hub could provide financial information to the ACO that, as alluded to early, will help in analysis for quality of care assessments by the ACO.

A rigorous program of comparison between care delivery and outcomes, coupled with the financial metrics, will position the ACO to implement potential improvements in care delivery and could result in better outcomes over time.



## Conclusion

The ACO delivery model is emerging across the healthcare delivery landscape. It will require active communication between healthcare providers operating within a risk sharing care continuum. Management of the care – to better coordinate care in the community and to steer better outcomes – must be coupled with a financial management system that enables a global view of patient entry, treatments and outcomes coupled with payments. Tighter integration between financial systems and clinical systems seems inevitable in order to reach this objective. Banking and financial systems will find multiple ways to engage to enable the ACO as it attempts to improve the quality of care for patient populations while improving overall costs.



# HIMSS G7

## The HIMSS G7

Recognizing the connection between all components and stakeholders of the electronic exchange of patient clinical and administrative information, HIMSS and the Medical Banking Project merged in 2009 to create a strategic platform around the business of healthcare focusing on information technology requirements. A key element in the Patient Protection and Affordable Care Act (PPACA), the electronic exchange of financial information, is a component of the emerging digital interchange in healthcare information that must be addressed. It will form the basis for multiple process improvements throughout the national and global healthcare system.

## What Is the HIMSS G7?

HIMSS Medical Banking Project, which is part of HIMSS Business-Centered Systems, formed the HIMSS G7 thought leadership platform to design the healthcare financial network of the future. Improving efficiency in digital financial transactions is a main focus of the HIMSS G7. Other possible issues the HIMSS G7 members will explore include expediting workflow automation with the increasing tide of electronic transactions, health-wealth paradigms, linking online banking with health information exchanges to move forward the adoption of electronic health records and other areas that impact the healthcare financial network.

## Why Is the HIMSS G7 Important?

The United States is evolving the policy and technology frameworks that will support a new digital platform for the business of healthcare. This platform includes:

- Regulatory mandates, such as detailed in the Affordable Care Act;
- Strong engagement by banking platforms;
- Increased use by healthcare providers of medical banking models; and
- Resolution and acceptance of compliance issues in HIPAA and HITECH

HIMSS G7 members convened for the first time in October 2010 at the Vanderbilt Center for Better Health in Nashville, Tenn., to facilitate critical thinking about how the health care financial network of the future will evolve.

Most HIMSS G7 member categories were present for the discussion.

Those participating during the October 2010 HIMSS G7 Conference included:

|                                  |                                     |
|----------------------------------|-------------------------------------|
| Andrew Frost, MBA                | GE Healthcare                       |
| B P Fulmer                       | Exchange Edi LLC                    |
| Beth Meadors                     | Comerica Bank                       |
| David Cheli                      | Gateway EDI, Inc.                   |
| Dustin Wuest, RHIA               | ClaimTrust                          |
| Gordon Sellers, CPEHR,CPHIT      | Systemware, Inc.                    |
| Hamilton Todd, MSc               | Mayo Clinic                         |
| Howard Burde, JD                 | Howard Burde Health Law LLC         |
| John Phelan, PhD                 | Milliman                            |
| John Casillas                    | HIMSS                               |
| Juliet Santos, MSN, CCRN, FNP-BC | HIMSS                               |
| June St. John                    | Wells Fargo Bank, N.A.              |
| Kimberle Kennedy                 | US Bank                             |
| Maureen Turo                     | BNY Mellon                          |
| Pete Wooten                      | Avenue Bank                         |
| Rick Morrison                    | Medical Banking Rx                  |
| Ted Perkins, MBA, CPHIMS         | Allscripts                          |
| Thomas Torre                     | FIS                                 |
| Vladimir Kaminsky                | KPIT Revenue Cycle Technology       |
| William Barbato                  | FIS Global                          |
| William Kirsh, MPH,DO            | Sentry Data Systems                 |
| Tom Lloyd                        | Vanderbilt Center for Better Health |
| Sara Ladd                        | Vanderbilt Center for Better Health |

