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ACO LEADERSHIP TOOLKIT

The ACO Analytics Maturity Assessment

A 15-question self-assessment for ACO Executive Directors, CFOs, and Medical Directors operating in MSSP and ACO REACH.

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HOW TO USE THIS ASSESSMENT

Eight minutes from start to score.

This assessment is built for the ACO leadership team — Executive Director, CFO, Chief Medical Officer, and Quality / Population Health lead. It works best taken individually, then compared. The places where your scores diverge are the most important conversations you can have this quarter.

There are **15 questions** across **5 capability domains**. For each question, score yourself **1 to 5** based on the anchor descriptions. Your scores roll up into a domain score (3–15) and an overall score (15–75) that maps to a maturity band on the final page.

Be honest. The value of this assessment is in the conversation it starts, not the score you produce. If you score yourself as a 5 across the board, you don't need this assessment — and you don't need a partner like us. If you score yourself between 2 and 3 on most questions, you're in the same place as the majority of mid-size ACOs we talk to. That's not a problem; it's an opportunity.

THE SCORING SCALE

1	**Not in place**	No formal capability or process.
2	**Ad-hoc / project-based**	Done occasionally; not systematized.
3	**Operational but reactive**	In place; runs on demand or to schedule.
4	**Operational & proactive**	Drives action; informs decisions.
5	**Best-in-class**	Continuously optimized; competitive advantage.

DOMAIN 1

Risk Adjustment & RAF Capture

Whether your ACO is collecting the risk adjustment lift it's entitled to depends on documentation discipline, coding accuracy, and the systematic identification of unaddressed conditions. Three questions:

Q1. We can quantify our HCC capture rate vs. the population's expected disease burden, by provider, by quarter.

1 No view into capture rates at any level.
2 Annual lookback only, organization-wide.
3 Quarterly reports at the ACO level.
4 Quarterly by provider, with gap lists.
5 Real-time dashboard, per provider, with prioritized intervention lists.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Q2. We have a defensible, documented process for closing diagnosis gaps that meets OIG and CMS audit standards.

1 Ad hoc — providers code what they see.
2 Reactive — we close gaps when audit risk surfaces.
3 Annual chart-review program in place.
4 Continuous CDI program with documented protocols.
5 Audit-defensible, OIG-ready, with clinical sign-off and full trail.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Q3. We can model the financial impact of RAF improvement before investing in a coding or chart-review program.

1 No financial modeling capability.
2 Rough back-of-envelope estimates only.
3 Spreadsheet-based ROI models per program.
4 Scenario modeling with confidence intervals.
5 CFO-grade financial models with attribution and risk adjustment built in.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Domain 1 total (sum of three scores, max 15): _____

DOMAIN 2

Quality Measure Performance & Monitoring

Under MSSP and REACH, quality measure performance is no longer a soft compliance metric — it's a direct multiplier on shared savings. The question is whether your team can see, prioritize, and act on the gaps that move the multiplier.

Q4. We have member-level, measure-level visibility into open quality care gaps with weekly refresh.

1 No member-level visibility — only summary.
2 Quarterly extracts, no drill-down.
3 Monthly member-level reports, by measure.
4 Weekly refresh with provider routing.
5 Real-time dashboard with auto-routing and outreach orchestration.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Q5. We can rank quality measures by ROI — what each closed gap is worth in shared-savings dollars and cohort impact.

1 All measures treated equally.
2 Intuition-based prioritization by clinical leadership.
3 Static prioritization, refreshed annually.
4 Quantified ROI per measure, refreshed quarterly.
5 Dynamic prioritization, refreshed monthly with member-level cost data.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Q6. We have provider-facing scorecards that drive measurable behavior change at the practice level.

1 No provider scorecards.
2 Annual scorecards with limited detail.
3 Quarterly scorecards distributed but not actively reviewed.
4 Monthly scorecards with peer benchmarking.
5 Provider-facing dashboards with workflow integration and accountability cycles.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Domain 2 total (sum of three scores, max 15): _____

DOMAIN 3

Population Health & Risk Stratification

Knowing which 5 percent of your members will drive 50 percent of next year's cost — and which interventions actually work — is the difference between care management as a cost center and as a savings engine.

Q7. We have a forward-looking risk stratification model that predicts cost and utilization 12 months ahead.

1 No predictive stratification — lookback only.
2 Off-the-shelf tool with limited tuning.
3 In-house lookback-based segmentation.
4 Forward-looking model tuned to our population.
5 ML-based predictive model with continuous retraining and intervention attribution.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Q8. Our care management team prioritizes outreach using model-derived rankings, not just claims-based "frequent flyer" lists.

1 Manual list-building from claims data.
2 Top-utilizer lists from prior period.
3 Risk score plus clinical judgment.
4 Model-driven ranking with override.
5 Model-driven ranking with intervention-impact prediction and ROI feedback.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Q9. We track intervention effectiveness — does our care management reduce cost vs. an unintervened control?

1 No measurement of intervention impact.
2 Pre/post comparison without controls.
3 Matched cohort comparison, periodic review.
4 Quasi-experimental design with regular reporting.
5 Continuous A/B-style intervention testing with attribution to shared-savings results.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Domain 3 total (sum of three scores, max 15): _____

DOMAIN 4

Shared Savings Forecasting & Financial Modeling

Walking into the board meeting with confidence about whether you'll collect shared savings — and what the next dollar of investment is worth — separates well-run ACOs from anxious ones.

Q10. We can forecast the current performance year benchmark vs. expenditure with monthly precision.

1 No mid-year forecasting.
2 Annual forecast at the start of PY.
3 Mid-year forecast update, manual.
4 Monthly forecast with rolling claims data.
5 Real-time forecast with completion factors, run-out adjustments, and confidence intervals.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Q11. We model "what-if" scenarios for investment decisions — would adding a CDI program, hiring care managers, or expanding telehealth pay off?

1 No scenario modeling capability.
2 Spreadsheet ROI estimates per ask.
3 Standardized program ROI templates.
4 Scenario modeling tool with population-specific inputs.
5 CFO-grade scenario modeling with sensitivity analysis and attribution back to PY results.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Q12. We have CFO/board-ready materials that translate analytics into shared-savings probability and dollar impact.

1 Board materials are operational, not financial.
2 Quarterly financials separate from analytics.
3 Annual board pack ties operations to results.
4 Quarterly integrated reporting.
5 Real-time CFO dashboard with shared-savings probability, run-rates, and investment-decision support.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Domain 4 total (sum of three scores, max 15): _____

DOMAIN 5

Data Infrastructure & Analytics Operations

Even the best models and dashboards depend on a data foundation that's complete, current, and trusted. Most ACOs we see are punching below their weight here — running VBC analytics on infrastructure designed for fee-for-service reporting.

Q13. We have a single source of truth for member-level claims, eligibility, quality, and cost data.

1 Multiple sources, no integration.
2 Manual reconciliation in spreadsheets.
3 Periodic ETL into a shared warehouse.
4 Automated data pipelines with validation.
5 Integrated cloud or on-prem warehouse with lineage, governance, and SLAs.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Q14. Our analytics team can deliver a new dashboard or measure on demand within two weeks, not two quarters.

1 New analytics requests take months.
2 Analytics team is overwhelmed and reactive.
3 Standard requests met in 30–60 days.
4 Standard requests met in 1–2 weeks.
5 Self-service analytics for business users; deep-dives in days.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Q15. We can demonstrate to an auditor or partner that our analytics methodology is documented, repeatable, and defensible.

1 Methodology lives in spreadsheets and people's heads.
2 Some written documentation, scattered.
3 Centralized methodology documentation, reviewed annually.
4 Formal methodology with version control and review cycle.
5 Audit-grade methodology with provenance, version control, and external attestation-ready trail.

Your score: ■ 1 ■ 2 ■ 3 ■ 4 ■ 5

Domain 5 total (sum of three scores, max 15): _____

YOUR RESULTS

Tally your scores.

Domain	Your score (max 15)
1. Risk Adjustment & RAF Capture	_____ / 15
2. Quality Measure Performance & Monitoring	_____ / 15
3. Population Health & Risk Stratification	_____ / 15
4. Shared Savings Forecasting & Financial Modeling	_____ / 15
5. Data Infrastructure & Analytics Operations	_____ / 15
OVERALL (max 75)	**_____ / 75**

WHAT YOUR SCORE MEANS

Maturity bands and what to do next.

15-30 points — **Foundational**
Significant maturity gap; analytics is not yet a strategic asset.

31-45 points — **Operational**
Solid foundation; key gaps to close before VBC scale.

46-60 points — **Advanced**
Performing well; specific optimization opportunities.

61-75 points — **Best-in-class**
Leadership level; analytics is a competitive moat.

BENCHMARKING — WHAT WE TYPICALLY SEE

Where most mid-size ACOs sit today.

Across the mid-size ACO market (10K–50K attributed lives), most organizations score in the **31–45 (Operational)** band. The most common pattern: strong on Quality Measure visibility and Risk Adjustment basics; weaker on Forward-Looking Risk Stratification, Shared-Savings Forecasting, and Audit-Defensible Methodology. ACOs that have crossed into the **46–60 (Advanced)** band almost always made a deliberate investment in Domain 4 (Forecasting) — turning analytics from a reporting function into a financial-decision function. ACOs in the top quartile (61+) almost always have a senior analytics partner, internal or external, who's done this work at scale before.

THE CONVERSATION YOU SHOULD HAVE NEXT

Ready to talk about your scores?

Take this assessment to your next leadership team meeting. Compare scores across the ED, CFO, CMO, and Analytics lead. The places where you diverge most are the places to start — those are the conversations the rest of the year hinges on.

And when you're ready to talk about which two or three moves would lift you a band, we'd be glad to walk through it together. 30 minutes, no commitment, confidential.

Schedule an ACO Strategy Session →

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About BFILABS.AI · Senior-led healthcare analytics for provider-owned ACOs in MSSP and ACO REACH. Founder Jawad Bajjou brings 20+ years of healthcare analytics leadership at UnitedHealth Group / Optum and CVS Health, with $100B+ in MA revenue and 5M+ lives under analytics direction. Risk adjustment, quality, population health, and shared-savings forecasting — cloud or on-prem.