

# The Impact of Accountable Care Hospital Involvement with Accountable Care Organizations

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## EXECUTIVE SUMMARY

Accountable care organizations (ACOs) require providers to bear financial responsibility for the cost and quality of a defined population. Hospitals and health care systems throughout the U.S. are increasingly forming ACOs or partnering with other providers to create ACOs. Most hospitals entering into accountable care arrangements use shared savings arrangements while others are accepting fully capitated payments for the populations they serve. Several hospitals are directly offering health insurance products. Hospitals operating as ACOs will face challenges that include a potential decrease in inpatient volumes as care is moved toward the outpatient setting. Other issues they must address include further alignment with physicians, choosing and adopting advanced health information technology, and focusing on quality reporting and quality improvement. Successfully managing a population will require significant administrative investments, strong leadership, close work with physicians and the development of new skill sets to manage risk at the organizational and individual levels. Large health care systems, stand-alone hospitals and integrated delivery systems all have entered into ACO contracts and have seen promising results. Adoption of an ACO model requires substantive changes for hospitals but also represents an opportunity to improve the delivery of care.

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INTRODUCTION

Since the Affordable Care Act authorized the U.S. Secretary of Health and Human Services to create the Medicare Shared Savings Program (MSSP), discussions of delivery and payment reform have focused almost entirely on the concept of the accountable care organization (ACO). While the ACO’s various incarnations in Medicaid, Medicare and the commercial sector vary widely, hospitals agree that the model is influencing U.S. health care.

This white paper summarizes the early and potential effects that adoption of the ACO model can have on America’s hospitals. The first section, *Risk-Sharing Arrangements*, looks at both the current and likely future state of risk-sharing payment methods and what ramifications such a transition will have on the profitability and sustainability of the current hospital model. The next section, *Quality Improvement*, addresses the impact that ACO adoption will have on how hospitals work to ensure and improve quality. *Leadership and Operational Challenges* covers operational aspects that are affected by a hospital’s decision to transition to value-based care contracts, such as evolving leadership structures and the increasing focus on aligning with community providers through partnership or acquisition. In the section entitled *Diverse Experiences in Accountable Care*, three differently structured hospitals—a stand-alone hospital, an integrated network, and a hospital system—are juxtaposed to show the variety of pathways that hospitals are taking toward the “second curve” of value-based care delivery.<sup>1</sup> The last section, *Lessons Learned for Hospitals*, reviews the overall lessons for hospitals and suggests what the future environment will be.

RISK-SHARING ARRANGEMENTS

Many hospital and health systems see the discussion around payment method as an opportunity to make substantive changes to their delivery system and provide leadership within the field. However, much of the initial thinking behind payment reform, both in academia and among policymakers, was that hospitals would need a change in payment structures before they could make changes to the delivery model.<sup>2</sup> What has resulted, however, is a landscape that includes a variety of transition pathways based on the market and individual organizational readiness.

Current State of Risk-Sharing

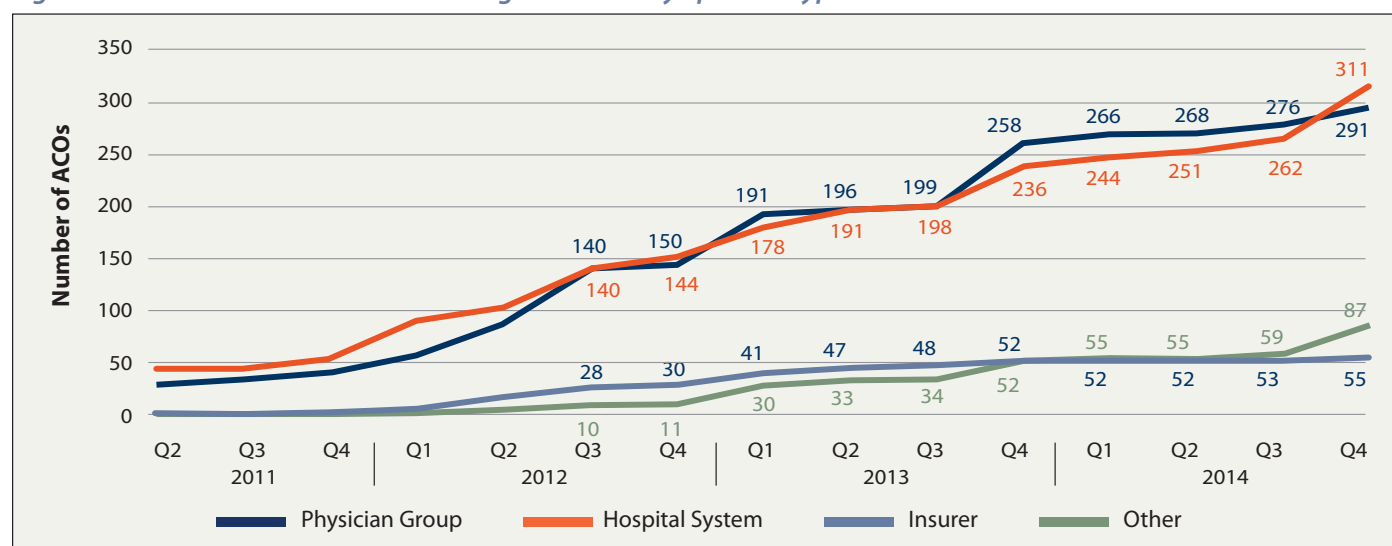
Since the 1990s era of health maintenance organizations (HMO) represents the most recent large-scale attempt to control costs, many hospitals and health systems have used HMOs as a reference point for what should and should not be done under current health reform efforts. The most common risk arrangement during this era was capitation, leading many to assume that ACOs would represent a return to those same structures. What has emerged is a multitude of payment models that overlay the current fee-for-service system but also incorporate aspects of budget reconciliation and bonus payments designed to incent cost awareness and quality (see Table 1).

The most common payment arrangement currently used by both public and commercial payers is the shared savings model,<sup>3,4</sup>—a model closely associated with Medicare’s largest ACO program, the Shared Savings Program (MSSP).<sup>5</sup> Common under commercial and Medicaid ACO programs are payments based on

Table 1. New Payment Models

|               | Payment Arrangement        | Model Description  |
|---------------|----------------------------|--|
| Current State | Shared Savings             | A payment approach whereby a provider organization shares in the savings (and in a two-sided model, the losses) that accrue when actual spending for a defined population is less (or more) than a target amount.  |
|               | Care Management Fees/Bonus | Payer will give the provider a bonus for carrying out newly agreed upon activities such as care coordination or focusing on high-risk patients. This payment is based upon traditional fee-for-service but is above and beyond the standard fee-for-service rates. |
| Future State  | Capitation                 | A single payment is made to a provider organization to cover the cost of a predefined set of services delivered to a patient.  |
|               | Bundled Payment            | A payment method in which a single payment is made to cover the cost of services delivered by multiple providers over a defined period of time to treat a given episode of care.   |

Figure 1. Growth in Accountable Care Organizations by Sponsor Type\*



\* Includes ACOs with both government and commercial contracts. Source: Leavitt Partners, 2015.

the performance of additional care management services or on achieving predetermined cost and quality targets. Most care management payments are paid upfront in exchange for the promise that the assigned population will get extra services designed to lower overall expenditures.<sup>6</sup> This arrangement is considered a temporary—perhaps one to three years at most—but facilitating element on the path toward more concrete risk assumption, such as a shared savings or loss model. Such arrangements have been important for hospital-led ACOs that are not currently staffed in a way that allows them to coordinate care beyond the hospital walls. Table 2, Benefits of Payment Models, lays out the design benefits and drawbacks of the payment arrangements currently being utilized.

### Future State of Risk-Sharing

In the 1990s, the HMO fulfilled the role of the general or prime contractor by taking on the insurance risk and overseeing care management. Hospitals and physicians often served as subcontractors, operating within a budget determined by the subcontracted payment amount. After the Affordable Care Act introduced the ACO concept to a broader audience, questions about who would and should fulfill the role that HMOs originally occupied took center stage.

Early tracking efforts showed that hospitals were more likely than their physician counterparts to engage in ACOs (see Figure 1). Furthermore, there was a strong

association of participation in the early stages of the Medicare ACO programs with hospital risk-bearing.<sup>7</sup> Data points like these contribute to the growing debate around whether it should be hospitals or physician groups acting as the prime contractor for health care services. In a market where risk-bearing efforts are being led by larger physician groups, hospitals could end up competing for inpatient referrals that will increasingly be determined by cost and quality outcomes and less by historical relationships. In service areas where hospitals are leading risk-assumption, efforts to acquire physician practices or facilitate the development of better organized physician groups as subcontracting partners will become commonplace. Regardless of which group ends up taking the financial leadership role in a given market, the relationship between hospitals and physicians will continue to see major changes.

In the discussion around increased provider risk-bearing, a topic that has loomed large is that of provider-owned health plans. Over the years, larger health systems have extended the experience and competencies garnered from administering health plans for their own employees to create stand-alone insurance products for their local markets. Though just a fraction of the current health insurance market place, these health systems are doing what many think will be the end point of payment reform—learning to operate within the premium dollar, thereby obviating the need for the insurance intermediary. For most

**Table 2. Benefits of Payment Models**

|               | Payment Arrangement        | Design Benefits   | Design Drawbacks   |
|---------------|----------------------------|---|--|
| Current State | Shared Savings             | <ul style="list-style-type: none"> <li>Utilizes current fee-for-service model familiar to most providers</li> <li>Allows for a variety of prospective and retrospective budgeting options</li> <li>Allows for gradual assumption of risk</li> <li>Providers can be paid separately while business relationships evolve</li> </ul> | <ul style="list-style-type: none"> <li>Maintains to some degree the underlying fee-for-service structure that can incentivize volume and preserve siloed care domains</li> <li>Doesn't provide hospitals with upfront funding to carry out preventive care management</li> <li>Tends to benefit groups who are historically high spenders</li> </ul> |
|               | Care Management Fees/Bonus | <ul style="list-style-type: none"> <li>Functions apart from the traditional fee-for-service system</li> <li>Allows a payer to make investment in provider partner's care management infrastructure</li> <li>Provides upfront capital for providers doing extra work</li> </ul>  | <ul style="list-style-type: none"> <li>May lack sufficient financial incentive to motivate lasting changes</li> <li>Payers reluctant to paying above and beyond current reimbursement without being strictly tied to performance</li> </ul>  |
| Future State  | Capitation                 | <ul style="list-style-type: none"> <li>Upfront payment allows providers autonomy to finance preventive and custom care strategies</li> <li>Predetermined payment amounts lend to budget predictability for payers and providers</li> </ul>  | <ul style="list-style-type: none"> <li>Full risk management is not within the abilities of most providers</li> <li>Often leads to narrow network products that can leave consumers with a limited selection of providers</li> </ul>  |
|               | Bundled Payment            | <ul style="list-style-type: none"> <li>Modular approach permits providers to build cost-containment strategies incrementally</li> <li>Encourages coordination around predetermined set of related services</li> </ul>   | <ul style="list-style-type: none"> <li>Inverse incentive to create acute episodes of care and chronic illness</li> <li>Creates challenges determining fair payments and how to divide payment between providers</li> </ul>   |

providers, however, stepping into the insurance world represents an effort too far outside their organizational competencies. The vast majority of instances where the lines between provider and insurer responsibilities are being blurred are situations where the insurers are partnering with prominent health systems to provide a narrow network product. Many of these agreements include an element of risk-sharing with the provider to incent greater care management that, in turn, allows the payer to offer lower-cost products to local employers and place competitive products on the various public and private health insurance exchanges.<sup>8,9</sup>

The payment mechanism that has fit most squarely into the competencies of hospitals to this point has been bundled payments. Since hospitals have operated under the diagnosis-related group (DRG) system for years, expanding the “bundle” of services has made sense for many hospitals looking for some way to get involved in delivery reform. Bundled payments are episodic but may represent an opportunity for providers to later transition into population-level risk sharing. Though bundled payments have been less prevalent in health

reform discussions, various public and commercial payers have launched pilot programs to test the model. The Bundled Payments for Care Improvement Initiative by the Centers for Medicare and Medicaid Services (CMS) has had wide participation despite what turned out to be significant hurdles in developing a model that stakeholders found feasible.<sup>10</sup> Commercial efforts in bundled payments have likewise had difficulty finding a viable model but have had considerably less activity than the Medicare program.<sup>11</sup>

An important nuance to current provider risk-sharing trends is that many of the agreements represent, by and large, increased risk-assumption at the organizational level and not necessarily at the level of the individual providers.<sup>12</sup> One of the reasons that risk-sharing has remained largely at the organizational level is that disseminating risk throughout large, multilayered organizations may be too difficult at this stage in the development of value-based contracts and will require more experience before seeing an enterprise commitment. There is concern that until risk-sharing reaches the level of the individual providers, the health care field won't be able to understand the

full potential of financial incentives in bending the cost curve. Hospitals for their part will need to develop new payment strategies to engage more and more of the hospital staff as newer care strategies come into focus.

### **Hospital Sustainability and Profitability**

One of the aims of payment reform in health care is changing the financial incentives so providers and patients will begin to focus on preventive rather than remedial or “sick” care. If such efforts yield the desired outcomes over time, the demand for acute care services, on a per capita basis, could decline.<sup>13</sup> Such shifts in demand could change the size and reach of hospital service areas, redirect investments in technology and necessitate the creation of new workforce structures. One potential outcome could be that hospitals shift their delivery focus to higher-acuity services while simultaneously coordinating with partners to manage population health—a change that would have a real effect on hospital workforce composition. Examples include increasing the number of tertiary and quaternary care providers in addition to hiring or developing leadership and staff dedicated to population health.<sup>14</sup> Since population health is a developing science, personnel dedicated to ongoing training will be essential. The closely related and ever-increasing dependence on health information technology at every level will also require another level of training and expertise. Nevertheless, most hospitals are not yet experiencing the dramatic shifts in services trends that would lead to wholesale changes in the hospital business model.

A more concrete and present scenario is that of the health system-payer partnership that has seen increased activity over the last three to five years. Such partnerships are in response to current cost pressures that have led payers to create narrower networks in order to offer lower premiums to various customers.<sup>15</sup> These partnerships have pushed health systems and payers to offer services above and beyond the traditional industry practice. Payers are sharing increased amounts of data, in addition to providing care management infrastructure by lease or as part of a contract. Hospitals are doing work that has been traditionally done by care management organizations, working with patients along the care continuum.

Another aspect that has received increased attention is the growing need for more sophisticated infrastructure, including enhanced health information technology. Hospitals are making large investments in advanced electronic health record (EHR) systems and enterprise data warehouse solutions that allow providers to stratify patient data and conduct other population health management analyses.<sup>16,17</sup> These technologies are costly and require continual investment and maintenance as care models continue to evolve.

### **QUALITY IMPROVEMENT**

In addition to making care more affordable and improving the patient experience, the Triple Aim of health care includes the goal to improve the health of patient populations.<sup>18</sup> Assuring quality health care through rigorous assessment—in addition to the intrinsic value of improving population health—provides an opportunity to ensure care at the right time and in the right setting in these new risk-sharing arrangements. The health care field’s ability to determine and accurately measure quality in health care is still developing. In the early stages of quality measurement, discussions have naturally centered on the metrics themselves.

Medicare made the first attempt to delineate a specific set of population health management quality metrics under the MSSP. After significant feedback from various stakeholders, CMS settled on 33 metrics that will serve as the initial benchmark. Under commercial ACO arrangements, how and what is measured to ensure quality varies significantly.<sup>19</sup> Overall quality measurement represents an investment in time and effort for providers and particularly hospital clinical and administrative staff. Those systems with experience in implementing and improving quality assurance programs have been able to realize the full benefits of such programs.

For hospitals, the category of what care can be improved through programs like continuous quality improvement (CQI) and Six Sigma is very broad. Early initiatives, such as the Hospital Engagement Network, have yielded positive results in improved outcomes



**Table 3. Strategies for Quality Improvement**

| Areas for Improvement  | Associated Strategy   |
|------------------------|---|
| Post-acute care        | <ul style="list-style-type: none"> <li>• Provide patients with information to help them select high-quality and lower-cost facilities</li> <li>• Co-locate physicians who conduct regular rounds</li> </ul>   |
| Care coordination      | <ul style="list-style-type: none"> <li>• Deploy nurse practitioners and medical assistants to coordinate between hospital staff and non hospital entities such as primary care providers and auxiliary providers</li> <li>• Focus on eliminating duplicative services like imaging and lab tests</li> </ul> |
| Avoidable readmissions | <ul style="list-style-type: none"> <li>• Overlap with other CMS initiatives</li> <li>• Use care transition programs to support seamless patient handoffs</li> <li>• Ensure treatment compliance through care guidelines for providers</li> <li>• Include strategies from the previous categories</li> </ul> |

and cost savings in the inpatient setting.<sup>20</sup> Programs centered on avoidable readmissions proved especially effective since success in programs like CMS' Value-Based Purchasing could also lead to significant savings in the MSSP and Pioneer Model. In carrying out quality improvement programs, hospitals have to grapple with the question of what aspects of care are truly within their realm of meaningful influence. For example, hospitals without a significant primary care foundation are reluctant to build preventive medicine aspects into their value-based contracts. The aspects of care hospitals determine they can impact directly will influence what a hospital chooses to focus on in the early years of any value-based contract. Table 3 summarizes several areas for quality improvement that a hospital could target to improve population health.

## LEADERSHIP AND OPERATIONAL CHALLENGES

Apart from the added administrative and coordinating efforts that risk-sharing and quality improvement initiatives represent, adopting the ACO model has other challenges. One of the larger challenges includes reassessing leadership structures, more specifically the role of the physician. One lesson learned from the HMO experiment noted earlier is that providers and patient communities will not accept a system with medical management from the insurance entity. Consequently, there has been an emphasis on physician leadership even when the "sponsoring entity," in terms of contracting and investment, is considered the hospital. Other issues like organizational culture and clinical integration can represent significant challenges to a

hospital attempting to transition to population health management. Organizations that have learned to operate in a volume-based environment will need a clear vision from leadership on where the organization is headed as well as incentives that align with that mission and keep all staff and external partners working toward the same end.<sup>21</sup>

Other challenges have more day-to-day consequences, like determining how to distribute shared savings or how to engage physicians. If a hospital is able to create savings, decisions will need to be made about who is mainly responsible for avoiding more costly and preventable inpatient encounters. Often, these newly discovered efficiencies come at the expense of "downstream" providers who see increased pressure for their cooperation in such care management efforts. Often the larger, more pressing issue is which physicians will be included in the ACO in the first place. In some service regions, acquisition of physician practices has been an effective although risky and expensive approach. In other regions, hospitals are actively recruiting physician group partners. Attribution models based on where patients receive their primary care services have increased the demand for "aligned" primary care physicians.

Early adopters of value-based contracts have experienced what researchers call the "spill-over effect"—that is, despite focused care management efforts on populations covered by a specific program or payer, other populations end up benefiting from those same efforts. Although this is a positive outcome from a public health standpoint, providers worry that they are creating value that is not being compensated

**Table 4. Challenges Associated with ACO Adoption**

|             | Category                     | Common Challenges  |
|-------------|------------------------------|--|
| Leadership  | Physician Leadership         | <ul style="list-style-type: none"> <li>Hospital administrators have to balance physician autonomy and the need for some guidance and standardization under quality improvement initiatives</li> </ul>  |
|             | Cultural Changes             | <ul style="list-style-type: none"> <li>A culture of continuous quality improvement will be paramount to ACO efforts</li> <li>Incentives should avoid pitting departments or categories of providers against each other</li> <li>Proper and sufficient investment will signal a commitment to transition</li> </ul>   |
|             | Clinical Integration         | <ul style="list-style-type: none"> <li>Hospitals have made significant investments in clinical integration, adding an extra layer of sophistication to participation in ACO contracts</li> </ul>   |
| Operational | Shared Savings Distributions | <ul style="list-style-type: none"> <li>Administrators have to decide how and when these revenue sources should be distributed</li> <li>Difficulty stems from assessments leadership is forced to make regarding who is responsible for generating what savings and to what degree they should be rewarded</li> </ul>   |
|             | Physician Alignment          | <ul style="list-style-type: none"> <li>Attribution models based on the provision of primary care services and quality measures have raised the profile and demand for primary care physicians</li> <li>Hospitals have acquired physician practices in some markets whereas in other markets hospitals have focused on finding or building competent physician group partners that can self-manage</li> </ul> |
|             | Payer Mix                    | <ul style="list-style-type: none"> <li>Payers not currently participating in value-based contracting nonetheless are benefiting from care delivery improvement efforts (the “spillover effect”)</li> <li>Improvements are not being rewarded, and all savings are accruing to the payer</li> <li>Resulting strategy is to move as much business as possible into value-based contracts</li> </ul>            |

and could eventually undermine the sustainability of such contracts. A resulting strategy has been to move a majority of current business as quickly as possible to value-based contracts.

## DIVERSE EXPERIENCES IN ACCOUNTABLE CARE

Several factors influence the approach a hospital may take when entering risk-bearing contracts under the auspices of accountable care. A region’s unique history will have the greatest impact. Individual organizational readiness and the availability of willing and organized partners also will have a significant impact on what can be accomplished. Following are three examples of different hospital types whose unique backgrounds have led to distinct initiatives.

### Large hospital system: Dignity Health, Calif.

Like many in the first wave of ACOs, Dignity is a health care system with the size and operational ability to take on large-scale quality and care management efforts. Initial efforts were centered on the decision to coordinate existing operational infrastructure and clinical processes to help eliminate unnecessary utilization in the inpatient setting. Strategies included an

emphasis on personalized care and disease management utilizing quantitative analysis and effective use of an electronic health record. Dignity Health partnered with a physician group, Hill Physicians, and a health plan, Blue Shield of California, in order to extend their influence beyond the traditional inpatient setting. With its regional footprint, Dignity was able to use the partnership with Hill Physicians to contract for the care of a large public employer, CalPERS (California Public Employees’ Retirement System).<sup>22</sup>

### Stand-alone hospital: Tucson Medical Center, Ariz.

Tucson Medical Center (TMC), despite national trends toward consolidation, has instead found a multitude of partners with which to help co-manage its ACO populations. With a smaller footprint, TMC has relied on its local brand to engender provider-patient loyalty. Despite limited capital resources relative to larger systems, TMC relies upon its smaller, and what it considers to be, more nimble leadership structure to quickly adapt to a changing environment. To achieve a population large enough to engage payers, TMC has found it necessary to engage multiple provider partners in the community, which has required more collaboration and newly developed lines of communication.<sup>23</sup>

## **Integrated delivery system: UnityPoint, Iowa**

As is typical of most integrated delivery systems, UnityPoint has benefited from a structure experienced in promoting physician involvement, coordinated care and a focus on primary and clinical management systems. Additionally, UnityPoint has been better positioned to absorb shifts in revenue as the point of care moves away from hospitals to patient-centered medical homes, urgent care centers and retail health clinics. A challenge unique to integrated delivery systems like UnityPoint is restructuring previously developed care and quality management efforts to accommodate recently developed ACO programs like the MSSP and the Pioneer Model. Like the large health care systems, UnityPoint benefits from a regional footprint that allows it to contract for large populations.<sup>24</sup>

## **CONCLUSION**

### **Opportunities**

Hospitals have multiple options when it comes to how and with whom they decide to engage in ACO contracts. The various risk-bearing options offered by public and private payers allow for groups to go as slowly or as fast—depending upon the region—as their organizational structure and competencies permit. Hospitals are generally well positioned to engage in large-scale initiatives, thanks to existing infrastructure and leadership experienced in running a large enterprise. Other advantages include capital reserves that allow for investment in new staffing models and additional health information technology. Despite substantial growth in ACO adoption, the health care field believes this is the early stages of a much broader shift toward value-based care and the existing models will necessarily evolve. Hospitals that have already made the decision to pursue value-based contracts will be better positioned to operate under mandatory risk-sharing proposals. If risk arrangements fail to become an industry standard, providers who better understand and control their cost structures and have developed concrete strategies to control costs will be better prepared to operate under conditions that put pressure on already thin margins.

## **Challenges and Concerns**

The same variety of pathways for ACO involvement discussed in this paper also poses a challenge to groups looking for a simple transition template. Individual assessments will be made that take into account market history, organization preparedness and other factors unique to the situation of every hospital. One major hurdle addressed in several sections of this paper is the danger posed by comprehensive care models for groups such as hospitals that have come to depend heavily on the current fee structure for acute care services. Hospital administrators will have to simultaneously manage the search for savings in the inpatient setting and the development of competencies that will permit them to serve more patients. Risk management will continue to be a challenge to hospitals that have not historically operated under financial structures that encourage care management beyond the walls of the hospital. Additionally, the quality improvement strategies that are essential to value-based care models represent a large and additional administrative lift for groups already operating at or above normal capacity. Finally, years of payment and delivery model experimentation, though unavoidable, will present challenges to hospitals. There will be stretches where newer programs may end up being structured, albeit temporarily, in a way that does not allow a hospital to truly demonstrate the efficiencies and savings that are actually being realized.

### **Looking Forward**

Despite the immediate challenges facing hospitals and health care systems, the opportunities for evolution and reinvention are many. Hospitals, traditionally the model of innovation in American health care, will need to find a way to parlay that success into models that foster affordability as well as clinical advancement. Current hospital leaders also represent much of the systems-operations experience that exists in health care and will be needed as the field works to find better models that lower costs and improve care while simultaneously improving population health.



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# The Impact of Accountable Care

**Part 1:**  
Origins and Future  
of Accountable  
Care Organizations

**Part 2:**  
Physician  
Participation in  
Accountable Care  
Organizations

**Part 3:**  
Hospital  
Involvement with  
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**Part 4:**  
Health Insurers and  
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**Part 5:**  
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**Part 6:**  
How Accountable  
Care Impacts the  
Way Consumers  
Receive Care

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**Suggested Citation:** Health Research & Educational Trust and Leavitt Partners. (2015, May). *The Impact of Accountable Care: Hospital Involvement with Accountable Care Organizations*. Chicago, IL: Health Research & Educational Trust. Salt Lake City, UT: Leavitt Partners. Accessed at [www.hpoe.org](http://www.hpoe.org)

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