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Hospital Readiness for Population-based Accountable Care

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HRET
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Contents

Tables

Figures

Executive Summary

With the generous support of The Commonwealth Fund, the Health Research & Educational Trust performed a national survey of all hospitals in 2011 to assess the current state of hospital readiness in the development of accountable care organizations (ACOs). There were 1,672 responses to the survey for a response rate of 34%. Based on the survey responses and analyses, the following major themes were identified:

1. **A small percentage of hospitals currently participates in an ACO (3%) or is preparing to participate in an ACO (10%).**
   These hospitals were more likely to be larger, a teaching hospital, part of a health system, and located in urban areas. Most hospitals participating or preparing to participate in an ACO reported it as a joint venture between physicians and the hospital.

2. **Hospitals expect their revenue sources from risk-based financial reimbursements to double over the next two years (from 9% to 18%).**
   Across all hospitals, bundled payments (physician plus hospital services) are expected to increase 6%, and partial and global capitation payments are expected to increase 3%.

3. **A majority of hospitals are actively engaged in numerous care coordination efforts, though there is variation in the use of specific practices.**
   Although there is variation in the standard implementation of care coordination practices, hospitals participating or preparing to participate in an ACO more often implemented these practices than hospitals not exploring the ACO model.

4. **There are different perceived barriers between hospitals preparing to participate in an ACO and hospitals participating in an ACO.**
   The greatest challenges for hospitals participating in an ACO were perceived to be reducing clinical variation and reducing costs (mean score of 3.62 on both measures on a scale of 1 to 5 where 5 = extreme challenge). For hospitals preparing to participate in an ACO, the greatest challenge was increasing the size of the covered patient population (mean score of 3.67).

5. **ACO hospitals are significantly involved in population health management services.**
   Hospitals participating in ACOs are working to improve coordination across the continuum of care through involvement in a variety of health management services. These services include the use of wellness or preventive care services (80%), chronic disease management services (87%), end-of-life/palliative care services (73%), and complex case management services (87%).

   ACO hospitals also identified several processes used to determine which patients were eligible to receive these health management services, including: the use of health risk assessments (77%); the use of outpatient claims or encounter data from participating practitioners and providers (100%); the use of outpatient claims or encounter data from nonparticipating practitioners and providers (69%); and the use of inpatient claims or encounter data from participating practitioners and providers (100%).

6. **There are significant gaps in care coordination functionalities.**
   Although a high percentage of hospitals reconcile medications as part of an established plan of care (89% of hospitals participating in an ACO, 90% of hospitals preparing to participate in an ACO, and 85% of hospitals not exploring the ACO model), there is a low use of risk stratification and other care coordination activities. For example, only 38% of hospitals participating in an ACO, 33% of hospitals preparing to participate in an ACO, and 24% of hospitals not exploring the ACO model assign case managers to patients at risk for hospital admission or readmission for outpatient follow-up. Less than one-quarter of the hospitals in each group have nurse case managers

who work with patients with chronic diseases. Similarly, 23% of hospitals participating in an ACO, 21% of hospitals preparing to participate in an ACO, and 11% of hospitals not exploring the ACO model have a post–hospital discharge continuity of care program with scaled intensiveness. This scale is based on a severity or risk profile for adult medical-surgical patients using defined diagnostic categories or severity profiles.

7. **ACOs are striving to improve the quality of their services by using valid performance measures and making results available to the public and participating providers.** Far more hospitals participating in an ACO have an organized program to train clinical leadership in continuous quality improvement (84%) than hospitals not exploring the ACO model (54%). Half of ACO hospitals track and routinely share performance against measures with all members of the ACO. Of those currently sharing performance data, 46% are providing utilization measures by each setting of care as well as clinical quality measures by each setting of care. Forty-four percent (44%) are providing financial measures by each setting of care, and 39% are providing patient satisfaction measures by setting of care.

   Using the findings from the survey and an in-depth literature review, we developed an HRET ACO Readiness Tool as a basis for internal discussions by the hospital leadership regarding self-assessment of the capabilities, attributes, and experiences that are critical to the success of an accountable care organization.

- This report is organized as follows:
- Introduction
- Methods
- Current Progress in Hospital Participation in the ACO model
- Governance Structure
- Legal Structures of ACOs
- Ability to Take on Financial Risk
- ACO Payment Models
- Partnerships and Ability to Provide Primary, Acute, and Post-acute Care
- Care Management
- Performance Reporting and Quality Improvement
- ACO Challenges
- Conclusion
- The ACO Readiness Tool

Introduction

There is widespread agreement among policymakers, payers, and health care leaders that the current fee-for-service method of paying for care is one of the drivers of the unsustainable growth in health care costs in the United States. In response, the concept of accountable care organizations (ACOs) has been widely touted as a potential solution to bending the health care cost curve and encouraging care coordination. ACOs accept responsibility for the cost and quality of care delivered to a specific population of patients cared for by the group's clinicians. ACOs serve to align the incentives of multiple providers, and they hold the potential to address some of the limitations in the fee-for-service payment system. The success of the ACO model resides in fostering clinical excellence and continual improvement; effectively managing costs hinges on its ability to incentivize hospitals, physicians, post-acute care facilities, and other providers to form linkages that facilitate coordination of care delivery and collect and analyze data on costs and outcomes.

The Patient Protection and Affordable Care Act of 2010 established a national voluntary program under Medicare for ACOs in 2012. If it is successful, the U.S. Secretary of Health and Human Services has the authority to expand the program. Although the concept of ACOs has been embraced by health care and health policy leaders, there are no national indicators of how many hospitals are participating in ACOs

and what their current capabilities are in care management, financial management, information management, and performance improvement.

Methods

Data for this project were collected through a national survey of hospitals. This survey was developed by HRET staff with the guidance of an external panel of experts, including representatives from the Commonwealth Fund, the Dartmouth Institute for Health Policy and Clinical Practice, the National Committee for Quality Assurance, Premiere Inc., as well as other prominent national experts. The survey was additionally pilot tested with several organizations and then refined further based on the feedback.

The completed survey was mailed to 4,973 short-term general acute care hospitals, as identified through the American Hospital Association annual survey. Psychiatric hospitals, long-term care facilities, rehabilitation hospitals, and children's and cancer hospitals were not surveyed.

The survey was in two parts. Part 1, completed by all sampled hospitals, asked questions pertaining to care coordination, finances, and the monitoring and sharing of performance data. Hospitals participating in or preparing to participate in an ACO went on to complete part 2, which posed questions regarding ACO formation, characteristics, leadership and governance, and risk management. Specific efforts, such as the use of targeted email blasts, were made to solicit the participation of larger hospitals that were more likely to join ACOs. It should be noted that the survey was in the field from May through September 2011, thereby preceding the issuance of the ACO program final rule by the Centers for Medicare & Medicaid Services in October 2011.

After the data collection phase, a preliminary analysis was undertaken to examine the representativeness of the sample by comparing differences in demographic characteristics between respondents and nonrespondents, as well as the differences between respondents and the broader hospital population. This study then explored the characteristics of ACO participants, including elements such as leadership, governance, and payment models. Next, the responses of ACO participants and hospitals preparing to participate in ACOs were compared across the several dimensions, such as care coordination practices, perceived barriers to ACO participation, performance measurement, and clinical information exchange. Finally, for hospitals responding to part 2 of the survey, responses were examined in terms of risk arrangements, patient management, performance reporting, quality improvement, and ACO preparedness.

Respondents

Of those surveyed, 1,672 hospitals responded to part 1 of the survey, for an overall response rate of 34%. Hospitals with more than 300 beds had a response rate of 47%, and hospitals with 400 or more beds had a response rate of 52%. Of the 1,672 total responses, 186 respondents (11%) went on to complete part 2. This represents a completion rate of 87% for those eligible to proceed from part 1 to part 2.

Differences between Respondents and Nonrespondents

We compared characteristics of respondents and nonrespondents and found differences with respect to size, location, ownership, teaching hospital status, and centralization.

Respondent hospitals tended to be larger on average (197 beds vs. 144 beds). These hospitals were also more representative of the New England, Mid-Atlantic Regions and East North Central regions, and less representative among the East South Central, West South Central, Mountain, and Pacific regions. Hospital ownership also varied, with respondents more frequently representing nonfederal government

(25% vs. 20%) and not-for-profit institutions (66% vs. 55%). It should also be noted that respondent hospitals were more representative of metropolitan areas (43% vs. 46%), as opposed to micropolitan areas (19% vs. 16%). Finally, respondents were more likely to be teaching hospitals (9% vs. 5%) and were less frequently associated with decentralized (18% vs. 23%) and independent hospital systems (8% vs. 15%).

See table 1 for a full presentation of comparisons between respondent and nonrespondent hospitals.

Our results suggest that nonresponse would not greatly affect relative risk estimates in this study, except possibly regarding investor-owned/ for-profit, nongovernment not-for-profit, and independent hospital systems.

Table 1: Demographic Characteristics of Respondents and Nonrespondents

Category	Variable	Respondents	Non-Respondents	p-value
Hospital Size				
	Total bed size	197	144	0.00
Region				
	New England	6%	3%	0.00
	Mid-Atlantic	13%	7%	0.00
	South Atlantic	16%	15%	0.21
	East North Central	19%	15%	0.00
	East South Central	7%	10%	0.00
	West North Central	14%	14%	0.27
	West South Central	12%	17%	0.00
	Mountain	6%	8%	0.00
	Pacific	9%	12%	0.00
Hospital Control				
	Government, Nonfederal	25%	20%	0.00
	Nongovernment, not-for-profit	66%	55%	0.00
	Investor-owned/for-profit	10%	25%	0.00
	Federal	0%	0%	
Urban Status				
	Division (>2.5 million persons)	15%	15%	0.33
	Metropolitan (between 50,000 and 2.5 million persons)	43%	46%	0.00
	Micropolitan (between 10,000 and 50,000 persons)	19%	16%	0.00
	Rural (under 10,000 persons)	23%	23%	0.25
Teaching Hospital Status				
	Council of Teaching Hospitals and Health Systems (COTH) membership	9%	5%	0.00

Hospital Centralization				
	Centralized health system	6%	6%	0.73
	Centralized insurance/physician system	3%	3%	0.43
	Moderately centralized health system	15%	15%	0.75
	Decentralized health system	18%	23%	0.00
	Independent hospital system	8%	15%	0.00

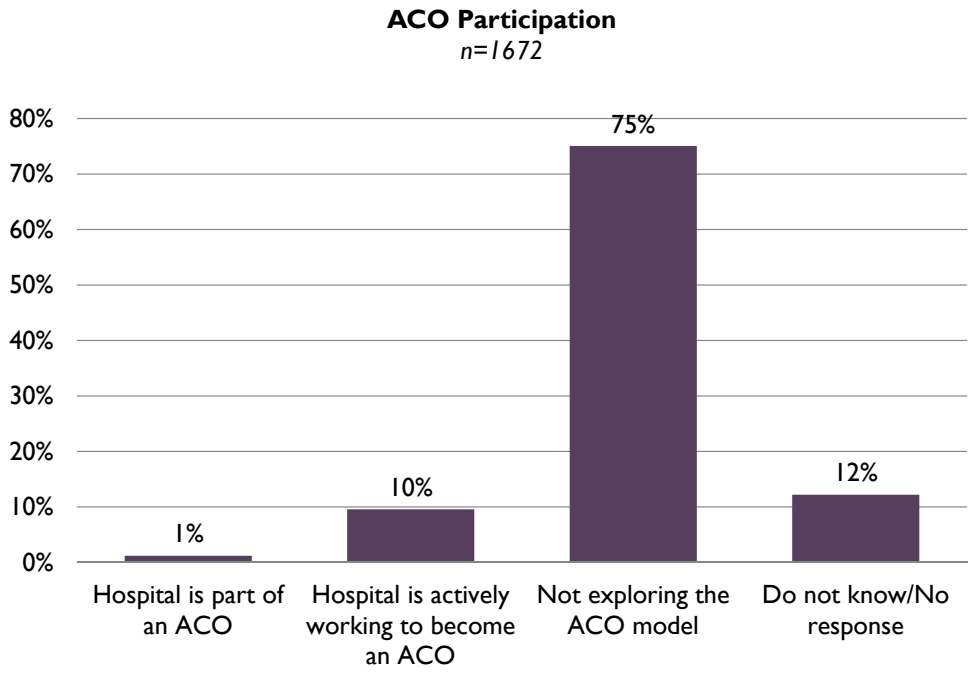
Reporting of Findings

The following sections report the results of the survey. Hospitals participating in an ACO, hospitals preparing to participate in an ACO, and hospitals not exploring the ACO model all answered questions in part 1 of the survey. But only hospitals participating or preparing to participate in an ACO answered questions in part 2 of the questionnaire. Therefore, results are reported across all three groups only when available.

Current Progress in Hospital Participation in the ACO Model

Details regarding what types of provider organizations should qualify as ACOs under the Medicare Share Savings Program and how financial incentives are structured were released in October 2011. As a result, implementation is still in its infancy. Specific details surrounding ACOs were not determined by CMS until after this survey was completed. Of the 1,672 hospitals who responded to the survey, only 1% reported being part of an ACO and 2% indicated having established an ACO. Ten percent (10%) indicated that they were preparing to participate in an ACO, 75% are not exploring the ACO model, and 12% either did not know if they were part of an ACO or did not respond to the question (see fig. 1).

Figure 1



Demographic Characteristics of ACO Participating and Nonparticipating Hospitals

Hospitals participating or preparing to participate in an ACO are generally larger than hospitals not exploring the ACO model (368 beds, 307 beds, and 173 beds, respectively). In general, ACO hospitals and hospitals working to join an ACO are also more likely than hospitals not exploring the ACO model to belong to health systems (77%, 60%, and 47%, respectively); more likely to be located in larger urban areas (51%, 24%, and 13%) as opposed to smaller rural areas (4%, 8%, and 25%); more likely to be teaching hospitals (34%, 21%, and 7%); more likely to be governed by not-for-profit structures (94%, 90%, and 75%); and less likely to be under nonfederal government control (3%, 9%, and 19%,). In addition, hospitals participating in an ACO are less prominent in the New England and West South Central regions of the country, while being more common in the Mid-Atlantic region. See table 2 for a full comparison of hospitals participating in an ACO, hospitals preparing to participate in an ACO, and hospitals not exploring the ACO model.

Table 2: Demographic Characteristics of ACO Participating and Nonparticipating Hospitals

Category	Variable	Hospitals Participating in an ACO	Hospitals Preparing to Participate in an ACO	Hospitals not Exploring the ACO Model	p-value
Hospital Size					
	Total bed size	368	307	173	0.000
Health System					
	Health system membership	77%	60%	47%	0.000
Urban Status					
	Division (>2.5 million persons)	51%	24%	13%	0.000
	Metropolitan (between 50,000 and 2.5 million persons)	40%	59%	40%	0.000
	Micropolitan (between 10,000 and 50,000 persons)	6%	10%	21%	0.000
	Rural (under 10,000 persons)	4%	8%	25%	0.000
Teaching Status					
	Council of Teaching Hospitals and Health Systems (COTH) membership	34%	21%	7%	0.000
Governance					
	Government	3%	9%	19%	0.000
	Nongovernment, Not-for-profit	94%	90%	75%	0.000
	Investor-owned, For-profit	4%	3%	11%	0.003
	Federal	0%	0%	0%	
Region					
	New England	4%	13%	5%	0.000
	Mid-Atlantic	30%	13%	12%	0.001
	South Atlantic	11%	12%	16%	0.243

	East North Central	23%	24%	18%	0.119
	East South Central	6%	4%	7%	0.291
	West North Central	15%	8%	15%	0.033
	West South Central	0%	12%	12%	0.030
	Mountain	8%	7%	6%	0.934
	Pacific	4%	9%	9%	0.423

Predicting ACO Participation

In order to explore the variables associated with ACO participation, univariate analyses were undertaken to model ACO participation as a factor of demographic and care coordination variables. Table 3 summarizes the statistically significant findings.

Table 3: Statistically Significant Univariate Correlates of ACO Participation

Category	Variable	Correlation Coefficient	p-value
Hospital Size			
	Total bed size	0.222	0.000
Region			
	New England	0.077	0.002
	Mid-Atlantic	0.048	0.049
	East North Central	0.049	0.043
	West North Central	-0.052	0.033
Hospital Control			
	Investor-owned/for-profit	-0.083	0.001
	Government, nonfederal	-0.140	0.000
	Nongovernment, not-for-profit	0.179	0.000
Urban Status			
	Division (>2.5 million persons)	0.162	0.000
	Metropolitan (between 50,000 and 2.5 million persons)	0.086	0.000
	Micropolitan (between 10,000 and 50,000 persons)	-0.101	0.000
	Rural (under 10,000 persons)	-0.146	0.000
Teaching Hospital Status			
	COTH membership	0.199	0.000
Hospital Centralization			
	Centralized health system	0.138	0.000
	Moderately centralized health system	0.114	0.000
	Independent health care system	-0.077	0.002
Care Coordination			

	Chronic care management	0.136	0.000
	Predictive analytic tools	0.085	0.001
	Prospective management of patients	0.062	0.012
	Case managers	0.075	0.002
	Medication reconciliation	0.056	0.022
	Provision of visit summaries	0.059	0.016
	Post-discharge continuity of care program	0.099	0.000
	Nurse case managers	0.086	0.000
	Disease management programs	0.121	0.000
	Hospitalists	0.183	0.000
	Telephonic outreach	0.088	0.000

Having found that many of the predictors examined were independently associated with ACO participation, it was deemed appropriate to undertake a logistic regression analysis to determine what factors remained significant following the addition of multiple control variables. This analysis revealed that relatively few factors proved to be statistically significant predictors of whether or not a hospital would opt to participate in an ACO. Significant predictors included teaching hospital status ($p< 0.01$) and the use of nurse case managers to improve the quality of outpatient care for patients with chronic disease ($p< 0.05$). Other factors—such as care coordination practices, geographic location, urban status, and hospital ownership—did not have a significant effect on ACO participation. These findings are not surprising considering the infancy of ACO development and our early understanding and hypotheses of the relevant factors for success. See table 4.

Table 4: Predicting ACO Participation

Category	Variable	Correlation Coefficient	p-value
Hospital Size			
	Total bed size	-0.001	0.096
Region	*reference=Pacific*		
	New England	-0.073	0.846
	Mid-Atlantic	0.416	0.299
	South Atlantic	0.348	0.311
	East North Central	0.010	0.972
	East South Central	-0.009	0.975
	West North Central	0.015	0.958
	West South Central	0.112	0.695
	Mountain	0.227	0.513
Hospital Control	*reference=investor-owned/for-profit*		
	Government, nonfederal	-0.074	0.666
	Nongovernment, not-for-profit	0.039	0.795
Urban Status	*reference=division (>2.5 million persons)*		

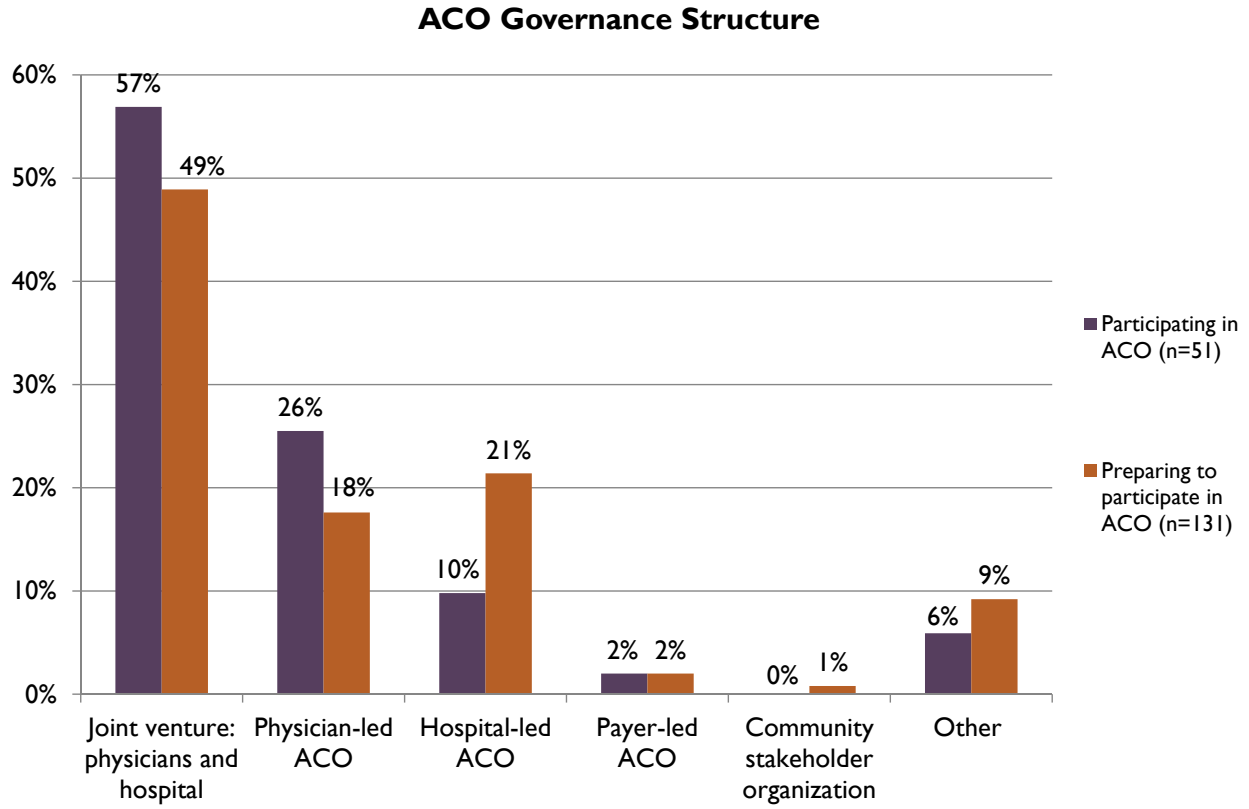
	Metropolitan (between 50,000 and 2.5 million persons)	-0.177	0.149
	Micropolitan (between 10,000 and 50,000 persons)	-0.226	0.122
	Rural (under 10,000 persons)	-0.036	0.859
Teaching Hospital Status			
	Council of Teaching Hospitals and Health Systems (COTH) membership	0.626	0.009
Hospital Centralization	*reference=independent hospital system*		
	Centralized health system	0.019	0.940
	Centralized insurance/physician system	0.138	0.673
	Moderately centralized health system	0.211	0.158
	Decentralized health system	-0.008	0.948
Care Coordination			
	Chronic care management	-0.017	0.893
	Predictive analytic tools	0.100	0.627
	Prospective management of patients	-0.107	0.553
	Case managers	-0.020	0.886
	Medication reconciliation	0.145	0.444
	Provision of visit summaries	0.085	0.427
	Post-discharge continuity of care program	-0.142	0.415
	Arrangement of home visits	-0.162	0.092
	Nurse case managers	0.375	0.015
	Disease management programs	0.177	0.157
	Hospitalists	0.133	0.296
	Telephone outreach	0.023	0.795

Governance Structure

ACOs are likely to encompass multiple health care providers, so organizational alignments will be critical for ACOs to better manage care across the full spectrum of services provided to their patients. As many ACOs are still in a formative stage, definitive lessons are lacking on how new ACO organizations can or should be structured.

Most hospitals participating in an ACO reported consisting of a joint venture between physicians and the hospital (57%). Other forms of ACO governance included the following: physician-led ACOs (26%), hospital-led ACOs (10%), payer-led ACOs (2%), and other forms (6%). No ACOs reported being part of a community stakeholder organization. Hospitals that are preparing to participate in an ACO indicated they will follow a similar pattern, but a greater percentage expect to participate in a hospital-led ACO (21%) than hospitals already participating in an ACO (10%). See figure 2.

Figure 2



Whether they are moving toward an ACO immediately or to an interim model (e.g., bundled payment, pay-for-performance, clinical integration), ACOs cannot succeed without strong physician involvement. Hospitals that already have strong collaborative relationships with their physicians and existing contractual alignment can leverage these arrangements to create structural and governance models that meet the federal requirements for an ACO. Table 5 indicates that hospitals participating in or hospitals preparing to participate in an ACO are currently using a variety of contractual arrangements.

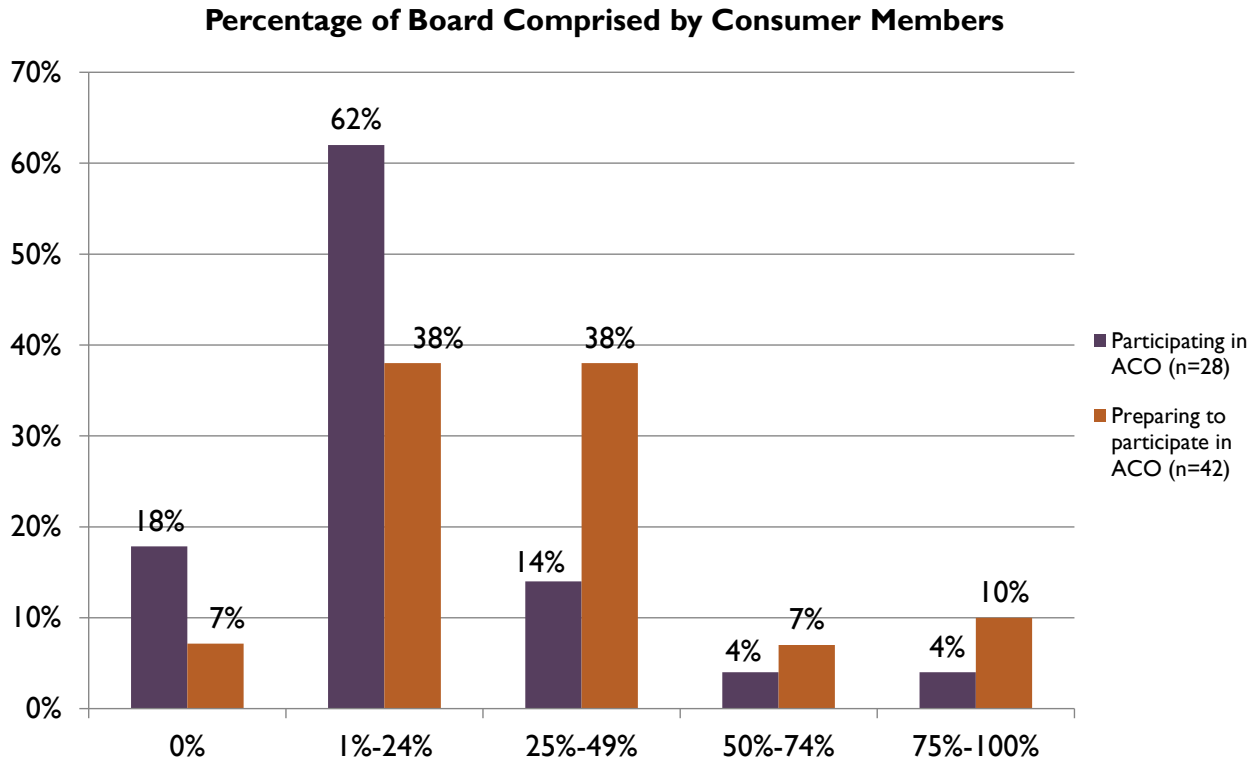
Table 5: ACO Physician Arrangements

Arrangement in which ACO Participates	Participating in ACO (n=30)	Preparing to Participate in ACO (n=133)
Independent practice association (A legal entity that holds managed care contracts and then contracts with physicians to provide care either on a fee-for-service or capitated basis)	13%	11%
Group practice without walls (A practice in which a hospital sponsors the formation of, or provides capital to physicians to establish, a group to share administrative expenses while remaining independent practitioners)	7%	8%
Open physician-hospital organization (PHO) (A PHO that is a joint venture between the hospital and all members of the medical staff who wish to participate)	17%	4%

Closed physician-hospital organization (PHO) (A PHO that restricts physician membership to those practitioners who meet criteria for cost effectiveness and/or high quality)	10%	11%
Management service organization (MSO) (A corporation, owned by the hospital or a PHO joint venture, that provides management services to one or more medical group practices)	3%	7%
Integrated salary model (A model in which physicians are salaried by the hospital or health system entity to provide medical services for primary and specialty care)	10%	9%
Equity model (An arrangement that splits the revenue stream of a physician practice, or a group of practices, into two components: the professional revenue used to compensate physicians working in the practice and the revenue generated to cover the practice's overhead)	20%	5%
Foundation (A model in which a corporation purchases both the tangible and intangible assets of one or more medical group practices. Physicians remain in a separate corporate entity but sign a professional services agreement with the foundation.)	7%	2%
Other	13%	3%

The Medicare Shared Savings Program (MSSP) also requires each ACO to include health care providers and at least one Medicare beneficiary representative on its governing board. Hospitals participating in an MSSP ACO lag behind hospitals preparing to join an ACO in consumer membership on their boards. While 18% of hospitals participating in an ACO do not have any consumer members on their boards, just 7% of the boards of hospitals preparing to participate in an ACO are absent consumer members (see fig. 3). It could be, however, that many of the ACOs reporting no consumer representation on their boards have contracts with private health insurers, and these private sector arrangements may not require consumer representation.

Figure 3



Legal Structures of ACOs

According to the Medicare Shared Savings Program rules and regulations, an ACO must have a formal legal structure that would allow the organization to receive and distribute payments for shared savings to participating providers of services and supplies. The ACO's legal entity may be structured in a variety of ways, including as a corporation, partnership, limited liability company, foundation, or other entity permitted by state law. An existing legal entity that meets the eligibility requirements to be an ACO need not form a separate entity to participate in MSSP.

Approximately one-third of ACOs are formed as corporations. An additional 23% are formed as limited liability corporations, and about one in ten are independent practice associations.

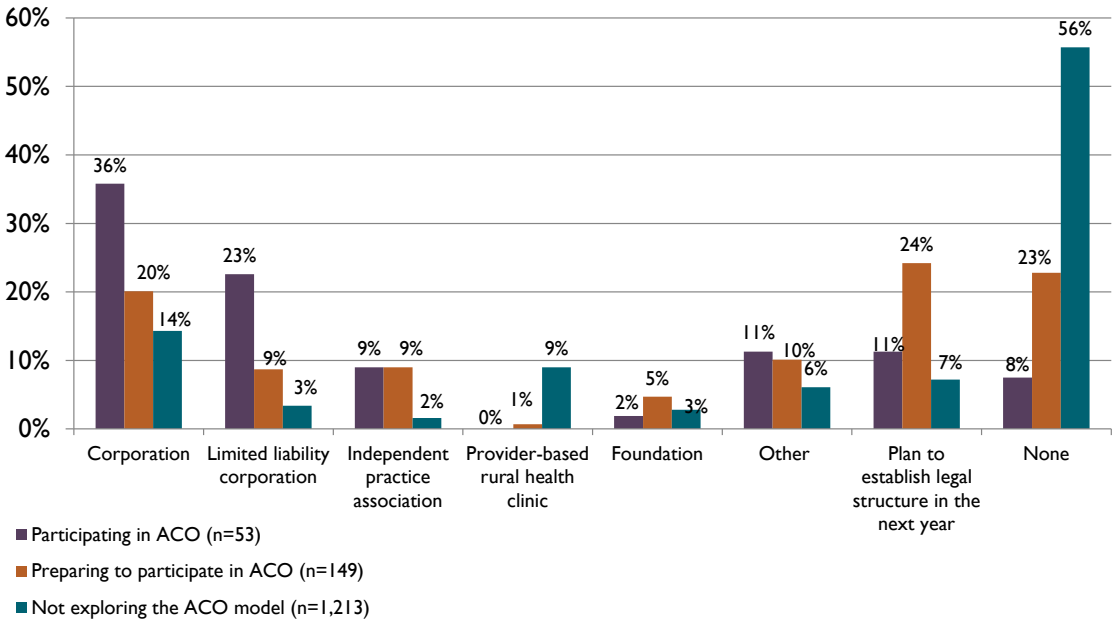
Eight percent (8%) of hospitals participating in an ACO have no current legal structure in place to receive and distribute payments to participating providers of care. It is important to note that there have been a number of private-sector efforts to form ACOs, initiated by physician-led health systems, integrated delivery systems, commercial payers, and other types of organizations. Rather than being noncompliant, some or all of the ACOs that do not have a legal structure may be commercial ACOs and therefore have different legal and organizational structure than those required by the Medicare Shared Savings Program.

Commercial ACOs are distinct from Medicare ACOs in that a commercial payer, rather than Medicare, is the entity providing the financial incentives for quality and cost performance to the provider organizations.

More than half (56%) of hospitals not exploring the ACO model and 23% of hospitals preparing to participate in an ACO have no legal structure in place to receive and distribute payments to participating providers of care. Of those that do have a legal structure, the preferred structured is a corporation (14% and 20%, respectively). See figure 4.

Figure 4

Type of Legal Structure in Place to Receive and Distribute Payments



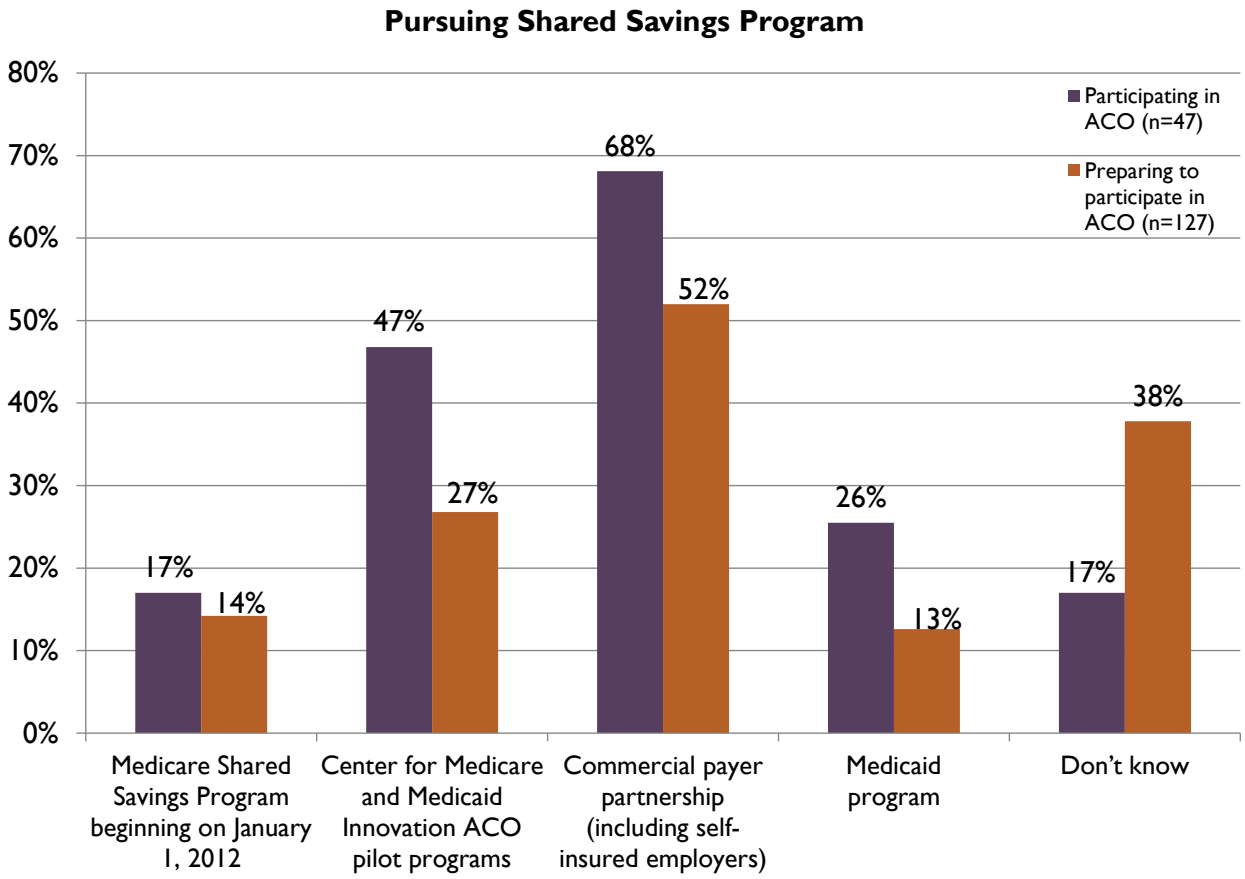
Ability to Take on Financial Risk

Providers and payers recognize that for ACOs to reach their potential there is a need for payment models other than the fee-for-service approach dominant today. As the new ACOs form, payers are establishing shared-savings programs and other payment models in an effort to create financial incentives for high-quality care.

Much of the attention in the health care reform discussion so far has centered on Section 3022 of the Patient Protection and Affordable Care Act—the Medicare Shared Savings Program, which will provide funding for accountable care organizations. A second pathway for funding will come in the new Center for Medicare and Medicaid Innovation, which will provide more flexible pathways for ACO development. However, some of the most promising efforts are coming not from the federal government but from the private sector, where clinically integrated care delivery organizations and private health insurance providers are beginning to put "value-based" contracting into place. These contracts are designed to ensure that patients receive safe, effective care and that employers and employees benefit by making premium increases more predictable and adjusted for inflation. New payment models are emerging which combine fee-for-service and performance-based payment components that make providers responsible—and reasonably compensated—for the total cost of care as well as health care quality.

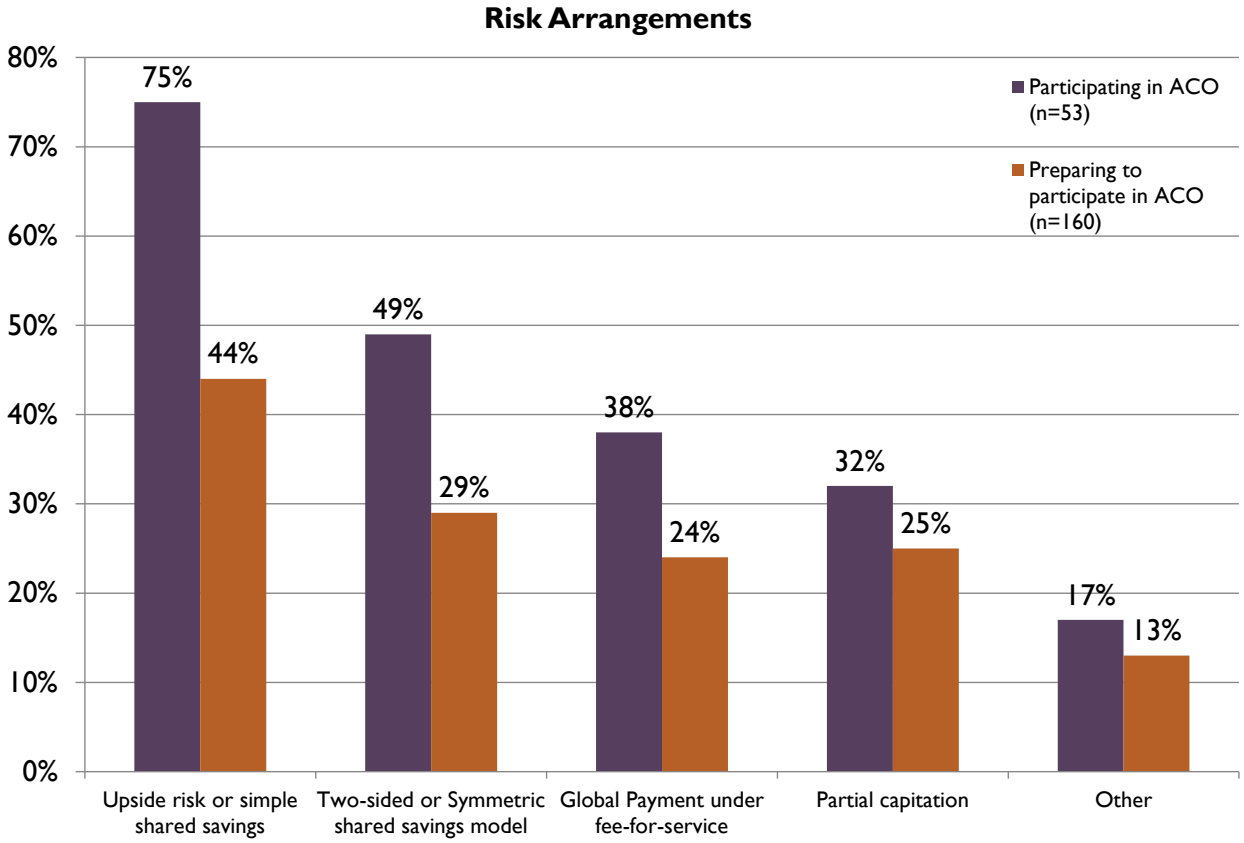
The majority of hospitals participating in an ACO (68%) and hospitals preparing to participate in an ACO are actively planning to pursue a commercial payer partnership. Forty-seven percent (47%) of hospitals participating in an ACO and 27% of hospitals preparing to participate in an ACO are pursuing becoming part of the CMS Innovation ACO pilot program. Fewer hospitals participating in an ACO and hospitals preparing to participate in an ACO (26% and 13%, respectively) will pursue payment under the Medicaid program. In addition, at the time of the survey, less than one-fifth of hospitals participating in an ACO and hospitals preparing to participate in an ACO were actively pursuing the Medicare Shared Saving Program. See Figure 5.

Figure 5



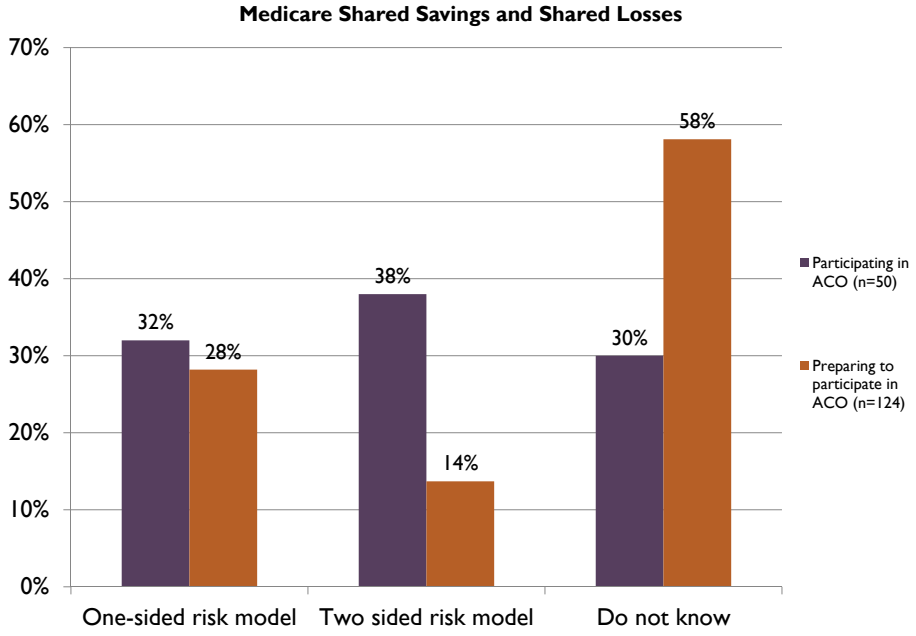
Respondents were asked what kind of risk arrangements they anticipated the ACO contract would specify at any point during the next three years. A large portion of ACO hospitals (78%) indicated they would be pursuing an upside risk or simple shared savings model in which the ACO receives a share of savings when actual spending is below the total cost of care target, but is not at risk for losses if spending exceeds the total cost of care target. Fewer reported pursuing a two-sided symmetric shared shavings model (51%), a global payment fee-for-service model, or some other risk arrangement model. Almost two-fifths of hospitals participating in an ACO and a little less than one-third of hospitals preparing to participate in an ACO expect to choose partial capitation as a payment method (defined as an arrangement in which highly integrated care systems would assume the full financial risk of providing some range of Medicare services in return for a fixed monthly payment per beneficiary). See figure 6.

Figure 6



Under a shared saving program, ACOs may select to operate using one of two risk models during the first three years. A slightly higher percentage of hospitals participating in an ACO are choosing the two-sided risk model instead of the one-sided model (38% vs. 32%). Hospitals preparing to participate in an ACO expect to choose the one-sided model by a 2-to-1 margin (28% vs. 14%). See figure 7.

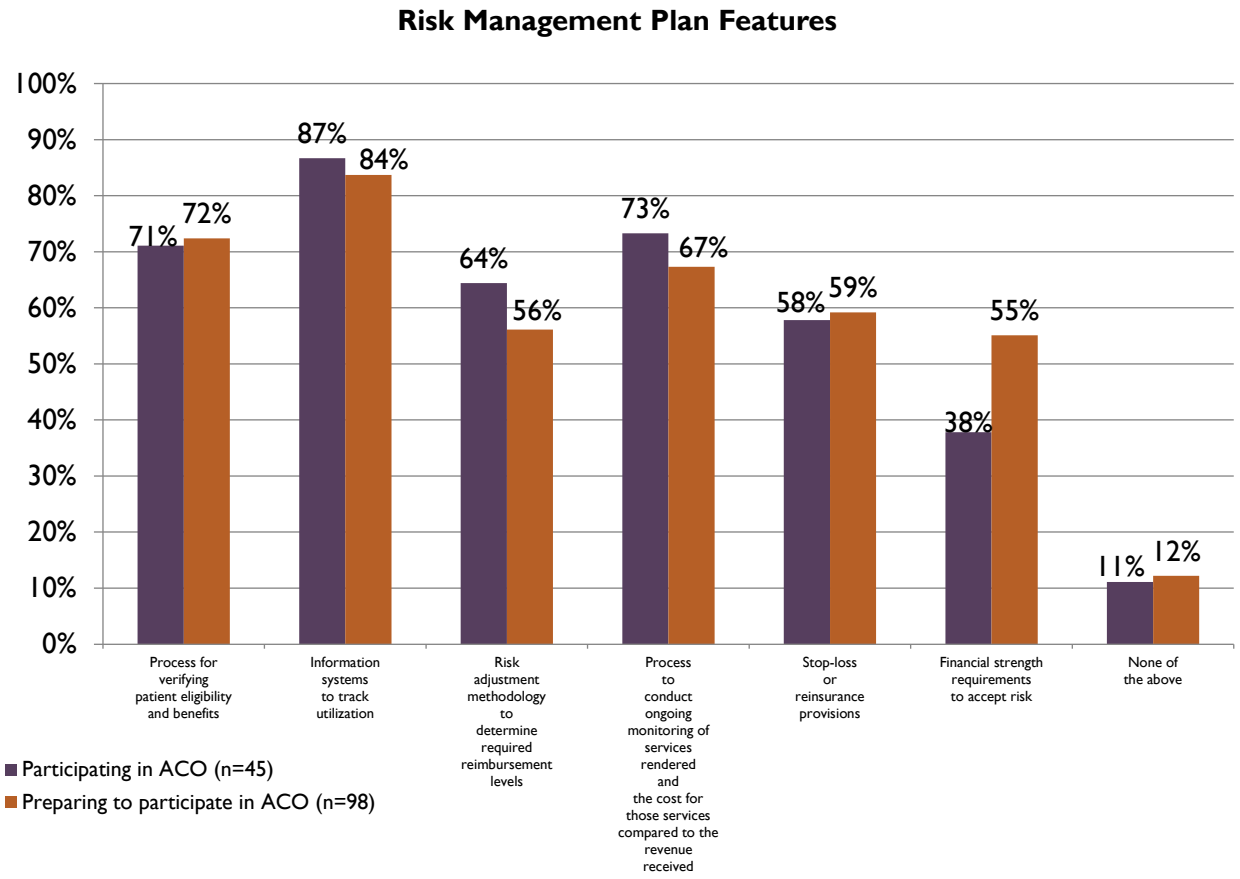
Figure 7



Approximately one in ten hospitals participating in or preparing to participate in an ACO do not have a financial risk management plan in place. Almost two-fifths of hospitals participating in an ACO and over half of hospitals preparing to participate in an ACO do not feel they have the financial strength requirements to accept risk. Both groups of hospitals are doing much better, however, in terms of providing other infrastructure features to manage under a risk management plan.

Health Information Technology (HIT) seems to be the strongest feature, its use reported by 87% of ACO hospitals and 84% of hospitals working to join an ACO. About seven in ten hospitals in both groups have a process for verifying patient eligibility and benefits. And 73% of ACO hospitals and 67% of hospitals working to join an ACO have a process to monitor services rendered along with the cost for those services compared to the revenue received. See figure 8.

Figure 8



ACO Payment Models

As many providers and payers prepare to participate in ACOs, there has been minimal information on what payment models ACOs have been using. This report summarizes the risk models used, the payment structures that current revenues are derived from, expected revenue sources in the future, and plans to participate in bundled payment arrangements.

Payment Structures

All hospitals expect a significant increase in revenue sources from risk-based payment arrangements such as bundled payments for hospital and physician services. Bundled payments are expected to increase by 6% for both hospitals participating in an ACO and hospitals not exploring the ACO model, and 9% for hospitals preparing to participate in an ACO in two years. Capitation is expected to increase by 10% for hospitals participating in an ACO, 4% for hospitals preparing to participate in an ACO, and 3% for hospitals not exploring the ACO model. See table 6.

Table 6: Mean Percentage of Net Patient Revenue and Expected Revenue in 2 Years by Payment Mechanism

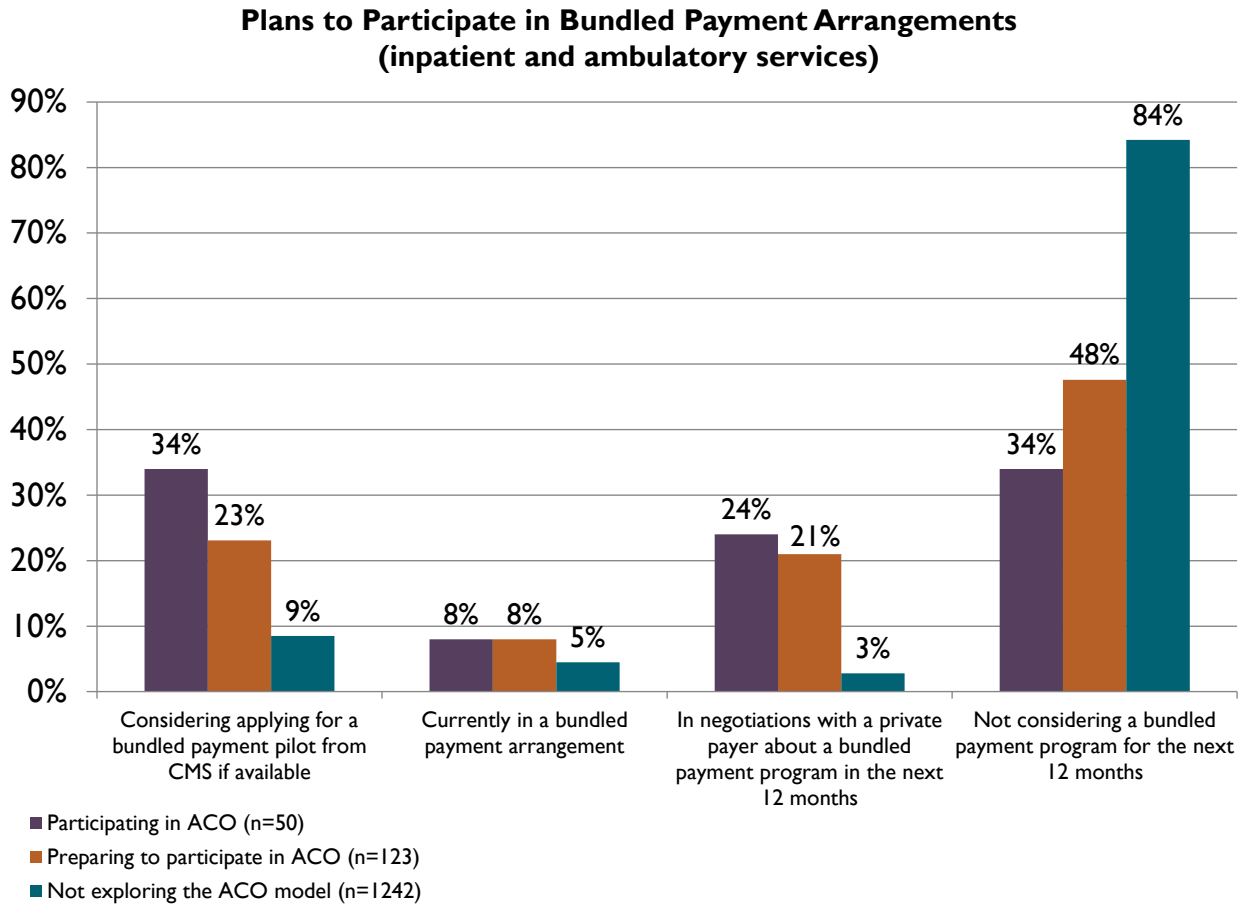
	Participating in ACO Year 1 (n=53)	Participating in ACO Year 3 (n=53)	Change	Preparing to Participate in ACO Year 1 (n=160)	Preparing to Participate in ACO Year 3 (n=160)	Change	Not Exploring the ACO Model Year 1 (n=1,255)	Not Exploring the ACO Model Year 3 (n=1,255)	Change
Fee-for-service —DRG	70%	56%	-14%	64%	55%	-9%	61%	57%	-4%
Fee-for-service —Per Diem	18%	14%	-4%	27%	22%	-5%	36%	34%	-2%
Fee-for-Service plus Shared Savings	7%	19%	12%	10%	19%	9%	10%	12%	2%
Bundled Payments (Inpatient plus Physician)	3%	9%	6%	4%	13%	9%	4%	10%	6%
Partial and Global Capitation Payments	9%	19%	10%	7%	11%	4%	5%	8%	3%

Pursuit of Bundled Payments

The bundled payment methodology carries potentially greater economic risk for an ACO than does a shared savings arrangement. It may also create a greater potential upside opportunity if the ACO is appropriately structured to reap the rewards of the bundled rate methodology. Under a bundled payment arrangement, the ACO accepts the downside risk that costs of treating the patient will exceed the bundled payment. To the extent an ACO includes providers that span the continuum of complete services for a patient with a particular medical condition, and the ACO has sufficient control or management of its participating providers, the ACO may be positioned to consider assuming the risk and potential reward from accepting bundled payments for an episode of care.

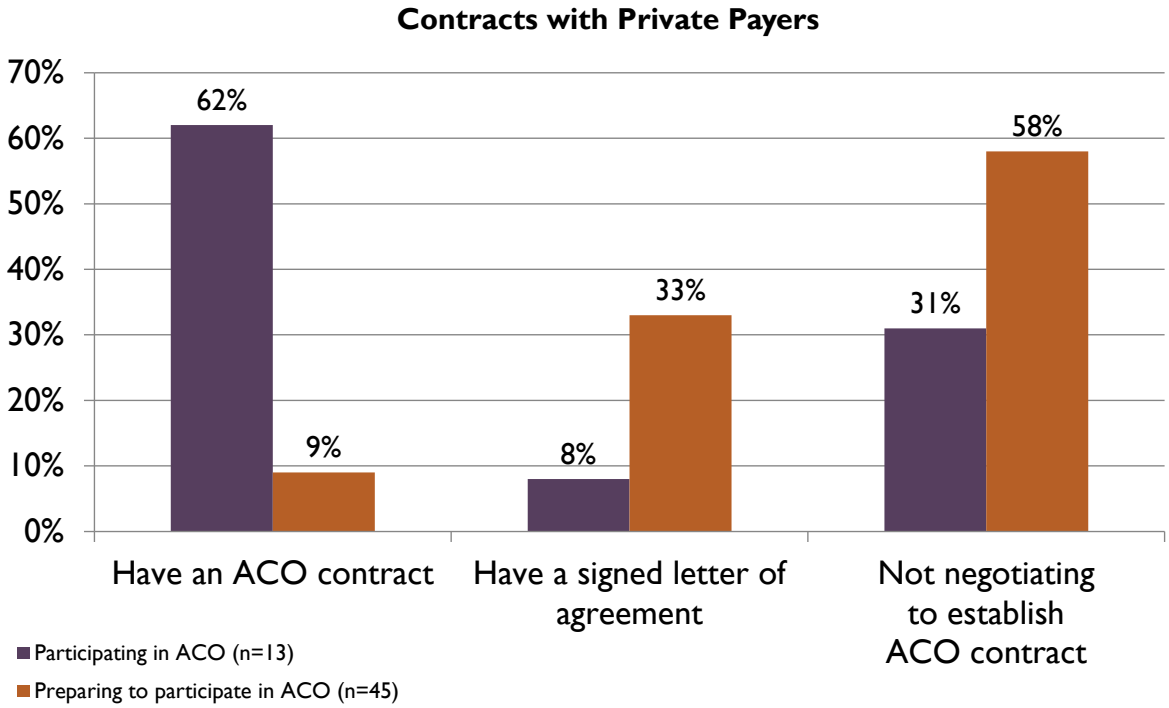
Overall, a large portion of hospitals did not have plans to participate in bundled payment arrangements (32% of ACO hospitalss, 43% of hospitals working to join ACOs, and 77% of non-ACO hospitals), while fewer hospitals were considering applying for a bundled payment pilot from CMS if available (32%, 21%, and 8%, respectively). In general, ACOs and hospitals working to join ACOs were more likely to be participating in or considering participation in bundled payment arrangements than non-ACOs (62%, 47%, and 15%). See figure 9.

Figure 9



Recognizing that new payment models are inevitable and faced with uncertainty about the relative benefits and risks of participation in federal programs, providers are exploring (or have established) ACO contracts with private payers. Seventy percent (70%) of hospitals participating in an ACO either have an ACO contract with a private payer or a signed letter of agreement, while 42% of hospitals preparing to participate in an ACO have done so (see fig. 10). It is unclear how hospitals are participating in an ACO without a private payer contract. Perhaps they are part of a public demonstration or pilot project. They could also be payer-owned systems, or they could be working with physician groups as an ACO without a formal arrangement.

Figure 10



In order to bring providers together under a single organization and have them coordinate care, improve quality, and lower costs, some ACOs provide monetary incentives to practitioners based on quality indicators, patient satisfaction, or cost/efficiency indicators. Approximately two-thirds of ACO hospitals are currently providing incentives based on each of these indicators. About half of the hospitals working to join an ACO are providing incentives based on clinical and patient satisfaction indicators, and a third of them are providing incentives based on cost and efficiency indicators. Ninety-seven percent (97%) to 100% of the hospitals participating or preparing to participate in an ACO are either currently providing or planning to provide incentives based on these indicators. See table 7.

Table 7: Performance Incentives

	Clinical Quality Indicators		Patient Experience/ Satisfaction Indicators		Cost/Efficiency Indicators	
	Participating in ACO	Preparing to Participate in ACO	Participating in ACO	Preparing to Participate in ACO	Participating in ACO	Preparing to Participate in ACO
Currently provide incentives	60%	53%	58%	50%	57%	33%
Planning to provide incentives	38%	44%	40%	48%	43%	65%
Not planning to provide incentives	2%	3%	2%	2%	0%	2%
Total	100%	100%	100%	100%	100%	100%

Partnership and Ability to Provide Primary, Acute, and Post-Acute Care

To reach the triple aim, ACO hospitals will need to consider delivering the right care at the right time and in the right place. This may require shifting care away from expensive venues—particularly the emergency room and hospital—to primary care and ambulatory care settings when appropriate. Regardless of whether the new payment model is shared cost savings (utilization risk) or full capitation (financial risk), ACOs will not be successful unless they have adequate primary care physicians and nurse practitioners who are capable of managing care across the continuum.

Overall, hospitals participating in an ACO provide more primary care services (96%) than either hospitals preparing to participate in an ACO (88%) or hospitals not exploring the ACO model (93%) (see table 8).

Table 8: Provision of Health Care Services

Health Care Service	Owned or Provided by Hospital or Provided by Network or Through Contractual Arrangement of Joint Venture in Community			Not Provided		
	Participating in ACO	Preparing to Participate in ACO	Not Exploring the ACO Model	Participating in ACO	Preparing to Participate in ACO	Not Exploring the ACO Model
Primary care	96%	88%	93%	4%	12%	7%

On average, hospitals participating in an ACO are providing more post-acute care services than hospitals preparing to participate in an ACO and hospitals not exploring the ACO model. The area that needs most attention is probably in providing post-acute-care skilled nursing since about one-third of all the hospital groups do not provide these services (see table 9).

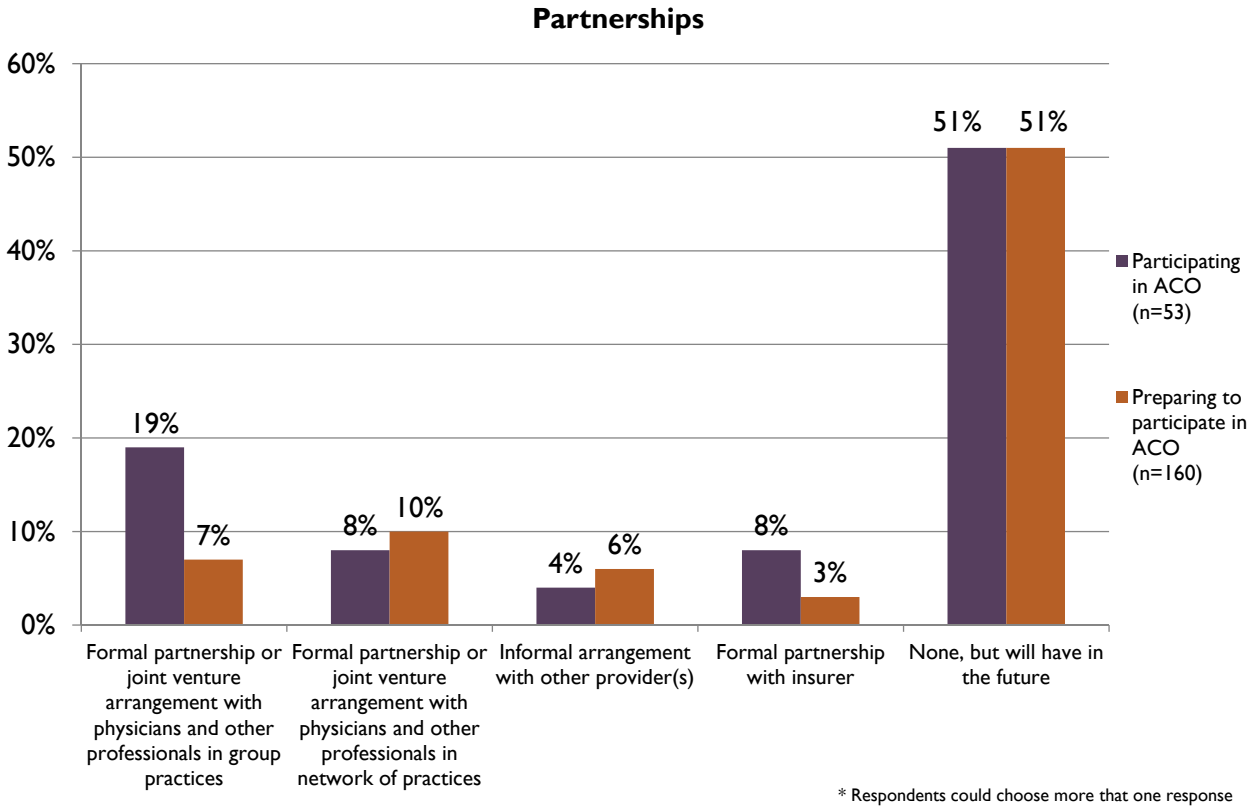
Table 9: Post-acute Care Services

Health Care Service	Owned or Provided by Hospital			Provided by Network or through Contractual Arrangement of Joint Venture in Community			Not Provided		
	Participating in ACO	Preparing to Participate in ACO	Not Exploring the ACO Model	Participating in ACO	Preparing to Participate in ACO	Not Exploring the ACO Model	Participating in ACO	Preparing to Participate in ACO	Not Exploring the ACO Model
Rehabilitation care	25%	15%	20%	68%	62%	68%	8%	23%	12%
Home health	49%	38%	46%	36%	29%	36%	15%	33%	18%
Skilled nursing	30%	48%	30%	40%	18%	36%	30%	34%	34%
Palliative/hospice care	74%	43%	63%	23%	30%	22%	4%	28%	16%

In the early stages of developing ACOs, the organizations can capitalize on existing provider relationships and develop new partnerships with community health providers. Most newly formed ACOs have only limited experience integrating care with that provided by skilled nursing facilities, assisted living facilities, home health agencies, or behavioral health providers, and this may prove challenging as organizations attempt to coordinate care and hold down costs.

Slightly less than one-half of hospitals belonging to or intending to form an ACO reported having already partnered with another entity that has established or is establishing an ACO (49%). This percentage will likely grow, as many hospitals plan to enter into such a partnership in the future (51%). See figure 11.

Figure 11



Care Management

A successful ACO will possess advanced care coordination capabilities through all facets of the patient's care beyond the primary care physician. Specialty care providers, home health agencies, ambulatory care providers, and acute care facilities should all play an active role in the patient's care management and accountability for outcomes. High-quality, well-coordinated care management is anchored by close relationships among all care providers and is focused on reducing costs through clinical integration. It must be a patient-centered, evidence-based care model adopted by all medical practices for maximum effectiveness. Best practices for care are shared, discussed, and monitored across the virtual network, supported by rigorous reviews and the establishment of clear links between quality measures and reimbursement.

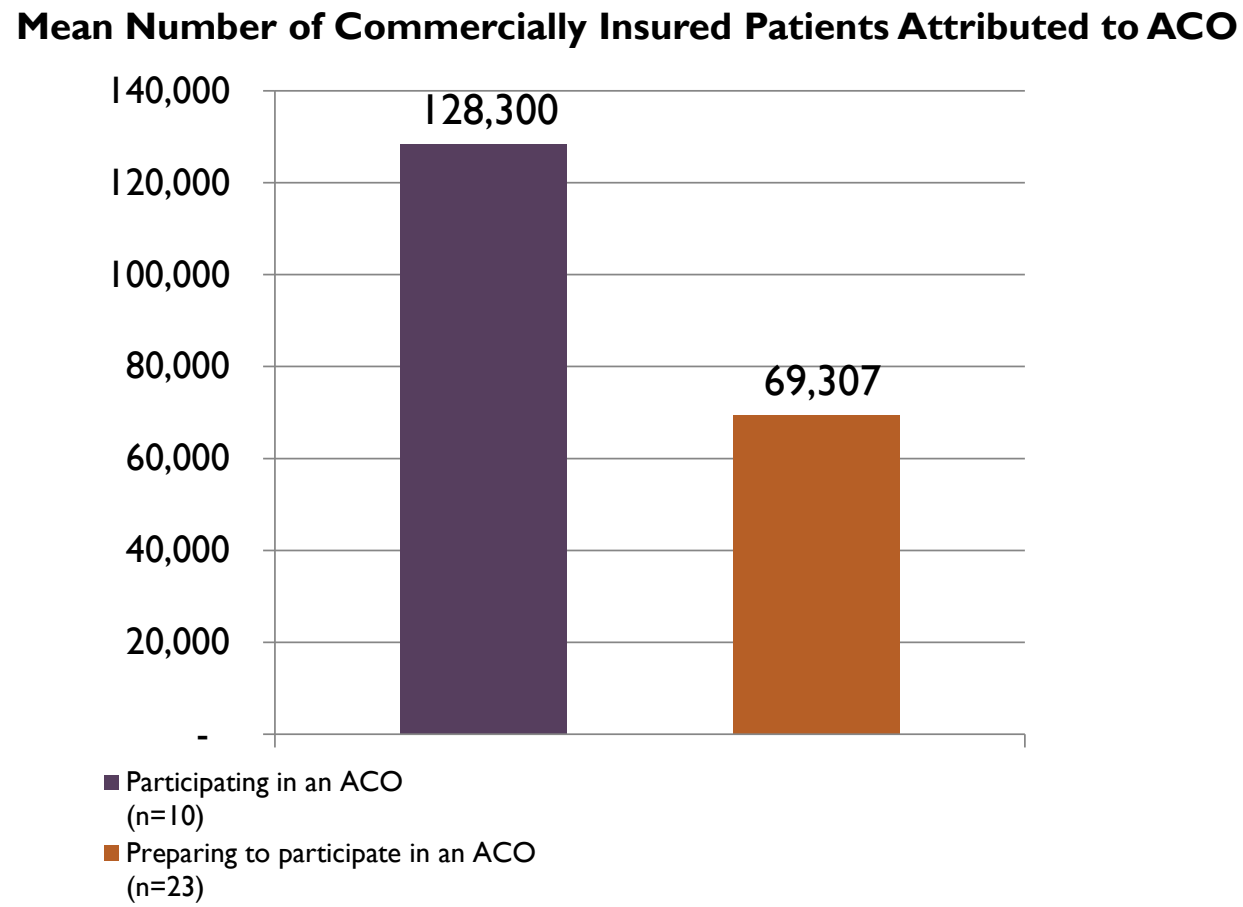
Patient Population Identification and Assignment

Under the final rule for the Medicare Shared Savings Program, a group of providers and suppliers of services agree to work together with the goal that patients get the right care at the right time in the right setting. ACOs are envisioned to be responsible for the full continuum of care for a defined population. To make an impact on cost and performance measurement, ACOs must have a sizable patient base. The final rule requires that each group of providers be held accountable for at least 5,000 Medicare beneficiaries annually for a period of three years.

Hospitals participating in an ACO have, on average, more than 128,000 commercially insured patients attributed to the ACO. Hospitals preparing to participate in an ACO have a patient population of 69,000

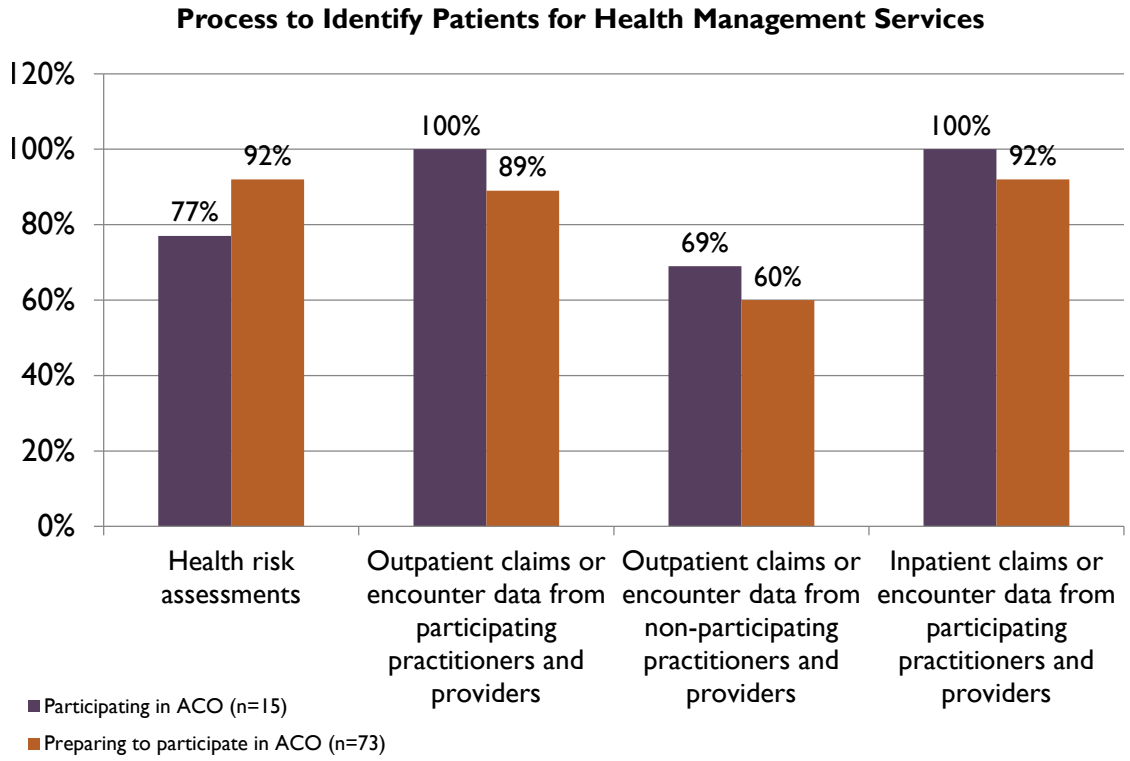
patients. Since approximately 17% of the U.S. population is eligible for Medicare, hospitals in each of these groups should have sufficient numbers of Medicare patients to meet the Medicare Shared Savings Programs beneficiary requirements. See figure 12.

Figure 12



ACO hospitals indicated several processes through which they identify patients who are eligible to receive population health management services. These processes included the use of health risk assessments (77%); the use of outpatient claims or encounter data from participating practitioners and providers (100%); the use of outpatient claims or encounter data from nonparticipating practitioners and providers (69%); and the use of inpatient claims or encounter data from participating practitioners and providers (100%). See figure 13.

Figure 13



Approximately 27% of the ACOs indicated that they have an explicit process to identify their patient population. Of these, 50% base their population estimates on the volume of patient panels of affiliated providers, 14% on demographic information, and 7% on enrollment in a program (See fig. 14.) It is also notable that 67% of responding hospitals participating in an ACO report categorizing patients according to their health care needs, while 51% of hospitals preparing to participate in an ACO do so (see fig. 15).

Figure 14

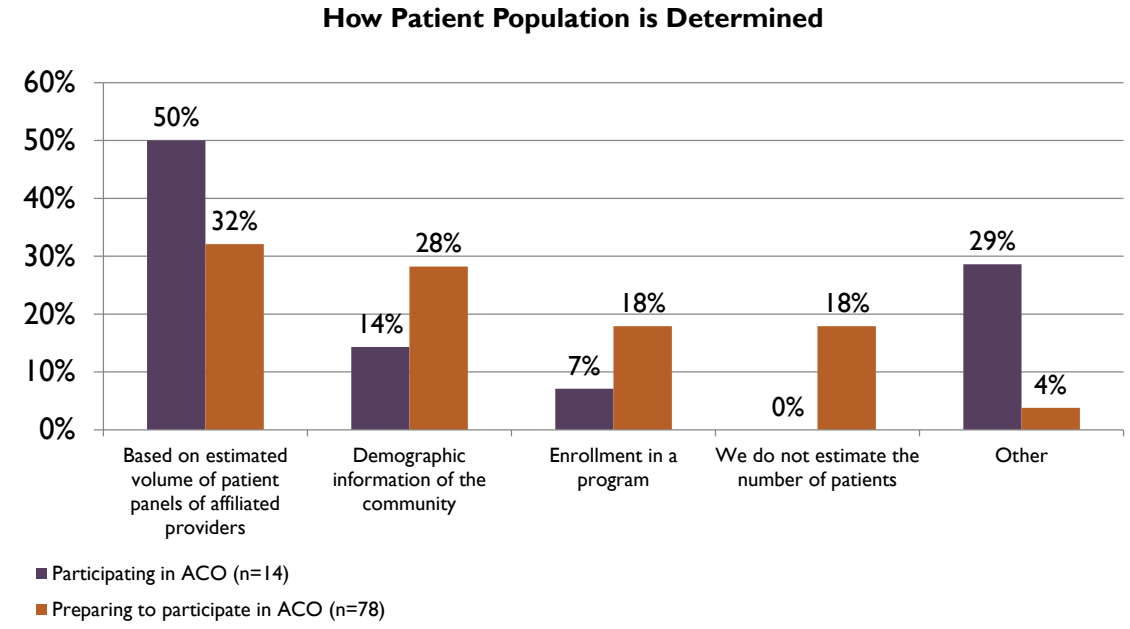
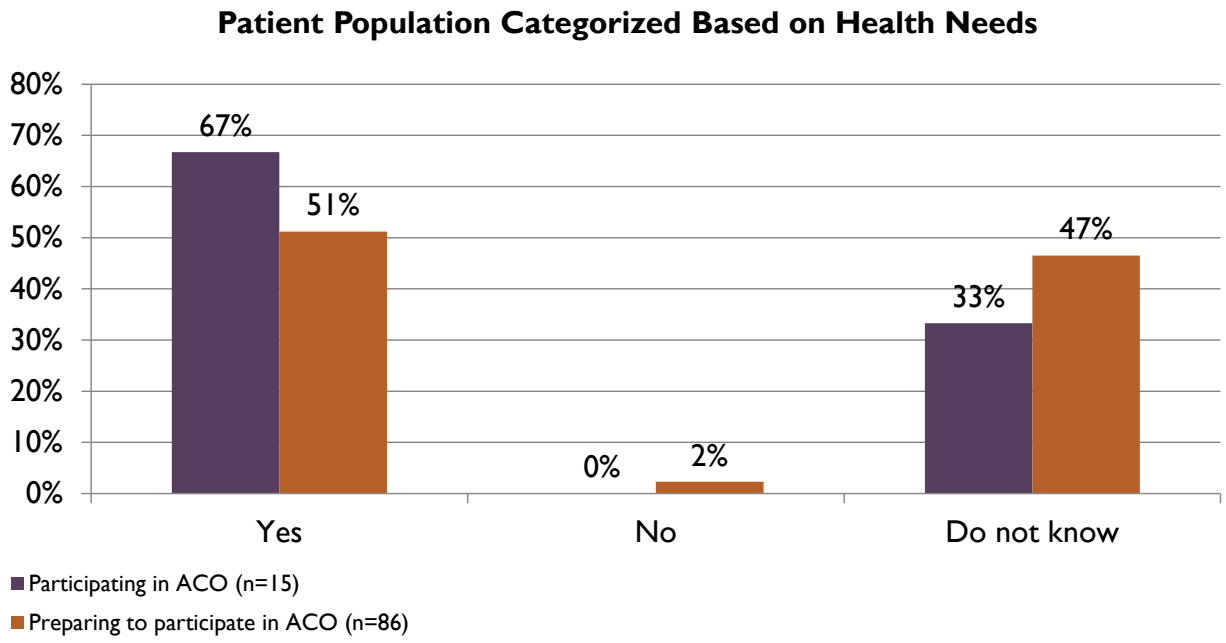


Figure 15



Population Management

ACOs are expected to create a shift from a volume-based reimbursement model to one based on quality and efficiency. The ACO model includes some degree of financial responsibility—or accountability—on the part of the practice. When Medicare and some private payers begin to contract with ACOs, they will initially reward these organizations on the basis of shared savings. However, in the future there may be other reimbursement methods, including prepayment models such as partial and full capitation. Capitation, or prepayment, is a fixed monthly payment for a defined set of services for each patient assigned to the practice. Unlike volume-based reimbursement, it encourages the provision of more care.

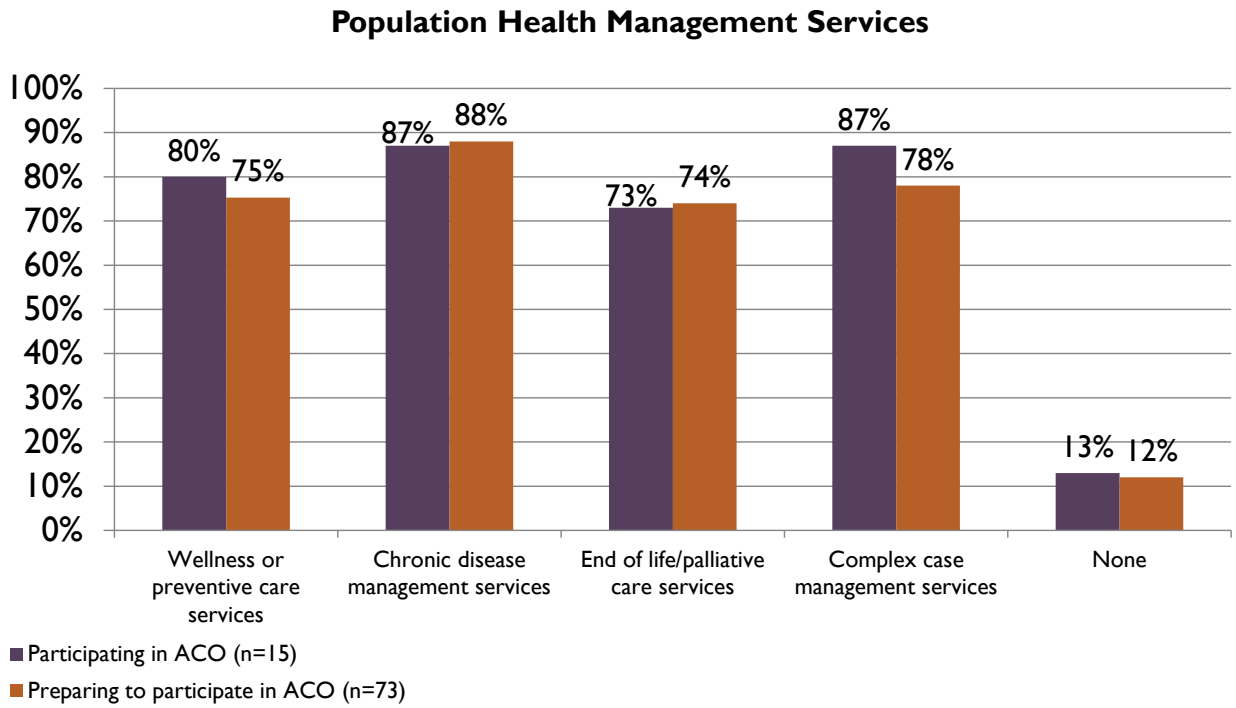
ACOs represent a shift to population health management, which will require an entirely different way of looking at health care. At the individual practice level, most physicians have not adopted prevention-oriented population health in their current model of health care delivery. Traditionally, physicians have mostly been involved in the treatment of acute problems; managing these problems consumes much of the patient visit, leaving little time for the physician to address preventive and chronic care needs. In an ACO practice, however, attention must shift to the management of all patients in a practice across the entire spectrum of health, from those who are well to those with the most complex conditions, including individuals at the end of life.

In addition, payment bundling (including partial and full cap or global budgeting approaches) and shared savings—two potential payment models for ACOs—also require the improvement of population health. Providers will need to switch their emphasis from merely treating sickness to also maintaining or improving health to prevent costly avoidable illnesses and unnecessary care. If physician groups aim to succeed as ACOs or ACO members, they will have to move to a population health management approach that is aligned with the new reimbursement models.

ACOs must appropriately allocate resources to ensure patients receive needed care. A management plan can help organizations manage financial resources efficiently. Hospitals participating in and preparing to participate in an ACO report having been involved in a variety of health management services, including wellness or preventive care services (80% vs. 75%), chronic disease management services (87% vs. 88%), end-of-life/ palliative care services (73% vs. 74%), and complex case management services (87% vs. 78%).

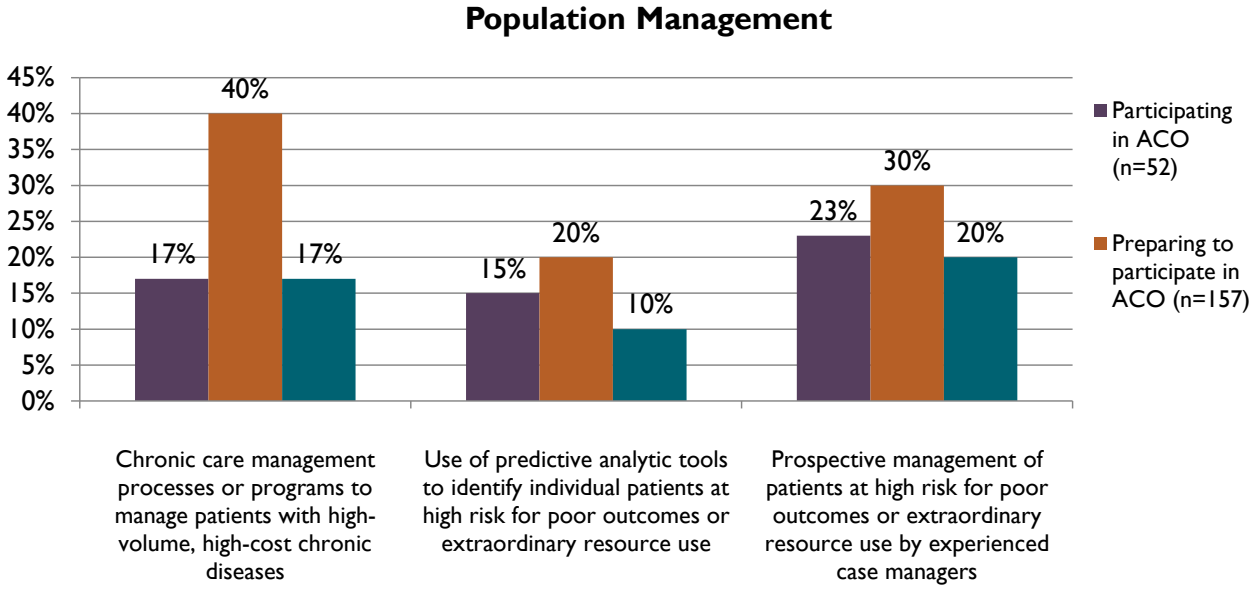
Only a small proportion of hospitals (13% vs. 12%) did not report involvement in any such health management activities. See figure 16.

Figure 16



Population health management also includes care management for the segment of patients that are high risk for poor outcomes or chronic disease. Population management programs aimed at coordination of care among providers are apparently underutilized by hospitals. Hospitals preparing to participate in the ACO model are twice as likely to use chronic care management processes or programs to manage patients with high-volume, high-cost chronic diseases than hospitals participating in or not exploring the ACO model (40%, 17% and 17%, respectively). Hospitals preparing to participate in the ACO model are also more likely to use predictive analytic tools to identify individual patients at high risk for poor outcomes or extraordinary resource use (20%) than hospitals participating in an ACO (15%) or hospitals not exploring the ACO model (10%). And between one-fifth and one-third of hospitals are prospectively managing patients at high risk for poor outcomes or extraordinary resource use by experienced case managers (20% of non-ACO hospitals, 23% of hospitals working to join an ACO, and 30% of ACO hospitals.) See figure 17.

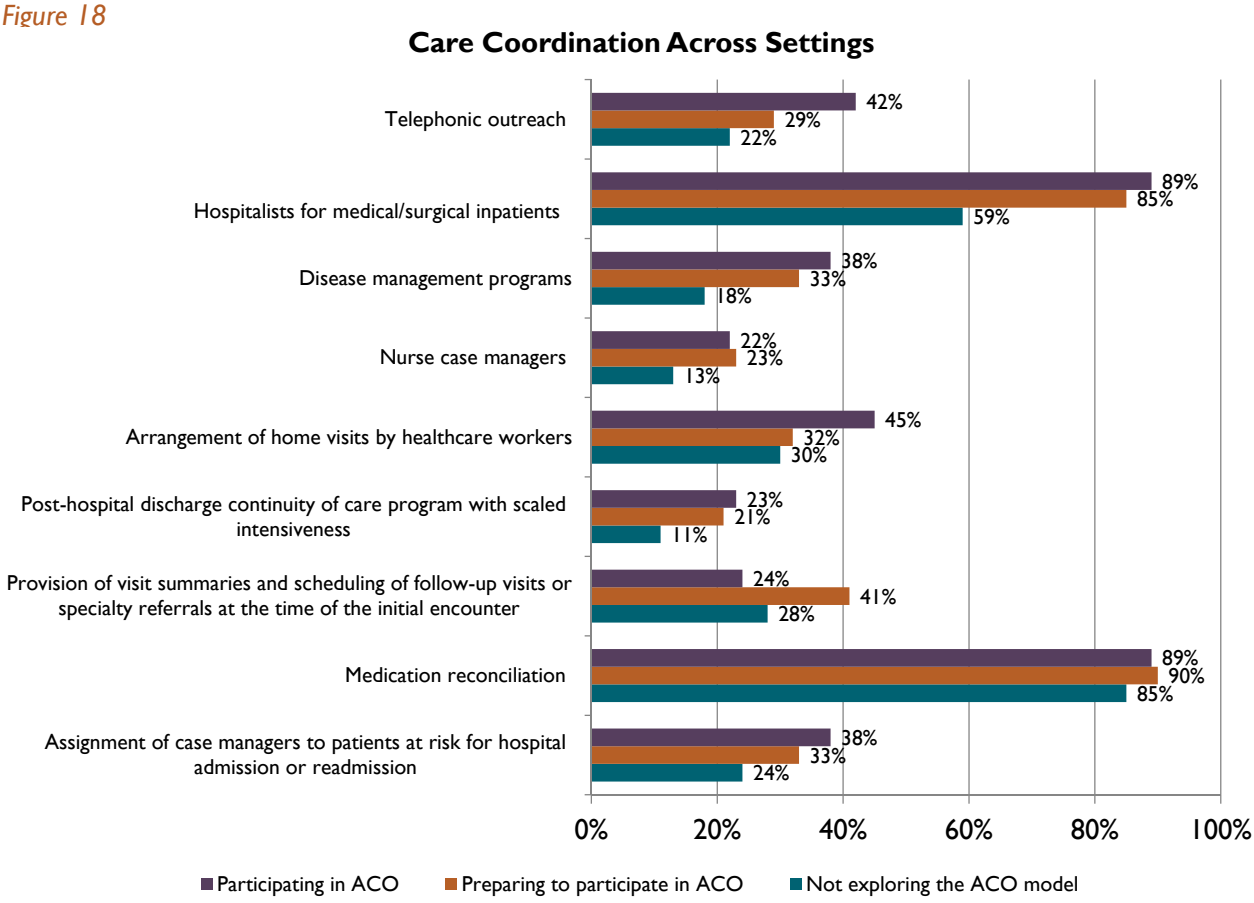
Figure 17



Care Coordination and Transitions

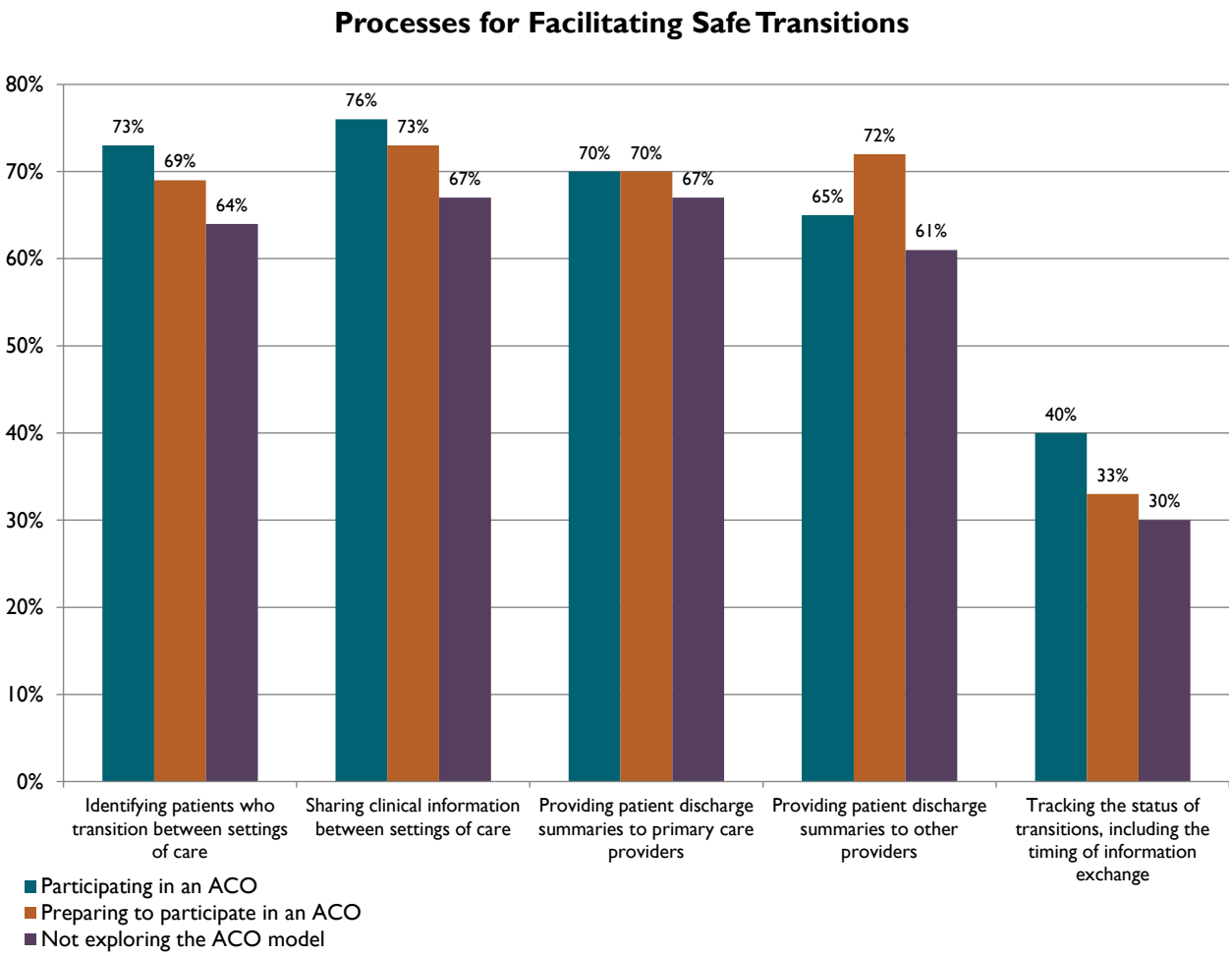
The survey instrument listed nine care coordination activities. Results are reported for activities that were widely used or used hospital-wide. The results indicate that although a high percentage of hospitals reconcile medications as part of an established plan of care (89% of hospitals participating in an ACO, 90% of hospitals preparing to participate In an ACO, and 85% of hospitals not exploring the ACO model), there is a low use of risk stratification and other care coordination activities. For example, only 38% of hospitals participating in an ACO, 33% of hospitals preparing to participate in an ACO, and 24% of hospitals not exploring the ACO model assign case managers to patients at risk for hospital admission or readmission for outpatient follow-up. Less than one-quarter of the hospitals in each group have nurse case managers who work with patients with chronic diseases. Similarly, 23% of hospitals participating in an ACO, 21% of hospitals preparing to participate in an ACO, and 11% of hospitals not exploring an ACO model have a post–hospital discharge continuity of care program with scaled intensiveness based upon a severity or risk profile for adult medical-surgical patients in defined diagnostic categories or severity profiles.

Figure 18



Hospitals are also involved in a number of processes to facilitate safe transitions. Between 61% and 76% of hospitals have a standardized process for: identifying patients who transition between settings of care; sharing clinical information between settings of care; providing patient discharge summaries to primary care providers; and providing patient discharge summaries to other providers. Two-fifths of hospitals participating in an ACO and 33% of hospitals preparing to participate in an ACO track the status of transitions, including the timing of information exchange, while 30% of hospitals not exploring the ACO model do so. See figure 19.

Figure 19



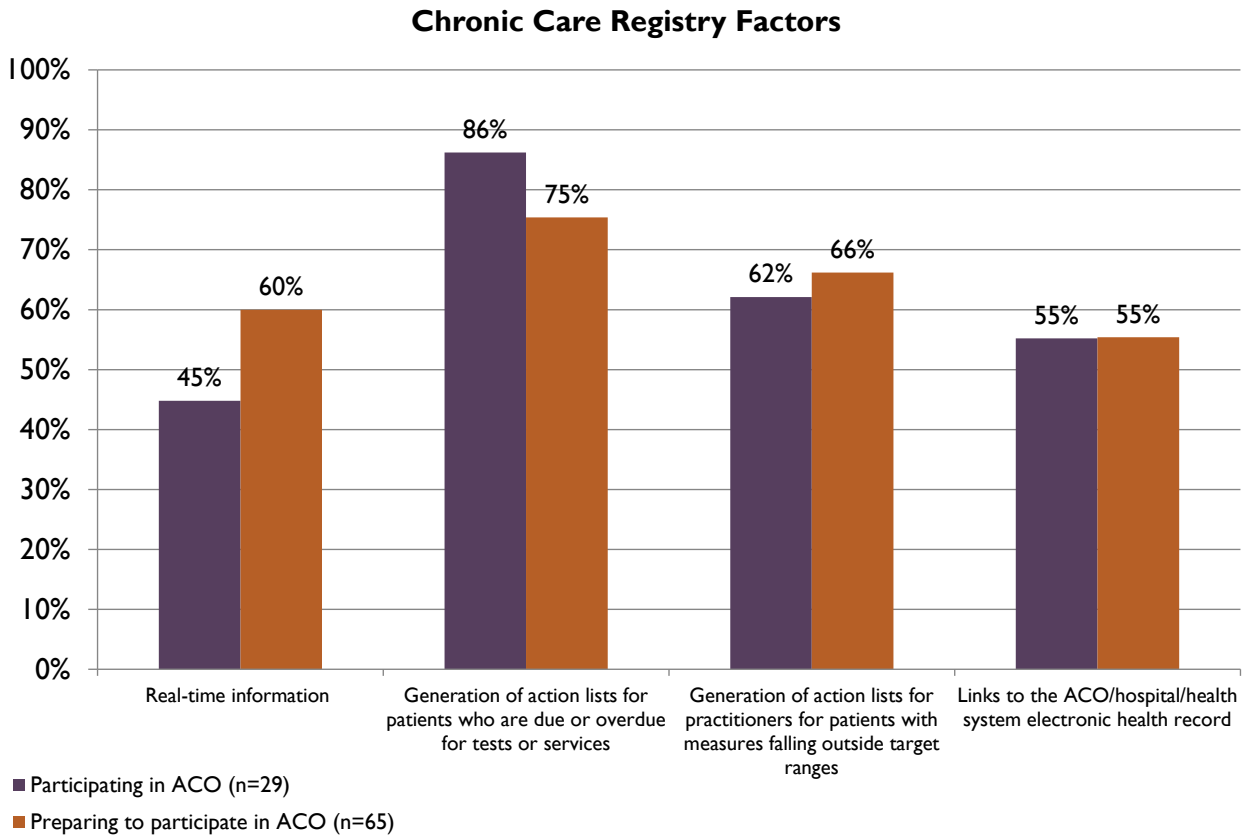
Under the proposed Medicare Shared Savings Program, ACO providers should be able to electronically exchange summary of care information when patients transition to another provider or setting of care, both within and outside the ACO, consistent with meaningful use requirements under the EHR incentive program.

Electronic registries also are essential to ACOs because they enable providers to manage the health of their populations. Registries let providers keep track of patients' health status as well as which patients need particular preventive and chronic care services. Driven by clinical protocols, registries help providers perform patient outreach and can trigger alerts at the point of care.

For example, each day, hospital staff members can run reports on patients scheduled for appointments the following day. The reports check multiple registries—such as pharmacy, laboratory, electronic health record, oncology, chronic disease, and preventive care—to identify gaps in care that physicians can address during the upcoming office visit.

Approximately one-third of hospitals participating in an ACO and hospitals preparing to participate in an ACO have no chronic care registry. About one-fifth have a registry for one condition, and two-fifths have a registry for two conditions. See figure 20.

Figure 20

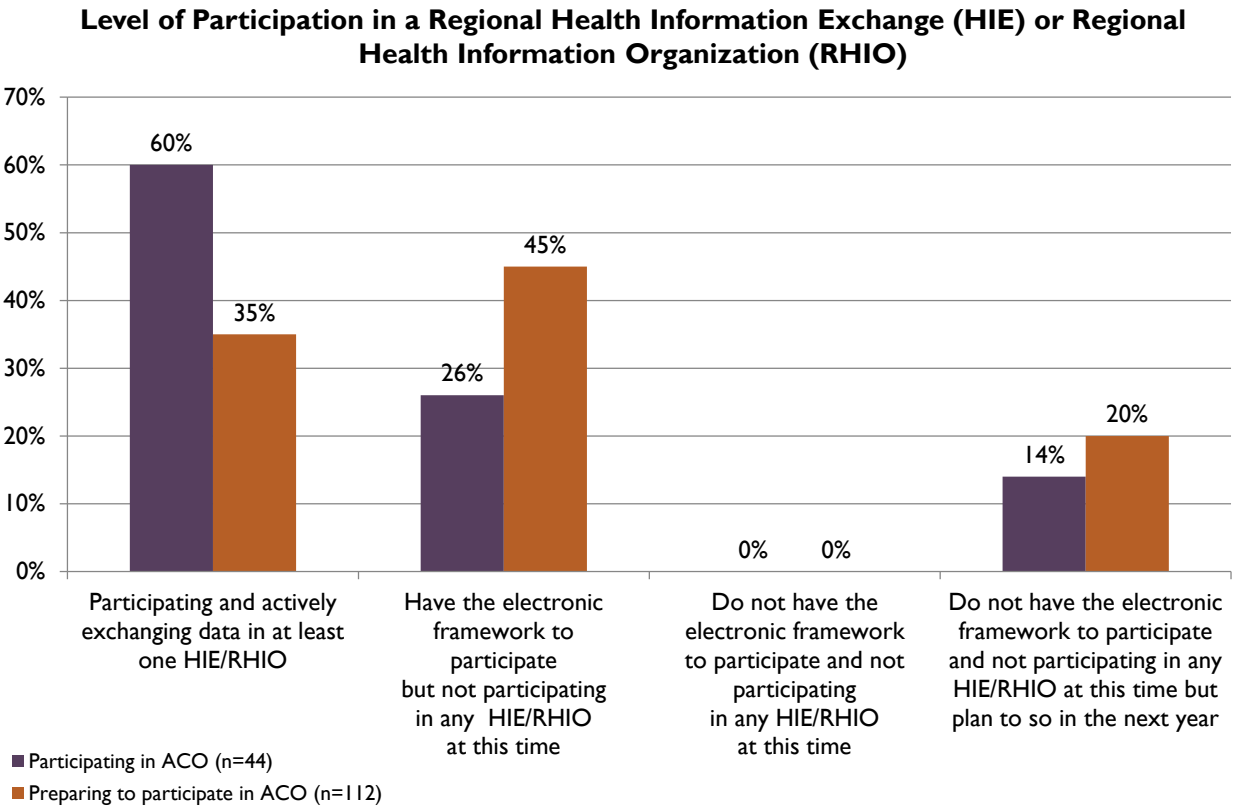


Exchange of Clinical Information

The exchange of information can be facilitated through participation in a regional health information exchange (HIE) or regional health Information organization (RHIO). Exchanges that effectively provide the secure transmission of up-to-date patient information between health care delivery organizations ensures that providers have immediate access to patient-level clinical information, updates, and clinical decision support. HIEs should facilitate the aggregation and integration of data such as computerized physician order entry, e-prescribing, and up-to-date alerts and reminders on the latest diagnostic, pharmacy, and treatment information.

Currently, 60% of ACO hospitals and 35% of hospitals working to join an ACO belong to an HIE or RHIO. Other hospitals have the electronic framework necessary to participate in an HIE or RHIO but are not doing so at this time (26% of ACO hospitals and 45% of hospitals working to join an ACO). Smaller numbers of hospitals lack the necessary electronic framework but intend to participate in the future (14% and 20%, respectively). See figure 21.

Figure 21

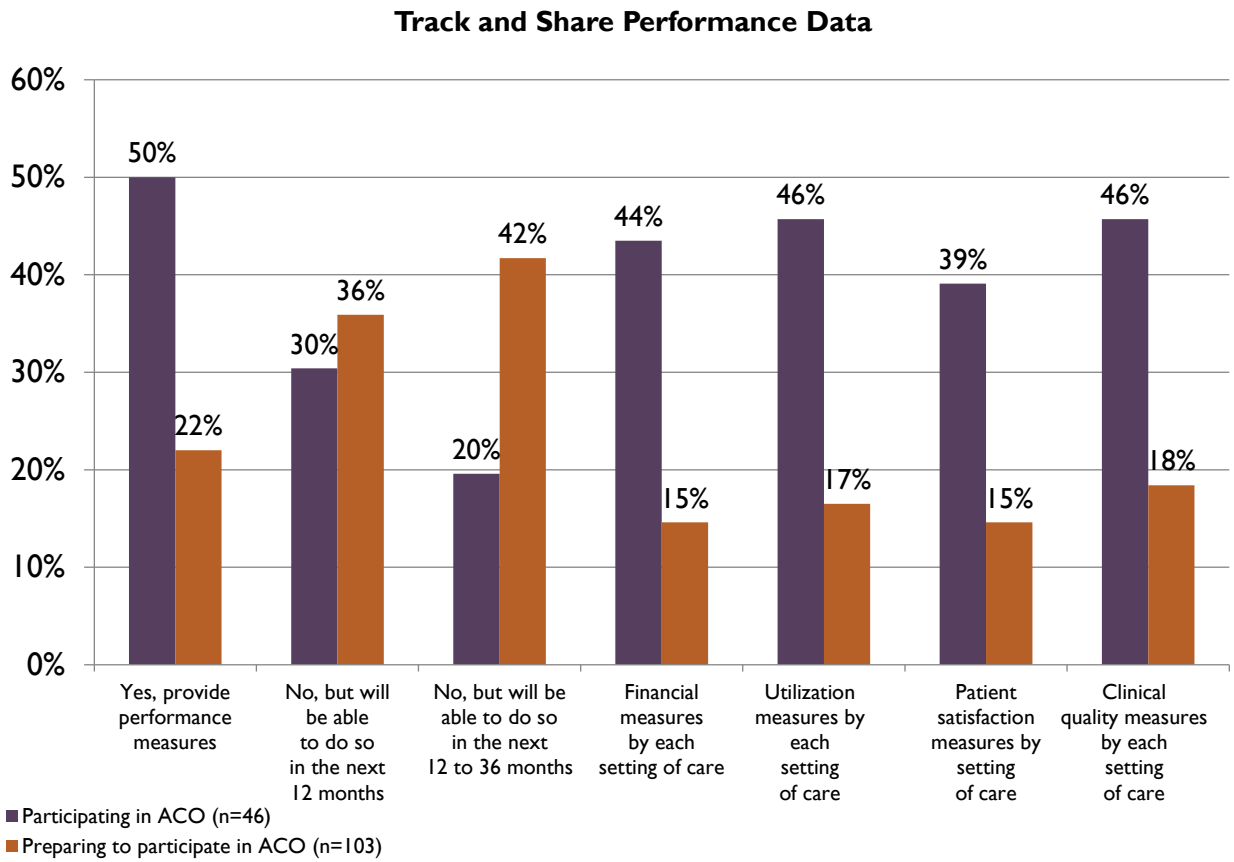


Performance Reporting and Quality Improvement

The goal of creating accountable care organizations is not just to reduce costs, but to do so while maintaining or improving the quality of care—that is, to actually improve value. Therefore, ACOs will be held to high standards of quality, safety, and patient satisfaction that must be met before rewards are paid.

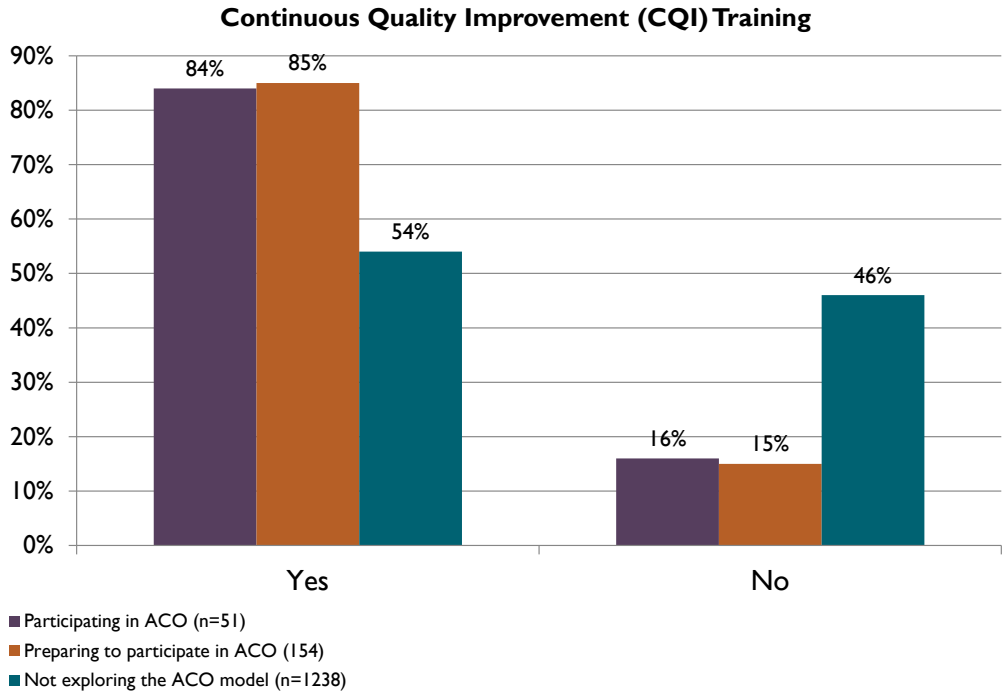
Half of hospitals participating in an ACO and almost one-fourth of hospitals preparing to participate in an ACO reported that they could not presently track and share performance data. However, institutions reporting that they did routinely monitor and share performance data indicated that they presently did so for the following measures: financial (44%); utilization (46%); patient satisfaction 39%); and clinical quality 46%). See figure 22.

Figure 22



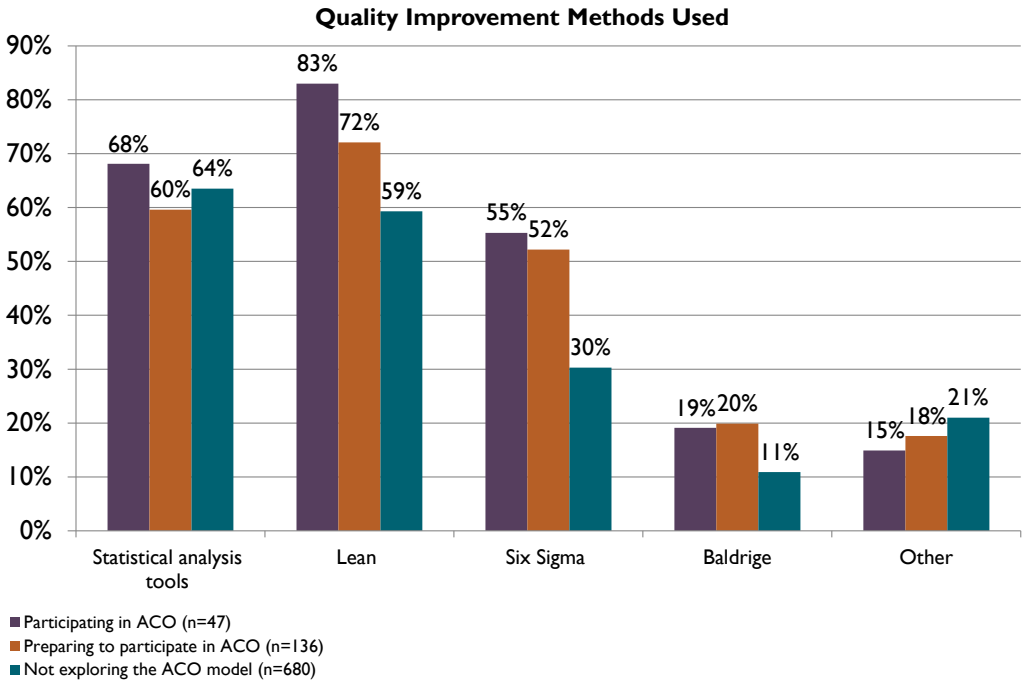
In addition to tracking and reporting data, most hospitals participating in an ACO (84%) and hospitals preparing to participate in an ACO (85%) reported training clinical leaders in continuous quality improvement (CQI) measures. Hospitals not exploring the ACO model were much less likely to provide such training (54%). See figure 23.

Figure 23



The most favored quality improvement method among hospitals participating in an ACO and hospitals preparing to participate in an ACO was using Lean implementation. The CQI training method preferred by the greatest percentage of non-ACO hospitals was statistical analysis, (64%) which was also used by 68% of ACO hospitals and 60% of hospitals working to join an ACO. See figure 24.

Figure 24



Challenges

As the complex work of health care reform continues, these survey results offer insights into the lessons learned and the perceived challenges encountered for making ACOs more successful. In the case of organizations that are already participating in an ACO, the challenges can be viewed as obstacles already faced. Organizations that want to participate in an ACO can compare their perceptions of the difficulty of the challenges to the reality already faced by existing ACOs.

Perceived Barriers to Becoming an ACO

Table 8 identifies a number of obstacles to becoming an ACO. Hospitals that want to establish or join an ACO can learn from the experiences of hospitals that have already formed or joined an ACO and allocate their resources accordingly. For example, 24% of hospitals that have formed or joined an ACO found motivating physicians to participate in the ACO system to be extremely challenging. Twelve percent (12%) of hospitals wanting to join or establish an ACO think this will be a major obstacle. These hospitals may want to put more effort into motivating physicians based on the experiences of hospitals already participating in an ACO.

One-fifth of hospitals wanting to join or establish an ACO believe that it will be an extreme challenge to align incentives to encourage provider productivity while minimizing unnecessary utilization of services, whereas only 6% of ACO hospitals actually found this to be their experience.

Additionally, one-fifth of hospitals preparing to participate in an ACO believe that raising start-up capital will be an extreme challenge. However, this factor will probably not be a deterrent, since only 4% of ACO hospitals did not find this an extreme challenge and 34% did not find it a challenge at all. See table 10.

Table 10: Perceived Difficulty of Obstacles to Becoming an ACO

Obstacle	No Challenge		Extreme Challenge		Mean (1=No Challenge, 5=Extreme Challenge)	
	Participating in an ACO	Preparing to Participate in an ACO	Participating in an ACO	Preparing to Participate in an ACO	Participating in an ACO	Preparing to Participate in an ACO
Reducing clinical variation	0%	3%	13%	21%	3.62	3.12
Reducing costs	0%	1%	11%	14%	3.62	2.99
Developing and maintaining common culture	2%	4%	28%	25%	3.55	3.14
Aligning incentives to encourage provider productivity, while minimizing unnecessary utilization of services	0%	4%	6%*	21%*	3.47	3.05
Motivating physicians to participate in the system	2%	6%	24%*	12%*	3.37	2.65
Developing clinical and management information systems	2%	3%	11%	18%	3.3	3.63

Resolving issues between primary care and specialty physicians	2%	4%	9%	11%	3.21	3.32
Accessing capital and investing on a system-wide basis	2%	9%	4%*	16%*	2.96	3.62
Increasing the size of the covered patient population	13%*	5%*	4%*	16%*	2.89	3.67
Developing physician leadership	23%	14%	11%	15%	2.79	3.5
Raising start-up capital	34%	21%	4%*	19%*	2.38	3.2
Developing a workable governance structure (e.g., agreeing on the number of physicians and hospital representatives to sit on the board)	32%*	11%*	2%	5%	2.13	3.33

*Statistically significant differences

Medicare Provision Challenges

Respondents also indicated that some provisions in the Medicare ACO regulations will pose a challenge to their organization's ability to participate in the Medicare Shared Savings Program. For hospitals participating in an ACO, the biggest challenge is shared savings payments (65%). Providers and suppliers participating in a Medicare ACO will continue to receive traditional Medicare fee-for-service payments under Medicare Parts A and B and also will be eligible to receive a portion of the shared savings if they successfully satisfy quality performance standards and reduce health care costs.

Consistent with the general theme of the final rule to provide greater financial incentives for physicians, hospitals and other health care providers to participate in the MSSP, the Centers for Medicare & Medicaid Services made several changes to payment models based on comments received on the proposed rule.

Under the final rule, an ACO will be paid under both a traditional fee-for-service method and—if the ACO meets both the quality and savings requirements set forth in the final rule—a share of the amount saved by the Medicare program. Under the proposed rule, savings otherwise payable to an ACO would be subject to withholding by CMS of 25% of the total amount of savings to ensure repayment of potential future losses. In the final rule, however, CMS eliminated this 25% withholding provision.

The final rule introduces a revised two-model system. The proposed rule required ACOs in the one-sided model to share losses in the third year of the initial agreement period. Under the final rule, ACOs participating in the one-sided model will not be exposed to any losses during the initial agreement period. ACOs participating in the two-sided model will remain responsible for shared losses in exchange for greater potential shared savings. ACOs choosing to begin in the one-sided model will be required to shift to the two-sided model after the initial agreement period.

An ACO is eligible to receive payment for shared savings only if its estimated average per capita Medicare expenditure is at least the percentage specified by CMS below the applicable benchmark, the minimum savings rate (MSR). The MSR for ACOs participating under the one-sided model will be established using

a sliding scale based on the size of the ACO's assigned beneficiary population. A flat 2% MSR will apply to all ACOs participating under the two-sided model. The proposed rule included a requirement under which ACOs participating under the one-sided model would have to produce savings of at least 2% over the MSR in order to be eligible for any shared savings payments, while ACOs participating under the two-sided model would share first dollar savings once the MSR was exceeded. Under the final rule, however, ACOs participating under either model will be allowed to share in the first dollar of savings once savings exceed the MSR.

Under the proposed rule, an ACO that did not meet the quality performance thresholds for all the proposed measures would not be eligible for shared savings, regardless of how much per capita costs were reduced. Under the final rule, however, an ACO that achieves the minimum attainment level for at least one measure in each of the four domains, and also satisfies the requirements for realizing shared savings under the final rule, would be eligible to receive the portion of those shared savings for which it qualifies.

For hospitals preparing to participate in an ACO, the biggest challenge to participating in the Medicare Shared Savings Program was perceived to be attribution (64%). Attribution is assigning a provider who will be held accountable for a member based on an analysis of that member's claim data. Assignment is controversial; physicians contend that if their performance is to be evaluated fairly, they should have control over the patients or episodes of care assigned to them.

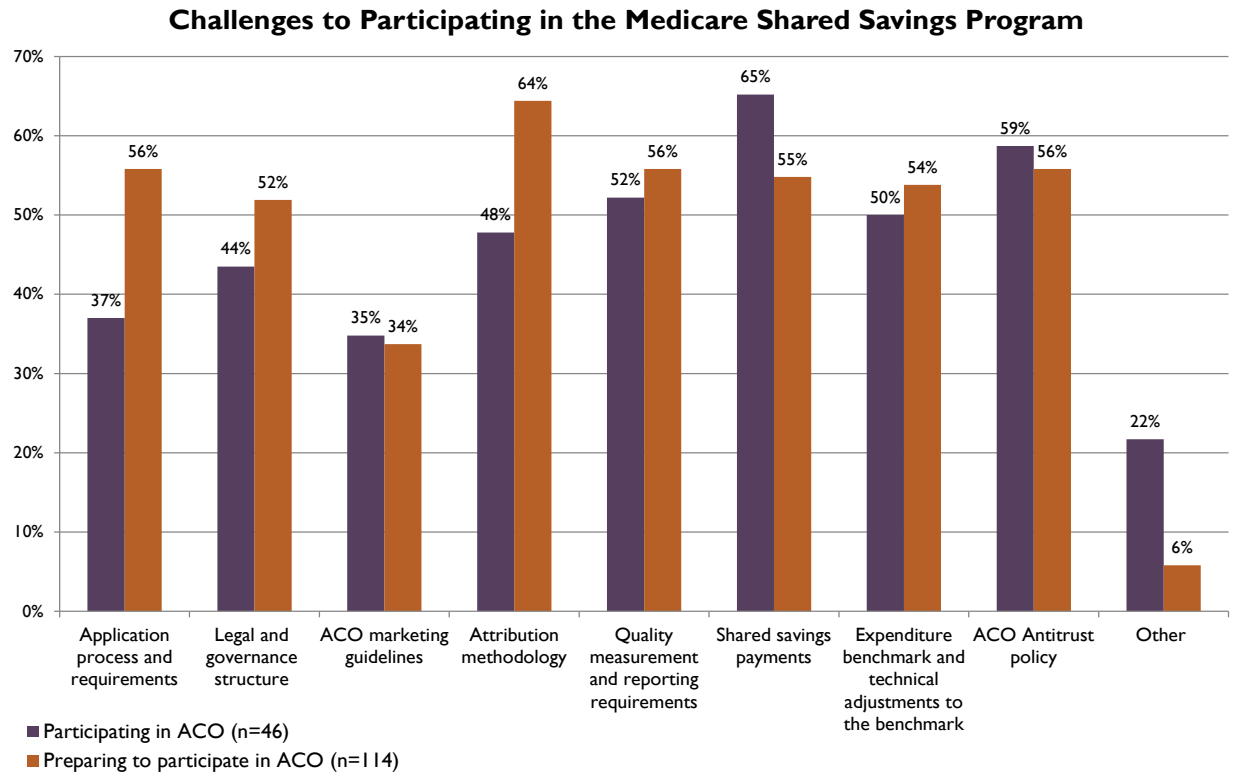
Under the final rules, CMS will use a "step-wise approach" as the basic assignment methodology. Under this method, beneficiaries will first be assigned to ACOs on the basis of services provided by their primary care physicians. Beneficiaries who are not seeing a primary care physician may be assigned to an ACO based on primary care services provided by other physicians. This final policy thus allows consideration of all physician specialties in the assignment process, according to the rule.

Also, the rule refutes any notions of cherry-picking: «We disagree that an attribution model based on primary care utilization could result in a disproportionate number of high-risk beneficiaries being assigned to the ACO.»

The second biggest challenge for ACO hospitals and hospitals working to join an ACO concerns antitrust policies (59% and 56%, respectively). Antitrust risk presents challenging issues for health care providers structuring an ACO under the MSSP. The MSSP includes incentives to providers to collaborate to achieve savings for Medicare beneficiaries. Collaborations among competitors, however, can raise risks under the antitrust laws if they result in increased prices, fewer choices for consumers and payers, or a decrease in quality. See figure 25.

The final rule no longer requires a mandatory antitrust review for certain collaborations as a condition of entry into the MSSP. In addition, the desire for competition is underscored by the Federal Trade Commission and the Antitrust Division of the Justice Department's previous guidance on antitrust and health care and its new guidance on ACOs. As with other types of health care collaborations, the threshold antitrust question for an ACO will be whether or not it impedes the functioning of a competitive market. The final rule focuses on standard antitrust concepts, including measurement of market share, and cautions against the most common forms of anticompetitive conduct. It provides safe harbors for ACOs that are unlikely to have market power, as well as a mechanism for business review. The guidance provided by the final rule suggests that it is unlikely that ACOs will be treated much differently from pre-ACO physician network joint ventures or multiprovider networks.

Figure 25



Conclusion

The accountable care organization is an emerging health care reform model, yet it is still limited to a handful of health care systems across the country. This study indicates that just 3% of hospitals currently participate in an ACO, with another 10% preparing to participate in an ACO. Seventy-five percent (75%) of the survey respondents said they were not currently pursuing the ACO model. The current movement with ACOs has started with commercial payers, as 70% of ACOs in the study have a contract or signed letter of agreement with a private payer.

Why the low level of participation in ACOs? It may be that many hospitals were waiting to participate in an ACO until after CMS released final details about how its shared savings model will work. Since the final CMS rules were released after the conclusion of this study, responses to this survey may reflect the undefined nature of the ACO rules. Or it may be that many hospitals do not currently have the components in place to deliver accountable care.

Organizational types. For the most part, there are no particular organizational types that are better prepared to manage the cost and quality of a population of patients than others. More multihospital systems and academic facilities participate in an ACO than do stand-alone hospitals. Relatively few demographic and care coordination factors proved to be statistically significant predictors of whether or not a hospital would opt to participate in an ACO. Significant predictors included teaching hospital status and the use of nurse case managers to improve the quality of outpatient care for patients with chronic disease. Other factors such as care coordination practices, geographic location, urban status, and hospital ownership did not have a significant effect on hospitals' ACO participation.

Barriers. Survey respondents identified a number of barriers to ACO participation. ACO hospitals and hospitals working to join an ACO view the barriers to becoming an ACO differently. The top-ranked barriers for hospitals participating in an ACO are reducing clinical variation, reducing costs, and develop-

ing and maintaining a common culture. For hospitals preparing to participate in an ACO, the top-ranked barriers were increasing the size of the covered patient population, developing clinical and management information systems, and accessing capital and investing on a systemwide basis.

Governance. According to survey respondents, the most popular form of governance is a joint venture between the hospital and physicians. This type of organization is well positioned to become an ACO. These organizations tend to have the capital, human resources, and administrative infrastructure needed to manage health care utilization and expense.

Typically, providers within a joint venture are also financially and clinically integrated, which provides certain legal advantages in pursuing ACO goals. For example, a joint venture is able to negotiate with all payers on behalf of participating providers without violating antitrust laws by fixing prices. A joint venture is likely to be better equipped to manage or coordinate the care provided by its participants and to have the resources to assume the financial risk of managing the health care of a population of patients than would less-integrated provider organizations and organizations that do not include health care facilities at their core. That a joint venture is well positioned to serve as an ACO is not to say that other provider organizations will not succeed as ACOs.

Ability to assume risk. Successful participation in an ACO requires providers to take financial risk. History has shown that not all providers can do that successfully. In an environment in which providers assume financial risk, providers need tools to review and control costs and utilization in a timely manner and to deliver care in an efficient manner. Alignment with a broad array of providers and effective care coordination are not enough. Successful ACOs will need to have protocols for cost-effective care, clinical decision-support tools, and real-time utilization monitoring capability to be effective in controlling costs while delivering quality care. Payment incentives will be important if tied to use of these tools and to appropriate value-based behavior. Reinsurance and adequate capital and financial resources are also key preconditions to any decision to enter into a significant risk-sharing arrangement. Otherwise, the ACO may not be in a position to bear such financial risk.

Payment structures. A significant barrier to forming an ACO is the current fee-for-service payment system. While respondents projected small increases in revenues from bundled payments and partial and global capitation payments over the next two years (thereby rewarding outcomes rather than volume), there do not appear to be the financial incentives in place to change the care model to lower utilization of acute and specialty care services. Respondents project that 79% of their revenue will come from fee-for-service payments two years from now. For early adopters of the ACO model, this means a higher degree of risk and may explain why some are reluctant to pursue the ACO model. If hospitals are expected to be accountable for delivering high-value care and managing population health at fixed costs, they must be reimbursed in ways that make that model financially sustainable.

Provider organizations will not make the capital and human resource investments and operational changes necessary to organize themselves into ACOs unless there are sufficient payers in their particular market. For example, if Medicare is the only payer that rewards ACOs on a shared savings or global capitation basis, and if Medicare is only 20% of the provider organization's business, then there may be insufficient incentives for a provider organization to invest in systems to administer shared savings or capitated payments and transforming itself into an ACO.

With such a payer mix, incentives to manage utilization and cost may be overwhelmed by fee-for-service incentives to provide more services. For many provider organizations, it is difficult to simultaneously administer a managed care program for one cohort of patients and a fee-for-service system for another cohort of patients. Even small differences in payer payment processes and policies (e.g., eligibility verification, prior authorization, or payment policy) can require entirely different provider workflow processes and can add significantly to the administrative burden and cost of delivering health care. This may distract

and detract from the ACO's primary mission of reorganizing providers to improve the way patient care is delivered.

Moreover, there is currently no assurance that any payer will make transitional payments to support a provider organization in building ACO infrastructure or capacity. If a critical mass of payers is not aligned in recognizing and paying their fair share for the development and operations of the ACO's administrative infrastructure, then the provider organization may not be able to afford to become an ACO.

ACOs will also need to determine how to allocate payments to their participants in a fair and equitable manner and to use payments to align incentives for coordinating care among participants and across facilities and sites of care. If the ACO receives a bundled payment but pays its participants on a fee-for-service basis, the misalignment of incentives could lead to distressing economic and clinical results. Aligning such incentives among ACO participants will be challenging as both a practical and a legal matter. ACOs will need to consider and experiment with various payment arrangements that reward adherence to care protocols and achievement of quality and efficiency goals.

Coordination of care. In large part, the success of an ACO will be a function of its ability to coordinate the care provided and to hold participating providers accountable for the cost and outcomes of care they provide. The results of this survey indicate that care coordination and transition activities are not yet fully deployed in any type of ACO.

About two-fifths of ACOs conduct telephonic outreach to discharged patients, have disease management programs, arrange for home visits, and assign case managers to patients at risk of hospital admission or readmission for outpatient follow-up. Only about a quarter of these hospitals provide visit summaries to patients, have a post–hospital discharge continuity of care program, or have nurse case managers assigned to improve outpatient care for patients with chronic diseases.

Hospitals participating in an ACO do much better in terms of facilitating the transition of patients. Between two-thirds and three-fourths of ACOs identify patients who transition between care settings, share clinical information between care settings, and provide patient discharge summaries.

Readmissions could be viewed as a measure of inappropriate care coordination following discharge. It is therefore important to track readmissions. Eighty-six percent (86%) of ACOs detect readmissions, although 58% detect readmissions only to their own hospital.

Infrastructure needs. The challenge of integrating disparate silos of clinical and administrative data may be addressed by regional health information exchanges (HIEs) or regional health information organizations (RHIOs) that coordinate health information exchanges within the boundaries of their community. While progress is being made as evidenced by 60% of ACOs participating and actively exchanging data in at least one HIE/RHIO, 14% of ACOs and 20% of hospitals preparing to participate in an ACO do not have the electronic framework to participate in these information exchanges.

Population management. Organizations wanting to participate in an ACO will also need some help in getting and managing population health. This is a new competency for the health care system as a whole. Population-based practice always begins with identifying everyone who is in a population-of-interest or a population-at-risk. It is not limited to only those who seek service or who are poor or otherwise vulnerable.

Between three-fourths (73%) and almost 90% ACO hospitals identified patients who were eligible to receive various population health management services. On the other hand, population management programs aimed at coordination of care among providers are apparently underutilized by hospitals. Only about one-fifth of hospitals participating in an ACO use chronic care management processes or programs to manage patients with high-volume, high-cost chronic diseases, use predictive analytic tools to

identify individual patients at high risk for poor outcomes or extraordinary resource use, and prospectively manage patients at high risk for poor outcomes or extraordinary resource use by experienced case managers.

Approximately two-thirds of hospitals participating in or preparing to participate in an ACO have a chronic care registry. Providers need a mechanism to track patients over time and identify patients who could benefit from more targeted outreach. Patient registries can assist providers in these ongoing efforts. Having a patient registry enables the practice to ensure that patients are receiving recommended care and to identify potential ways to improve outcomes.

Measuring and improving performance. There is widespread agreement that measurement is central to determining the success of an ACO and monitoring for unintended consequences. Half of ACO hospitals track and routinely share performance against measures with all members of the ACO. One possible reason measures are not being used more widely is the lack of electronic data and specifications for data collection. This means that either data are not available electronically or standards for linking already accessible electronic data are not available.

Another reason that hospitals may not be measuring performance is they are not set up to collect a new range of information. Both the definition and the functions of hospitals are changing, as emphasis shifts from inpatient care to ambulatory care, community outreach programs, and health care networks. Hospital performance thus may be expected to include elements of community care and public health.

This study is a snapshot of performance in the early-stage development of the ACO model. Because of the need to stem increasing health care costs and the need to shift the health care system from volume-based to value-based rewards, the ACO has been put forward as a possible model for restructuring traditional health care coverage and delivery. No single formula for a successful ACO is known at this time. Different approaches are being experimented with and transformations will take time. It is anticipated that the number of ACOs will grow as more evidence becomes available to support the ACO model. It may be necessary to supplement this study by examining the differences in practices and structures of ACO hospitals over time.

ACO Readiness Tool

The accountable care organization is emerging as an important care delivery and financing model to address the challenges of rising health care costs and fragmented care delivery. With health care reform offering new demonstration projects and commercial health plans piloting a variety of opportunities, provider organizations around the country are considering whether to pursue becoming an accountable care organization.

It would appear that some provider organizations are better equipped than others to form an ACO. For example, an integrated health system may already be acting as an ACO and could easily transition to a fully operating ACO. On the other hand, a collection of independent practice associations that choose to form an ACO may not have the IT infrastructure necessary to track patients and outcomes; may not have access to necessary capital; and may not have strong leadership to make choices about rates and utilization—and therefore may struggle initially.

To aid health care organizations in comprehensively evaluating their strengths and priorities as they progress toward accountable care, HRET has developed an ACO Readiness Assessment Tool (see the appendix). This tool identifies six assessment categories that are critical in making a detailed assessment of structure, governance, financial alignment, systems integration, and clinical integration.

This assessment process can help organizations meet their current challenges and develop a road map for building a higher performing organization. It can identify key investments that must be made in areas

such as information technology, care coordination, and post-acute care.

So start now to assess your organization's position and determine how to move further toward a sustainable accountable care model. Convene a team of individuals with deep understanding of how the organization functions. Task the team members with a critical assessment of how the organization rates against each of the elements in the tool. Then indicate the level of performance the organization demonstrates: whether it is early in the ACO journey, on track to becoming an ACO, or well advanced in the ACO journey.

Bibliography

Fisher, E. S., McClellan, M., & Safran, D. (2011). Building the path to accountable care. *New England Journal of Medicine*, *365,* 2445–2446.

Fisher, E. S., Staiger, D. O., Bynum, J. P.W., & Gottlieb, D. J. (2007). Creating accountable care organizations: The extended hospital medical staff. *Health Affairs 26*(1), w44–w57.

Galewitz P. (2009). ACOs: A primer. *Kaiser Health News*. Retrieved January 17, 2012, from http://www.kaiserhealthnews.org/stories/2009/July/17/aco.aspx

Longworth, D. (2011). Accountable care organizations, the patient-centered medical home and health reform: What does it all mean? *Cleveland Clinic Journal of Medicine, 78*, 571–582.

Merlis, M. Health policy brief: Accountable care organizations. *Health Affairs*. 2010. Retrieved January 17, 2012, from http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=23

Nelson, B. Quality over quantity. *The Hospitalist*. 2009. Retrieved January 17, 2012, from http://www.the-hospitalist.org/details/article/477391/Quality_over_Quantity.html

Stremikis, K., Davis, K., & Audet, A. (2010). *Health care opinion leaders' views on delivery system innovation and improvement.* New York: The Commonwealth Fund.

Robert Wood Johnson Foundation. (2011). *What are accountable care organizations and how could they improve health care quality?* Retrieved January 17, 2012, from http://www.rwjf.org/healthpolicy/quality/product.jsp?id=73768

Song, Z., Safran, D., Lando, B., et al. (2011). Health care spending and quality in year 1 of the alternative quality contract. *New England Journal of Medicine, 365,* 909–918.

Appendix

How to Use the HRET ACO Readiness Assessment Tool

This tool will assist organizations in performing a self-assessment of attributes, capabilities, and experiences that are critical to the success of an accountable care organization.

For each question, please determine as a leadership team if your organization is early in its ACO journey, on track, or well advanced.

HRET ACO READINESS TOOL

	Early in the ACO Journey	On Track	Well Advanced on the ACO Journey
Governance Structure/Leadership			
1. The organization has defined a culture that embodies an ACO—collaborative, transparent, patient centered, information-rich, and quality focused.			
2. There is a working governance and leadership structure for the ACO.			
3. The organization supports transformation of the care process to a team (patient-centered) approach.			
Finance/Legal			
4. Organization has the ability to receive and distribute revenue associated with the care provided.			
5. Compensation programs and incentives are aligned internally and externally among providers and payers.			
6. The organization meets the financial strength requirements to accept risk.			
7. A physician compensation program is in place that is flexible enough to accommodate both fee-for-service and shared savings care.			
8. Legal structures are in place to receive and distribute payments to participating providers of care; payment policies are in compliance with existing state and federal laws.			
Access and Availability			
9. Organization has an adequate primary care physician base and the specialists needed to manage a patient population of at least 5,000.			
10. The organization creates and maintains a practitioner network to facilitate linking patients with practitioners who can meet patients' cultural, racial, ethnic, and linguistic needs and preferences.			

11. The organization uses patients' expressed preferences to assess the availability of and facilitate linking patients to specified practitioner types.			
12. The practice provides patients/families with access to appropriate routine and urgent care.			
13. The organization has a process to administer a health appraisal to eligible individuals within 90 days of assignment.			
14. The organization uses appropriate data to identify population health needs and implements programs as necessary.			
Care Management			
15. The organization has a clinical data system that integrates patient records across both hospital and physician care and is able to assemble cost data at the case level.			
16. There are systems in place for risk assessment and risk stratification of patient populations.			
17. Internal data are used in a feedback loop to standardize care processes, continually improve performance, and measure and improve patient safety.			
18. To coordinate care for its patients, the organization has a documented process for exchanging health information across care settings			
19. Electronic patient communication and patient engagement tools, such as interactive personal health records and provider e-mail, are in place and widely used.			
20. Data systems are in place that provide a complete view of the (covered) care a patient receives, including care provided outside the organization.			
21. There are chronic care management processes or programs in place to manage patients with high-volume, high-cost chronic diseases.			
22. Systems are in place to assure smooth transitions of care across all practice settings including hospitals, long-term care, home care, and palliative care.			
23. Medication reconciliation occurs as part of an established plan of care.			
24. Visit summaries are provided to patients as part of all outpatient encounters; follow-up visits and/or specialty referrals are scheduled at the time of the initial encounter.			
25. Patients are educated about diagnostic and therapeutic alternatives and their preferences are respected in the design and execution of care plans (including advance directives).			
26. Communication tools are used to facilitate tight integration of practice teams, including clear handoffs of responsibility.			
Patient Engagement			
27. The organization states its commitment to patient rights, patient privacy, and expectations of patient responsibility.			

28. There are shared decision-making processes in place to engage patients and families in their care.			
Performance Reporting and Quality Improvement			
29. The organization measures and publicly reports performance on clinical quality of care, patient experience, and cost measures.			
30. The organization identifies opportunities for improvement and brings together providers and stakeholders to collaborate on improvement initiatives.			
31. There are systemwide measures of quality and efficiency that reflect the practice of evidence-based medicine and strive to reduce unwanted variation.			

Fill in these blanks with totals from the table above.	Early in the ACO Journey	On Track	Well Advanced on the ACO Journey
Governance Structure/Leadership			
Finance/Legal			
Access and Availability			
Care Management			
Patient Engagement			
Performance Reporting and Quality Improvement			