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Hospital-Centric ACOs Want to Keep Control as Payment Changes

Hospitals facing the decision to spearhead an accountable care organization — or even to participate in one — face a tough choice, since ACOs usually lead to falling hospital revenue as utilization drops. But for hospitals that have elected to take the plunge, it's more a matter of staying in control in a drastically changing health marketplace.

"If volume is dropping and reimbursement is dropping, who's benefiting? It's the payers right now," says John Grigson, who serves as both CFO of Covenant Health and CEO of Covenant Health Partners, the organization's ACO.

"We want to be in a position of control. We don't want to be on the table, being told how it works. We don't want to be at the mercy of a larger system ACO," Grigson told attendees Nov. 6 at the National Accountable Care Congress in Los Angeles, sponsored by Global Health Care, LLC. "We want to be an essential part of our community, and we want our community to look to us for help. We have the capital, and we can make this happen."

Covenant Health wants to be in a position to make the needed decisions and control the premium dollars, Grigson says, and the hospital system has the resources to create or influence all aspects of the network and build the required infrastructure.

Those sentiments were echoed by other hospital-based ACO representatives who spoke at the meeting.

Covenant Health views its ACO as critical to its strategy, first adopted in 2006, to transition from a system focused largely on acute care hospitals to one that improves the health of populations, says Grigson.

The ACO created by the five-hospital system in west Texas includes 180 private physicians and 160 employed physicians, Grigson says. "Physicians need to drive the ACO, and we believe that partnering with physicians is a requirement" to shift from an acute care system to one of population health management, he says. Covenant Health also has its own health plan with 200,000 covered lives, he says.

Covenant Lost $60 Million on Medicare

The transition underway at Covenant — which hospital system leaders expect to complete by 2018 — is necessary because commercial hospital reimbursement is declining toward Medicare rates, Grigson says. "Last year, our hospital system lost $60 million on Medicare. We had a profit, so we had to make it up on the commercial side." This won't continue, he adds.

Hospital volume also will decline as medicine is practiced more efficiently, and reimbursement and volume for the hospital's employed physicians also will fall, he says.

Nonetheless, the transition from volume to value is turning out to be much more difficult than anticipated. "Everyone in our system was trained to look at volume," he says. For example, Covenant Health's physician compensation plan was based on volume, not value, he says. "If you've got employed physicians, you need to think about this."

In addition, Covenant Health found that insurance companies were not as willing to share risk as the organization expected. "One of the big, major players didn't want to do a risk contract with us," Grigson says. And the hospital and ACO needed to get used to the idea that shared savings aren't actually shared until long after the money actually is earned. "You're investing and doing all of this work, and even if you're having success, the additional revenue comes up to 18 months later," he says.

Finally, Grigson says Covenant Health realized a totally different infrastructure and skill set of employees was needed. "We laid off 200 at the hospital and hired 40 at the ACO," he says. This didn't necessarily make sense to the employees, he adds.

Hackensack Leveraged Hospital Employees

Meanwhile, Hackensack University Medical Center's ACO, the Hackensack Alliance Accountable Care Organization, found it could leverage hospital employees and infrastructure to help the fledgling ACO take off, says Denise Patriaco, director of care coordination for the ACO.

Patriaco told meeting attendees that having an ACO within a hospital network helps to better align physicians to promote in-network referrals, allows the hospital to participate in anticipated shared savings, helps to reduce or eliminate readmission penalties and short stay denials,

and offers the hospital an opportunity to participate in commercial insurance-based ACOs.

Hospital systems typically have more access to capital for infrastructure investments, Patriaco says: "They have the cash to get you started and keep you going." They also often have an existing care management staff that can serve the ACO, she says, adding, "I didn't have to hire discharge planners and nutritionists — they were already there."

In addition, hospitals allow ACOs to incorporate more providers across the continuum of care, including primary care physicians, specialists, ancillary providers and post-acute facilities, Patriaco says. And most of the initial cost savings opportunities occur at the hospital, including the "low-hanging fruit" of emergency room visits and readmissions, she says.

To be successful as a hospital-based ACO, the organization needs to be able to leverage the hospital's infrastructure — including its information technology, finance, marketing, human resources and compliance staffs — for the benefit of the ACO, Patriaco says.

In addition, a hospital-based ACO needs to set condition-specific, community-wide disease care coordination protocols early, with input from all the stakeholders, she says. Like all ACOs, hospital-based ACOs need to improve care transitions from the hospital to acute care, skilled nursing facilities and home care, she adds.

Provider groups looking for the right hospital ACO partner should look for senior-level buy-in for the ACO; a robust network of providers across the entire continuum of care, including home care and skilled nursing; and a history of successful community partnerships, Patriaco says.

Arizona Care Network — the ACO that Dignity Health Arizona, a three-hospital system in Phoenix with a fourth hospital under construction, formed with Abrazo Health Care, a six-hospital network acquired by Tenet Healthcare earlier this year — is helping both Dignity and Tenet fight competitive pressures from the seven Medicare ACOs in the market, says Mark Hillard, chief development and integration officer for Dignity Health Arizona.

"We're conflicted as a hospital company," Hillard says. "We want hospital beds full. But our biggest problem is market share. We don't have the money to employ all our physicians in order to be a totally closed system. Our strategy in Phoenix has been to align with as many physicians as possible," he says.

Cost and price are the leading determinants in choosing where to receive care in the Phoenix market, he adds. "This is about market share. We believe Phoenix might be overbedded a bit, and we want to build our market share."

So far, Dignity has learned that "the ACO is not very good at controlling the costs at the hospital, but it's going to be very good at controlling price and controlling readmissions."

In addition, he adds that the Medicare Shared Savings Program ACO isn't going to bring in much additional revenue, because the hospital will lose money on Medicare patients. However, "it's a way to align everyone on the same page."

The ACO is unusual because Dignity is not-for-profit and Tenet is for-profit, Hillard told meeting attendees. The Arizona Care Network includes Medicare and Medicaid beneficiaries, plus hospital employees, and is expected to have more than 100,000 members in January 2014, Hillard says.

Hillard says that quality requirements have turned out to be very onerous for the providers involved in the ACO.

Clinical integration between the two hospital groups and the ACO's providers has proven to be a challenge, he says, adding, "be careful how you invest in technology, and plan on manual processes." Information technology systems may claim they can provide true integration and fully automated processes, but that hasn't been Dignity's experience so far, he says.

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