# Taking on the Risk of Accountable Care: Five Questions to Assess Organizational Readiness

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Many legacies of medical knowledge, such as surgical anesthesia, are considered among the mainstays of modern medicine. But other legacies are inevitably rendered irrelevant by continuing advances in knowledge—and our nation's fee-for-service healthcare payment system may be a prime example of this.

Of all the forces transforming our healthcare system, none is more significant than the turn from payment based on volume to payment based on value. Many healthcare stakeholders have expressed a commitment to pursuing value-based payment methodologies in the years ahead. Now board members and other healthcare leaders are seeking a path forward that does not pose undue risks to their organizations' abilities to continue fulfilling their missions.

Investor Warren Buffett has said that risk comes from not knowing what you're doing. The demand for value in healthcare is leading many hospitals to consider venturing into an area they know little about—population health management, which entails accepting financial risk for the health of a specific population, as health insurance companies do. Decisions about whether to start an insurance company, participate in an accountable care organization (ACO) or other population health management arrangement, or enter into certain risk contracts are, at their core, decisions about whether to take on insurance risk.

Insurance risk is defined as the chance that a possible—but uncertain and typically uncontrollable—event might occur. Examples include an accident that causes traumatic harm or the risk of being diagnosed with a life-threatening or life-changing disease. The degree of insurance risk is a combination of several factors, including the probability of an event occurring and the likely magnitude of harm if the event does occur. Insurance risk is not a function of a hospital's or other provider's performance. It cannot be controlled, but it can be managed.

Although many hospitals and health systems plan to invest in population health management capabilities, only 20 percent have already made such investments, according to research conducted by the Healthcare Financial Management Association (HFMA) in 2011. Provider organizations are rightly cautious in moving toward assumption of unlimited insurance risk for a population. As Ron Long, former HFMA chair, wrote in *hfm* magazine 10 years ago, "Hospitals were never designed to operate as insurance companies."

Before considering taking on any significant amount of insurance risk, a board should heed Buffett's advice and satisfy itself that the organization *does* know what it's doing—in other words, that the organization has the capabilities needed to manage insurance risk. Specifically, boards that are considering an ACO or similar arrangement should consider the following issues in assessing organizational readiness:

1. **Is the organization willing and able to put the necessary financial reserves on the table?** Insurance carriers are subject to risk-based capital requirements intended to protect the companies, those they insure, and their communities against the wide, unexplainable cost swings that will invariably occur. Risk-based capital also protects against the cyclical and market-based underwriting risk. To assume insurance risk, an organization needs the financial resources and balance sheet strength to weather unpredictable waves of utilization-related cost.
2. **Does the organization have a strong integrated primary care delivery network?** Population management strategies rely on increased use of primary care and preventive care services to reduce utilization of costly specialist services, maintain a referral base when more intensive services are required, avoid unnecessary procedures, and coordinate post-acute needs to reduce complications and readmissions. Increasingly, health systems' physician networks are combinations of employed and private practice physicians. Under value-based business models, physician networks should be held together with a compensation model that includes incentives tied to performance on quality and cost.
3. **Does the organization have an effective process improvement strategy that extends across care settings?** Success under population management strategies will require an ability to maintain the quality of patient outcomes while enhancing the cost-effectiveness of care. As evidence of its capabilities in this area, a hospital or health system should have a solid track record of planning and implementing successful process improvements across the organization. Research conducted by HFMA shows that process improvement initiatives tend to emphasize inpatient care. It is important to recognize that the success of population health management strategies depends on the organization's ability to implement effective process improvement across care settings, often resulting in reduced inpatient volume.
4. **Does the organization have the data access and data analytics needed for population health management?** Access to claims data for the relevant population, both historical and current, is essential. Hospitals and health systems that make the foray into population health management will also need access to clinical data from patient medical records and data on costs of care across the network. Often, access to claims data will require the cooperation of a partner on the payer/purchaser side that is willing to work closely with the provider on identifying and fulfilling data needs. The hospital or health system will also need the skills of data analysts and actuaries—either in-house or contracted—to mine the data for actionable information, identify cost and utilization trends, understand the ramifications of those trends, and communicate the analyses effectively. Eventually, leading organizations will employ predictive

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modeling, particularly related to shared savings and capitated contractual terms, to forecast likely utilization and cost patterns among defined patient sub-populations and to develop risk mitigation strategies based on payment methodologies and care management strategies.

5. **Does the board have the necessary expertise?** Future-oriented board members are learning about the emerging payment environment and changing marketplace dynamics to prepare for making difficult decisions that may diverge from past courses of action. Hospitals and health systems are also working to augment their governance structures. For example, multi-hospital systems are centralizing some board functions that were more decentralized in the areas of both quality and finance. Academic medical centers are also considering redesign of board and other governance structures to better centralize decision making. Many hospitals and health systems are seeking to recruit new board members with expertise in community relations, business intelligence, and insurance to prepare for population health management initiatives and other value-based business models.

If you answered "no" to any of these questions, it may be wise to direct resources toward building the organization's population health management capabilities before venturing into ACOs or other payment arrangements that involve significant insurance risk. For example, to improve coordination across care settings, an organization may choose to enter into bundled payment arrangements, add care coordinators, or develop disease registries.

Hospitals and health systems that are ready to accept limited insurance risk may opt to experiment in a risk-controlled environment. Health systems that own health plans have relatively greater leeway to experiment with population-based risk payment arrangements. Other provider organizations may opt to pursue collaborative initiatives with payers, pilot projects with their own employees, or accountable care arrangements limited to selected employers or medical conditions. For example, Baptist Health South Florida has launched a shared savings, accountable-care-like program specific to the treatment of cancer, in collaboration with Florida Blue, the Blue Cross and Blue Shield company of Florida, and a multi-site oncology physician group. Hospitals and health systems will reap many benefits from establishing relationships of trust across the provider continuum and with the payer and purchaser community. These relationships should support the coordination of care, sharing of data, and appropriate division of risk.

Many hospitals and health systems are taking advantage of opportunities to gain experience with value-based reforms today to prepare for intensified purchaser demands for greater healthcare value. They recognize that experimentation, within carefully established parameters, is essential to progress and to emerging from the grip of fee-for-service payment. By building organizational capabilities, experimenting with new payment models, and strengthening working relationships with other healthcare stakeholders, organizations and boards can gain confidence in their ability to assess and manage risk, their readiness to make the transition to value-based payment, and—last but not least—their legacy of value.

*The Governance Institute thanks Joseph J. Fifer, FHFMA, CPA, president and CEO of Healthcare Financial Management Association, for contributing this article. He can be reached at jfifer@hfma.org. For more information, see HFMA's Value Project resources, www.hfma.org/valueproject, and Leadership publication, www.hfma.org/leadership.*