



The ACO Conundrum: Safety-Net Hospitals in the Era of Accountable Care

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Introduction

An accountable care organization (ACO) has been broadly defined as “a group of health care providers who accept shared accountability for the cost and quality of care delivered to a population of patients.”¹ ACOs have proliferated across the United States in the wake of the Affordable Care Act, with over 600 ACOs established as of June 2014, covering an estimated 20.5 million lives in risk-based contracts.²⁻³ While participation in the Medicare Shared Savings Program and Pioneer ACOs has grown, so too has participation in Medicaid ACOs, aided by favorable legislation in several states (Colorado, Maine, Massachusetts, Minnesota, Oregon, Utah, and Vermont).⁴⁻⁵ Nineteen states are advancing ACO development in Medicaid and the Children’s Health Insurance Program, and a quarter of ACOs nationally have contracts with Medicaid.⁶⁻⁷ Nevertheless, safety-net providers are entering into ACO arrangements more gradually than commercial and Medicare providers due to lack of capital and inexperience with financial risk.⁸⁻¹⁰ Safety-net hospitals are entering into accountable care cautiously, and are infrequently serving as lead organizations in ACOs.¹¹

Methods

This issue brief is informed by two years of qualitative research supported by the Robert Wood Johnson Foundation. Between March 2013 and March 2015, our research team conducted site visits with executive, financial, and clinical leaders at four emerging safety-net ACOs, and supplemented the findings with interviews and background research using publicly available documents for multiple safety-net hospitals and other providers nationally. We selected ACOs that serve large economically disadvantaged and ethnically diverse Medicaid populations and increasing numbers of Medicaid patients enrolled in risk-based contracts. The studied sites included: AltaMed Health Care Services in Los Angeles, CA; Baystate Health in Springfield, MA; Commonwealth Care Alliance in Boston, MA; and Hennepin Health in Minneapolis, MN.

Our research with safety-net ACOs and hospitals focused on:

- » History and development of the ACO;
- » Governance, leadership, and organizational structure;
- » Market, policy, and regulatory context;
- » Payment arrangements;
- » Integrated delivery system and population health management, including high-cost care management, clinical care strategies, and care transitions;
- » Partnerships with community and social services;
- » Patient engagement; and
- » Monitoring and measurement of key processes and Triple Aim outcomes.¹²

Purpose of this Paper: Policy Questions

Two key policy questions related to hospitals emerged from our analysis of sites studied: (1) what challenges does ACO development pose to safety-net hospitals, and (2) how do they respond to these challenges? The following conundrum emerged as a significant challenge: if the promise of ACOs proves successful, the result will be reduced hospital revenues resulting primarily from the reduction of inpatient days, emergency department utilization, and technical fees associated with imaging and outpatient procedures. This prospect leaves hospitals, especially those already operating on low Medicaid reimbursement rates and decreasing Disproportionate Share Hospital (DSH) funds, facing a future where fewer dollars are spent on the services they provide. This paper will examine how select safety-net hospitals are addressing this “ACO conundrum,” three strategic options they are considering, and various dimensions of the challenge. We will also explore how some are viewing the transition to more accountable care as an opportunity to serve their communities, remain financially solvent, and contribute to lower costs and improved quality outcomes for Medicaid populations.

Background: Profile of Safety-Net Hospitals in the United States

While many hospitals tout a commitment to the community, for the purpose of this discussion, we define a “safety-net hospital” as having membership in America’s Essential Hospitals and/or serving 30 percent or more Medicaid patients. Such hospitals may be owned by state, local, or federal government, or may operate as a non-profit entity, and provide vital care, such as emergency and trauma care, to vulnerable populations.¹³ Using this definition, there are 519 safety-net hospitals across the nation, making up approximately 9 percent of all hospitals.¹⁴⁻¹⁵ For many safety-net hospitals, a majority of their patient population includes those who are covered by Medicaid or who are uninsured, are racial and ethnic minorities, and tend to have more complex health and behavioral health issues.¹⁶⁻¹⁷ Safety-net hospitals are also serving a significant need with increasingly scarce resources. National data from 2012 reflect that low-income communities experienced 29 percent higher rates of hospitalization, longer average length of stay, and 9 percent lower average hospital costs compared to higher-income communities.¹⁸ Furthermore, even without considering the impact of ACOs, many safety-net hospitals operate with negative margins and foresee a precarious financial future as designated federal funding aimed to support care for the uninsured is projected to decrease under the Affordable Care Act.¹⁹

The Hospital ACO Conundrum and Strategic Options

The heart of the financial challenge for all hospitals in the era of accountable care lies in the fact that reducing spending in the hospital setting is the primary mechanism for ACOs to achieve savings. While shared savings contracts can be complex, savings associated with an ACO can most simply be characterized by the difference between actual expenditure and predicted expenditure informed by historical experience.²⁰ Hospitals' historical revenue streams become the primary targets for achieving savings in the health system as a whole for two key reasons. First, most ACOs look to data and clinical evidence to identify opportunities to reduce expected spending while maintaining or increasing quality of care. Second, ACOs try to achieve savings by targeting the areas of largest expenditure. For safety-net hospitals, this challenge is intensified because of slim operating margins and low Medicaid reimbursement rates. Recent data and evidence depict a landscape where hospital revenues become a prime target for ACO savings in Medicaid. In 2012, 37 percent of the \$421.2 billion spent in Medicaid nationally was for hospital care, compared to 11 percent of Medicaid spending for physician and clinical services.²¹ Data from 2012 also showed a growth rate of 4.9 percent for hospital care, higher than the 3.7 percent growth rate for all health care expenditure nationally.²²

Furthermore, recent work by the Agency for Healthcare Research and Quality and others suggests that many Medicaid hospital admissions and readmissions are potentially avoidable.²³ For example, 15.6 percent of all 2012 non-maternal, non-neonatal Medicaid admissions were characterized as "ambulatory-care sensitive conditions," defined as a "condition for which good outpatient or preventive care can potentially prevent the need for hospitalization."²⁴ Medicaid readmissions for adults also exceed Medicare readmissions rates with much higher proportions related to behavioral health.²⁵ Furthermore, much research has hypothesized that the Medicaid readmission rate of 20.6 percent^a for adults could be significantly reduced.²⁶⁻²⁷

Thus, the challenge for hospitals engaged in ACOs becomes: how can they maintain or increase bottom line financial performance while also improving quality and patient experience, when the movement toward accountable care is targeting reducing hospital per capita revenue?

a Estimate of all-cause 30-day readmission rate for non-maternal adult (age 21-64) Medicaid beneficiaries. Data drawn from State Inpatient Databases 2012, Healthcare Cost and Utilization Project (HCUP), federal Agency for Healthcare Research and Quality (AHRQ).

Three Strategic Options

In the face of the “ACO hospital conundrum,” our analysis suggests that hospitals serving Medicaid and uninsured populations^b are considering three strategies: (1) increase revenue, (2) reduce operating costs, and (3) fundamentally redefine the organization to become an ACO. These strategies are not mutually exclusive and can be pursued simultaneously. The strategies of increasing revenue and reducing operating costs long pre-date the emergence of ACOs but become more pressing as a response to the emergence of ACOs or part of a broader strategy to become an ACO. The third option of actively participating in or leading an ACO is accompanied by other challenges and opportunities explored in the following section.

Strategy 1: Increase revenue

Increasing revenue is one strategy hospitals can pursue by gaining more insured patients, changing payer mix, and/or offering new services. On the surface, this strategy may seem like “trying to swim upstream” and depends heavily on regional market dynamics, such as the degree of competition among local hospitals and state Medicaid policy regarding expansion and reimbursement. However, some hospitals have strategically anticipated how to “backfill” lost revenue from reduced admissions by increasing local market share by attracting new patients or by converting previously uninsured populations to Medicaid or exchange-based insurance. One strategy for building market share is to acquire physician practices and thus increase the hospital’s referral base; for example, hospitals may acquire primary care practices in an effort to gain referrals to hospital-based specialty providers.²⁸ For instance, Hennepin County Medical Center (which organized Hennepin Health, an accountable care demonstration involving the county medical center, the county government, a county-organized health plan, and a federally qualified health center) merged with its previously separate physician group in the years leading up to becoming an ACO.

Another revenue growth strategy is to build market share by attracting new payers, such as health plans offered through Medicaid, exchanges, or Medicare. For example, when California’s Coordinated Care Initiative capitated managed care plans for individuals dually eligible for Medicare and Medicaid, safety-net hospitals in the competitive Los Angeles market entered into new sub-capitation contracts in partnership with independent practice associations serving the safety net in order to try to increase their market share for dually eligible beneficiaries.

A third revenue growth strategy is to add services for which patients have traditionally traveled to other providers. For example, Montefiore Medical Center, a large delivery system in the Bronx which has operated as an ACO for almost two decades, added a pancreas transplant program and thus took market share for that service away from Manhattan hospitals that had been performing that service for Montefiore’s patients.²⁹ Other hospital revenue strategies, not limited to safety-net hospitals, include repurposing space by signing leases with external entities, including hospice providers, primary care

^b These options are generally being pursued by larger urban safety-net hospitals. Critical Access Hospitals and other small independent safety-net hospitals are in dire straits, as they typically have small service volume, depend on federal supports to remain as points of care, and lack the funds to even invest in the presented strategies.

networks, and even hotel operators. For example, Boston’s Carney Hospital agreed to lease a floor of its hospital to a risk-bearing provider group, Commonwealth Care Alliance, who utilized it as a psychiatric step-down unit.

Strategy 2: Reduce costs

Reducing operating costs is a second strategic path hospital leaders are pursuing in the era of accountable care. Reducing operating costs involves identifying efficiencies in providing care, redefining service offerings and repurposing existing capacity, and modifying hospital workforce. “We must reduce our costs while maintaining our margin,” commented one safety-net hospital’s Chief Financial Officer. Another safety-net hospital executive saw a need to lower costs in response to projected ACO-based utilization reduction and described a plan to take \$30 million out of the hospital’s operating budget each year for two years, and to achieve 1.5 percent annual productivity gains thereafter. Specific actions safety-net hospitals have taken include Denver Health’s implementation of Lean Six Sigma to identify and improve inefficient processes. In the realm of workforce strategies, Hennepin County Medical Center (HCMC), the hospital partner within Hennepin Health, employs clinical pharmacists where physicians might have provided services previously, and was contemplating employing nurse anesthetists in addition to anesthesiologists.³⁰⁻³¹

Reducing inappropriate utilization is another mechanism for lowering operating costs. Both Hennepin Health and Denver Health have invested in intensive outpatient care programs (IOCPs) to address the needs of frequent utilizers of the emergency room who can be adequately or better cared for in a lower-cost setting. HCMC retrained inpatient nurses to serve as care managers in their IOCP. Given the high prevalence of behavioral health conditions addressed in safety-net hospitals, multiple hospitals are also increasingly employing clinical social workers and behavioral health specialists to provide care and counseling in an outpatient setting rather than addressing mental health and substance use disorders in the emergency department. For example, University of California, San Francisco Medical Center has implemented Care Support, “an integrated complex care management program that provides patient-centered education, care coordination and psychosocial support in the primary care setting,” that has resulted in lower emergency department and inpatient utilization.³²

While decreasing operating costs is occurring through workforce and high-cost care management programs, in many cases, inpatient units are simply closed and focus is placed on creating new outpatient services.³³⁻³⁴ For example, numerous public hospitals in California are strategically planning to provide more outpatient primary care services. However, the economics of losing beds is a complicated one for safety-net hospitals as their federal DSH^c funding is tied to their hospital bed utilization and hospitals are loath to jeopardize that funding.³⁵ For safety-net hospitals with teaching programs – even for primary care – federal funding

c For an explanation of the CMS Disproportionate Share Hospital funding formula, see: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html.

is also linked to use of inpatient beds.^d Some hospitals would like to reduce inpatient capacity, but feel trapped by federal funding formulae.

In response to provider ACO formation and other market contexts, many hospitals are utilizing multiple strategies and actions to increase revenue and reduce costs simultaneously. Ultimately, the relative degree of effort a safety-net hospital places on revenue growth and reducing operating costs depends largely on how the hospital decides to respond to the option of participating as an active member or leader of an ACO.

Strategy 3: Redefine as an ACO

A third strategic option for safety-net hospitals is to fundamentally redefine the organization to become an ACO. Redefining a hospital as an ACO likely involves a shift in vision, care delivery infrastructure and staffing, partnerships, and payment arrangements. Redefining a hospital as an ACO is a more transformative strategic path than adopting the options of revenue increase and cost reduction in isolation. As a result, many larger safety-net hospitals are pursuing this path slowly and incrementally.³⁶

Transforming into an ACO tends to be accompanied by a shift in vision to become a component of a health system rather than a secondary or tertiary care center. Such transformation also tends to involve expansion of primary care services and investments in elements of the patient-centered medical home (PCMH); hiring or training staff dedicated to care management and case coordination, with particular attention to care transitions and individuals with highest utilization; new levels of health information technology and analytics necessary to succeed under financial risk-bearing arrangements; and a reorientation toward the health of a population and away from episodic acute care. Given the high prevalence of behavioral health conditions as primary diagnoses in Medicaid admissions and readmissions, it also means placing increased attention on behavioral health.³⁷⁻³⁸ Redefining an organization requires strong leadership, upfront capital to invest in transformation activities, and a culture shift throughout the organization.

If a safety-net hospital does decide to become an ACO, the relative degree of impetus for change of the delivery system hinges on the nature of the financial contracts the ACO negotiates with payers. A shared savings contract that maintains traditional fee-for-service payments and offers a portion of savings relative to a projected spend to the ACO can leave a hospital, as one safety-net ACO leader put it, “feeling like we have one foot in each of two canoes going in opposite directions.” Because most savings are projected to derive from reduced inpatient costs, almost by definition, a share of such savings will not offset a hospital’s reduced revenue. Global capitation payment for a defined population of patients can be more financially attractive in that it provides more revenue certainty, creates better cash flow to support investment, and allows the hospital to capture a higher percentage of any savings associated with decreased inpatient utilization. For example, Hennepin Health cited their global capitation contract as a key facilitator for being able to make investments in delivery system transformations and programs that were likely to generate

^d For an explanation of the CMS Indirect Medical Education funding formula, see: www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/dsh.html.

savings. Global capitation payment also can fundamentally shift a hospital's business model into one where an inpatient bed goes from being a revenue stream to a cost center.

Examples from public hospitals in four states highlight how some safety-net hospitals are beginning to transition to health systems with strong primary care while shifting slowly into new financial incentives. For example, using Delivery System Reform Incentive Payment (DSRIP) funds^e available under a Medicaid Section 1115 Waiver, Santa Clara Valley Health and Hospital System has invested in transforming its primary care health centers into PCMHs. In addition, they have also invested in integration of mental health and substance abuse disorder treatment into primary care, in part by creating a Division of Integrated Behavioral Health to structurally integrate behavioral health in primary care clinics with designated staff to "create a shared understanding between the ambulatory care and behavioral health services settings."³⁹ At Montefiore, a Center for Medicare and Medicaid Innovations grant is supporting the testing of a common behavioral health integration model of care that includes behaviorists on the primary care team. The project uses a case-based payment reform (a per-member-per-month payment for patients with depression) that allows primary care the flexibility to provide behavioral health services and incentives to treat and improve outcomes for depression.⁴⁰ Cambridge Health Alliance (CHA), an acute care public hospital that reports having the highest percentage of revenue from Medicaid and low-income patients (85%) in Massachusetts, began to implement behavioral health integration as part of its PCMH transformation.⁴¹ Some CHA sites have integrated behavioral health treatment into primary care by co-locating mental health and primary care providers, training primary care providers to treat mild mental health issues, and developing shared care plans across behavioral health and primary care. All CHA patients are administered a standard depression screening tool, which includes a protocol for treatment if newly diagnosed, and specific strategies utilized depend on the patient's acuity.⁴²

Another illuminating example of evolving payment and delivery system transition comes from Hennepin Health's phased shared savings formula, whereby the four ACO partners accept a global capitation contract for a defined Medicaid expansion population. In Hennepin Health's first year, savings distribution between hospital and primary care partners was based on percentage of charges, a financing strategy that mostly incentivized traditional hospital utilization. In year two, the distribution formula was changed to be tied to primary care touches with patients.

A fourth example of a safety-net hospital evolving incrementally into an ACO is Baystate, a non-profit, acute care teaching hospital serving Medicaid, Medicare, and commercial patients in Western Massachusetts. Baystate has experimented with high-cost care management programs under commercial and Medicare risk-bearing contracts in advance of expanded risk-bearing Medicaid contracts in the future. While these examples illustrate the shifts in financial contracts and strategies pursued by safety-net hospitals participating in ACOs, transformation hurdles and opportunities expand well beyond the financial.

^e DSRIP initiatives are a component of state Medicaid Section 1115 Waiver programs. They provide states with significant funding to support hospitals and other providers in changing how they provide care to Medicaid beneficiaries.

Safety-Net Hospital ACO Formation: Challenges

A host of challenges lay before safety-net hospitals with an interest in ACO formation. Some of these challenges are common to all general acute care hospitals, but manifest themselves more acutely for safety-net hospitals, while others are specific to safety-net ACOs.

Redefining Mission

Perhaps the greatest challenge to any hospital interested in ACO formation is one of identity. Hospitals have traditionally been oriented around treating individual patients in discrete episodes. In contrast, ACOs are oriented towards continuing relationships with patient populations throughout changes in health status. Becoming an ACO means shifting to a population orientation wherein hospital admissions are costs rather than revenue.

Cambridge Health Alliance encapsulated the prospect of a shifting identity for a hospital participating in an ACO in the following comment: “CHA faces a fundamental dilemma that is common to aspiring ACOs. Should it become an integrated primary care network focused on population health with an aligned hospital, or will it become a hospital system that includes a primary care network? These approaches require fundamentally different strategies and resource allocation decisions. The former requires viewing the hospital as a cost center while the latter emphasizes generating volume to maintain the economic viability of the inpatient platform.”⁴³ Our interviews with other hospital executives involved in ACO formation echoed a similar trend of fundamental identity shift accompanied by shifts in the historic business model and care delivery.

Based on our interviews, safety-net hospitals that make the transformation to ACOs appear to perceive a “burning platform” that makes change an absolute necessity.⁴⁴ They also seem to have exceptionally strong leadership that will allow them to weather a challenging transition period. The change is not an easy one for many reasons, including that DSH funding is tied to hospital volume.⁴⁵

Securing Resources

While the challenge of shifting identity is applicable to all hospitals, resource challenges are certainly greater for safety-net hospitals than for most non-safety-net hospitals.⁴⁶ Their profitability and cash reserves are often compromised, making financing the investment needed to form an ACO challenging. These investments often include new staff and enhanced health informatics capacity. For ACOs assuming downside risk, there is also a financial need to hold reserves and to purchase stop loss coverage. It is

therefore not surprising that the safety-net hospitals that have been earlier developers of ACOs have been larger institutions with strong market share.

Though some safety-net hospital ACOs have been able to self-finance their start-up with existing reserves, not all hospitals can do this. One finance executive told us that their hospital had to invest \$8 million and wait almost two years for a shared savings distribution. Others have received a prospective payment and used those funds to make needed investments. Such payments are obtained through a risk contract with either a hospital-owned health plan or independent health plans.^f As cited above, Hennepin Health found prospective payment to be a key contributor to its ability to invest in necessary staffing and other resources.⁴⁷ This was due not only to the prospective nature of the payment, but to the amount of the payment. If prospective payments solely reflect past spending and do not contain a supplemental investment in the ACO, they are less effective in building ACO capacity. Even if enhanced to support investment, prospective payment does require significant financial risk assumption by the hospital, something which only hospitals with extensive experience with managed care or risk-bearing are usually willing to assume.

Safety-net hospitals in several states have access to DSRIP funds to help develop ACO capacity. CHA used the funds to initiate PCMH, behavioral health, and complex care management transformation activities.⁴⁸ The investments in transformation can be large. For example, New York state is potentially allocating \$6.42 billion in DSRIP funds beginning in 2015 with the specific purpose of helping safety-net providers perform health system transformation and ready themselves to enter value-based payment with Medicaid managed care plans.⁴⁹

Building Primary Care Infrastructure

Achieving improved population health as part of the Triple Aim is a key outcome for ACOs. The foundation of population health strategies is typically made up of robust primary care practices with linked or embedded care coordinators/care managers trained to deliver team-based care using a PCMH model. For safety-net ACOs in particular, the primary care strategy also ideally integrates behavioral health and primary care service provision and includes strong connections to community-based human services providers and other resources relevant to low-income populations. Some safety-net hospitals have such a primary care infrastructure, but many do not. In addition, the safety-net hospitals that we visited vary significantly in terms of the extent of their integration of primary care and behavioral health services. For example, in Hennepin Health, HCMC partnered with both a federally qualified health center and county mental health services to augment its primary care and behavioral health infrastructure. In another example, CHA has placed heavy emphasis on transformation of its ambulatory sites to PCMHs. In fact, CHA viewed development of advanced medical home infrastructure as the foundation for achievement of an ultimate goal of transition to an ACO.⁵⁰

^f CMS also made such payments available to Medicare ACOs as part of an advanced payment option in the Medicare Shared Savings Program.

For safety-net hospitals without a significant base of owned primary care practices, practice transformation can be daunting. In such cases, the hospital needs to rely in part on a network of contracted independent practices and/or federally qualified health centers. For example, more than 60 percent of the patients attributed to Montefiore's Medicare Pioneer ACO are under the care of private practice physicians in community offices, with the remainder under care of Montefiore's employed physicians.⁵¹

Addressing Patient Population Characteristics

Poverty is associated with many social determinants of poor health status, leading to elevated incidence of chronic illness. For example, living in poor quality housing with mold and rodent infestation can exacerbate asthma and other conditions. Poverty also makes accessing health and human services difficult at times. For these reasons, a safety-net hospital faces greater challenges in supporting improved population health than does a provider serving another patient population. These greater challenges make cost reduction more difficult to achieve.

Like most other ACOs, safety-net ACOs emphasize the provision of care coordination/care management services to those patients who are judged to be at elevated risk of intensive resource utilization in the future.⁵² What differentiates safety-net ACOs is the personnel profile and corresponding approach they must take to perform the function. Safety-net ACOs operated by hospitals are relying more heavily than commercial ACOs on social workers, behavioral health clinicians, pharmacists, and community health workers, to address the needs of their patient populations. This broader set of staff reflects the role that mental health, substance abuse, and social determinants of health play in the Medicaid population.

Safety-Net Hospital ACO Formation: Opportunities

While there is little question that safety-net hospitals face certain challenges in developing and operating ACOs, they often have unique strengths that can be overlooked in a focus upon challenges. These strengths can be leveraged to overcome some of the challenges identified above.

Population Focus

Unlike many large health systems that primarily serve commercially insured and Medicare populations and lack any strategic focus specific to patients living in poverty, safety-net hospitals are heavily oriented towards understanding and better serving safety-net patients. They have a deep knowledge of the patients they serve and are thus better positioned to operate an ACO with a safety-net population focus than non-safety-net providers. This understanding means that safety-net hospitals are acutely aware of the role of social determinants of health on health care access, health status, and cost. Some of them devise specific strategies to address issues such as housing and unemployment.

Addressing cost and quality drivers often requires a provider to reach beyond its traditional boundaries, and to engage and/or influence others who can address upstream factors that affect health outcomes. For example, the ACO of Nationwide Children's Hospital, Partners for Kids, serves over 300,000 children in the Ohio Medicaid program. While the ACO does not serve pregnant women, it has placed strategic focus on preventing premature births, because prematurely born children ultimately become their responsibility. Partners for Kids has been a co-convenor of an array of stakeholders which, according to the ACO, has been successful in reducing expenses associated with high rates of premature birth in Ohio. In fact, the results of the ACO's convening efforts include a multi-provider-led Ohio Better Birth Outcomes initiative that has started four distinct programs aimed at reducing premature births.⁵³

Relationships with Community-Based Agencies

The specific patient population characteristics cited above have spurred some safety-net hospitals to develop relationships with a wide range of community agencies across multiple sectors, including housing, human services, law enforcement, county government and services, schools, legal services, and many more. Maximizing these relationships can help address social determinants of health as well as avoidable health care utilization. Those safety-net hospitals that have formed ACOs have in some cases gone a step further and developed strategic, preferred relationships with key community partners.

Two examples from Hennepin Health and Cambridge Health Alliance highlight how safety-net hospitals participating in ACOs or ACO-like initiatives are leveraging community partnerships. Hennepin Health

serves a population of low-income adults with high prevalence of mental illness, chemical dependency, and homelessness. As a result, the ACO has targeted the provision of housing as a means to provide stability and safety, and to reduce the need for intensive service utilization that is exacerbated by homelessness.⁵⁴⁻⁵⁵ These efforts have demonstrated positive early results. Hennepin Health has successfully leveraged relationships with specific housing services providers for placement in supportive housing and with the public housing authority for preferred placement for transitional housing. For example, Hennepin Health worked with the Minneapolis Public Housing Authority to create a pilot to provide high-risk patients with temporary housing for up to 90 days post-discharge while case managers work with the patient to find long-term housing. Hennepin is currently leasing eight housing units, paid for with the ACO's share of earned savings. This example demonstrates how Hennepin Health, as an entity within county government, has taken advantage of its county government relationships. Hennepin Health reported that utilizing these county relationships "...was relatively easy for us since every partner is governed by the county and we serve the same populations."⁵⁶ These housing efforts have produced some promising early results. For example, through their program to provide supportive housing for 112 medically complex enrollees, Hennepin Health has self-reported a reduction of 55 percent in emergency room use and a reduction of 29 percent in hospital admissions for that group.

In a second example, CHA has partnered with two home care agencies in Massachusetts, called Aging Services Access Points (ASAPs), to improve transitions of care for Medicare patients. CHA reports that the program has been ranked third in the country by CMS among almost 100 similar programs. As a result, CHA is considering expanding to other populations. According to Rich Balaban (March 2015), a lead clinician at CHA, "This [partnership with ASAPs] was a whole new world that I knew nothing about." A transitions facilitator has effectively bridged the two cultures and supported the ASAPs' mission of supporting home-based care with the understanding that individuals fare better emotionally and physically if they can remain in their homes, while also being a less costly way to care for aging Medicare patients.

Conclusion

The ACO conundrum is one that faces all hospitals in the era of accountable care. Indeed, safety-net hospitals will need to respond to and/or actively participate in accountable care arrangements going forward. While the ACO conundrum is unique for safety-net hospitals because they tend to face the prospect of decreasing revenues from an already challenging financial starting place, vanguard safety-net hospitals are showing that becoming or participating in ACOs presents great opportunities. Some early adopters have shown that it is possible to succeed under new accountable care models.⁵⁷ However, success requires simultaneously reducing hospital service utilization while taking corresponding steps to ensure sustained financial stability for the hospital.

While increasing revenue and decreasing operating costs are two strategies that safety-net hospitals are pursuing to respond to this challenge, the more transformative strategic path is to redefine as an ACO. This appears to be a viable strategy, especially for larger safety-net hospitals, although not an easy one. Effective leadership, well-established market share, and adequate funding to finance needed investments in the early years seem to be three prerequisites for success. Supportive state policy can also be a strong and helpful facilitator for safety-net hospitals to participate in and/or respond to ACO formation; for example, favorable state policy for ACO development accelerated change in Minnesota. In the absence of state policy as a facilitator, partnerships with Medicaid health plans and other health system and community-based organizations become paramount.

Financial contracts shape both the incentives and mechanisms for delivery system change for safety-net hospitals. Whether safety-net hospitals catalyze significant shifts in their business model by entering into full-risk accountable care contracts or by adopting accountable care financial and delivery models more incrementally via DSRIP and shared savings incentives, they will inevitably have pressures externally or internally to prepare for a future of lower hospital utilization. From interviewing safety-net hospitals in the era of accountable care, it is clear that transformation is not a linear process but rather, a process characterized by incremental change, oftentimes slow adoption of financial risk, and experimentation with and refinement of care transformations.

Nevertheless, the ACO transformation process can lead to a reconceptualized safety-net hospital. Rather than an acute care center relying on inpatient bed days, a safety-net ACO has the potential to be a coordinated health system that promotes population health in the community, offers robust primary care and care management, and serves as the integrator for traditional and innovative medical and non-medical services necessary to achieve the Triple Aim for Medicaid populations.

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