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A NEW RISK MANAGEMENT FRONTIER: ACCOUNTABLE CARE ORGANIZATIONS

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The new model of accountable care that the health care industry is adopting holds substantial promise. Through greater coordination of services across the continuum of care—from hospitals and physician groups to skilled nursing, assisted living, and hospice facilities—health care organizations can realize substantial cost savings. But adopting new operating models will require organizations to undergo unprecedented cultural and operational shifts, which can carry substantial risks—many of which the industry has yet to fully identify and manage.

Successfully addressing these risks will not be simple. To achieve true success, organizations will be challenged to rethink many aspects of their risk management—defining new cultures focused on safety and patient care, reevaluating insurance programs and decisions, and establishing greater alignment between risk management and overall strategy.

A NEW MODEL FOR THE INDUSTRY

Since it was signed into law in March 2010, the Patient Protection and Affordable Care Act (PPACA) has been the subject of intense political debate and litigation, culminating in the June 2012 Supreme Court ruling on its constitutionality. Despite this uncertainty about the ultimate fate of health care reform, many industry participants have steadily moved toward the new accountable care operating model encouraged by the bill.

The Centers for Medicare & Medicaid Services (CMS) formally defines accountable care organizations (ACOs) as “groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients” and the chronically ill.

But “ACO” has come to be used more generically, referring to a wide range of health care population management models that do not always fit the strict CMS definition. Many types of organizations, from newly formed standalone entities to loose alliances, fall into this broader definition, and their focus is not restricted to Medicare patients and the chronically ill. In Oregon, for example, legislation passed in 2012 encourages the formation of “coordinated care organizations”—essentially ACOs with an added community involvement component.

Despite technical differences in how these organizations and networks operate, their common aspiration is to deliver cost savings and better patient outcomes through coordination across the health care continuum. Specifically, this can be achieved by preventing medical errors and eliminating duplication of medical services, including tests, examinations, and other procedures.
Some hospitals and health care providers became early adopters of the ACO model, by participating in the CMS-sponsored Pioneer ACO Model program. But many others delayed taking steps to form or join ACOs, adopting a wait-and-see approach ahead of the Supreme Court’s ruling on PPACA.

Now that the Supreme Court has upheld most of PPACA’s key provisions, the industry is clearly moving toward accountable care models. Since the ruling, several leading health care organizations have joined existing ACOs or begun to form new ones. Many others are expected to follow suit over the next few months.

Of course, there is still some question about the ultimate fate of the reform bill, all or parts of which could be repealed at some point in the future. But too much progress has been made already by the industry to turn back. Most industry participants agree that coordinated care—with its opportunities for savings and better outcomes—can benefit all parties, especially patients. And even without PPACA, CMS has the authority to drive the industry toward shared savings plans to benefit Medicare recipients. The bottom line is: Accountable care is here to stay.
TRANSITIONING TO ACCOUNTABLE CARE: RISKS AND REWARDS

CHANGING STRUCTURES AND CULTURES

In the long run, an accountable care model can help participating health care organizations improve their reputations, gain market share, and create more sustainable cost structures. But transitioning to accountable care will require hospitals and others to make significant cultural and operational changes—starting with the way they view patient care. And hand in glove with such changes comes the identification and management of associated risks.

For example, the industry’s focus traditionally has been on volume: More patient admissions, tests, and procedures meant more revenue. As a patient moved across the continuum of care—from an initial physician office visit, to the hospital setting, through to home and hospice care—physicians and others would often order the same test multiple times and capture patient information in multiple IT systems, with no communication between physicians and individual health care facilities.

Under accountable care models there is greater emphasis on using technology to improve communication and share knowledge among all providers, thus eliminating the duplication of testing and treatment. Instead of focusing on volume-driven metrics such as admissions and testing, all organizations along the continuum of care can function as a coordinated health care delivery system—with the focus squarely on patient health and quality of care.

The accountable care model also puts greater emphasis on how a patient is cared for after being discharged from a hospital. Offering value-added services, such as training and education for a patient’s family and more useful post-discharge guidance for high-risk patients, can help to reduce readmissions. New and innovative approaches, such as telemedicine and the establishment of medical homes, can help patients to participate in their own care and potentially eliminate unnecessary visits to hospitals and doctors.

Though it will take some time for the industry to fully embrace these cultural and organizational shifts, hospitals and health care providers are already moving to form or join networks. These networks can take many forms, including:

• new standalone legal entities;
• joint ventures;
• formal partnerships based on contractual relationships; and
• loose alliances and networks.

Each of these structures varies in the level of control that it affords to participants. Direct ownership of all aspects of the network, for example, enables senior leadership to drive strategy and best practices in operations and risk management throughout the entire organization. Joint ventures offer participants some degree of control through ownership stakes. Formal partnerships and loose alliances bring less control, and thus more risk for participants, particularly as patients are “handed off” from one part of the network to the next.
TRANSITION BRINGS NEW RISKS

No matter the precise structure of the ACO or network that they are joining or forming, it will be critical for participating firms to carefully manage the risks associated with this transition. Such risks include those associated with the following activities:

• Establishing provider networks. Decisions about which organizations to partner with in the ACO structure—whether a joint venture, formal partnership, series of alliances, standalone entity, or another format—and how to share payments and expenses can carry significant risks. Errors in the provision of nonmedical professional services, including the distribution of shared savings across the network, and other risks could lead to antitrust allegations, contractual liabilities, and lawsuits from patients, competitors, and regulators. If mergers and acquisitions are involved in the formation of the network, participating organizations could also face transactional risks.

• Entering into payor contracts. Depending on the structure of reimbursement agreements with the government and various benefit plans, an ACO could assume additional risks. Examples include the risks related to the pricing of medical services, contract mismanagement for member providers, or incurring medical expenses in excess of agreed capitation levels.

• Developing transitional care models. Transitioning to accountable care will require new behavior on the part of health care professionals to ensure coordination of care—including moving patients from one part of the network to the next—and sharing of information across the network. In the long run, this is likely to benefit patients and improve the quality of care provided. But in the short term, realigning organizational resources (including personnel), redefining measurements to track patient care and expenses, and establishing new processes and best practices could increase the risk of errors in delivery of medical services.

• Sharing of data. A critical component of achieving better patient outcomes through an ACO is the sharing of electronic medical records and other data across the network. But with more parties handling such data—including service providers outside of the formal network—the risk of a data breach grows. Even before the push toward accountable care, health care organizations that had been victimized by data breaches were well aware of the costs related to a data breach, including those related to patient notification, potential government fines imposed under the Health Information Technology for Economic and Clinical Health Act (HITECH) and the Health Insurance Portability and Accountability Act (HIPAA), and litigation.

• Physician integration. Whether through direct employment, provider service agreements, or loose affiliations, a key component of the transition to accountable care is the integration and alignment of physicians with hospitals. Depending on the nature of their agreements with physicians, hospitals and the ACOs in which they participate could face added risks, notably medical professional liability (medical malpractice) exposures.

Inherent in each of these risks is the potential for damage to the reputation of an ACO and its participants. Through the Internet and other means, patients are now looking for more information about their health care options before making choices. Meanwhile, as organizations transition to accountable care, the way in which they deliver care is now more visible to patients. This means that health care organizations’ reputations are more vulnerable than ever; a single mistake could severely or irreparably damage those reputations.
IMPROVING SAFETY, SECURITY, AND RISK RESPONSIVENESS

As the health care industry continues its march toward accountable care, organizations need to understand and manage the added risks they could be assuming through new business models and strategies. The key to mitigating these risks through insurance and other means lies in the strengthening of a culture of safety that supports risk management across the enterprise and in greater communication and coordination between risk and quality managers and business leaders.

CULTURE OF SAFETY AND PATIENT CARE

The most critical step is to build a culture of safety and patient care, which will create the right mindset for an effective risk management program. Of course, there is more to such a culture than simply drafting a written document. Success will take a concerted effort across the continuum of care with buy-in by all levels of the organization: senior management, frontline staff, physicians, and other health care professionals. Key characteristics of an effective safety culture include:

• **Robust training and education**, which should transform from the current computer-based training approach to a clinical simulation model. Health care organizations should not assume that employees will understand safety and risk management procedures simply because they can pass written examinations. Instead, training for all employees should mirror the training that doctors receive during residency—rooted in simulation and performance of key medical procedures—in order to effectively minimize errors during the delivery of care. Such training programs should be designed with the input of key stakeholders, including physicians, nurses, clinical education staff, quality managers, and risk managers.

• **Patient rounding** to validate quality of care and compliance with risk management and safety initiatives. Oftentimes, there is an assumption within health care organizations that all employees understand these initiatives—without real validation. The most successful organizations conduct patient and unit rounding, with the involvement of senior leadership, risk managers, and patient safety personnel to identify potential barriers to safety or caregiver communication. Critical to effective rounding is the use of detailed checklists, much like those used by professionals in other highly technical industries (for example, by airline pilots).

• **Root cause analyses** after an adverse outcome. Hospitals and other health care organizations often go through the initial steps of a root cause analysis, but adverse outcomes too often are not fully examined to the level and scope needed in order to avoid future adverse events. Proactive trending analysis, which can identify key trends and potential near-misses that should be evaluated before an adverse event occurs, should be a regular component of any organization’s risk evaluation and reporting mechanism. Once a root cause analysis has been completed, ongoing process measures should be reviewed on a routine basis and reported to leadership, to assure compliance. Such analyses, if conducted on a regular basis, can help organizations to significantly reduce the number of medical errors and adverse outcomes experienced by their patients.
• **Trust, transparency, and communication.** The most successful organizations embed this throughout the organization through regular evaluations and assessments of risk management programs. Detailed summaries of adverse events, recommendations on how teams can avoid similar events in the future, and metrics tied to root cause analyses can enable an environment of open communication that will help to reduce potential risk exposures across the organization.

**ALIGNING RISK WITH STRATEGY**

Risk managers can support the establishment of a culture of safety by more closely aligning themselves with their organizations’ overall strategy, gaining a deep understanding of all aspects of the business and looking beyond risk transfer and insurance purchasing. Indeed, senior leaders at companies across all industries are looking for strategic thinking from risk managers as a way to help their companies succeed.

In a recent survey on risk management trends, 85 percent of health care respondents said that C-suite expectations of the risk management department have increased over the past three years. Health care industry respondents to the annual Excellence in Risk Management survey from Marsh and the Risk and Insurance Management Society (RIMS) also said that a strategic view of risks and risk management’s role was the most important skill set a risk manager should possess, followed by an intimate knowledge of the business and industry (See Figure 1). Insurance knowledge, on the other hand, while certainly viewed as an important skill set, was selected by only 28 percent of health care respondents.

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**FIGURE 1: TOP ABILITIES REQUIRED TO LEAD RISK MANAGEMENT IN THE HEALTH CARE INDUSTRY**

<table>
<thead>
<tr>
<th>Ability</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strategic view of risks and risk management's role</td>
<td>57%</td>
</tr>
<tr>
<td>Intimate knowledge of the business and industry</td>
<td>50%</td>
</tr>
<tr>
<td>Broad-based operational perspective</td>
<td>37%</td>
</tr>
<tr>
<td>Insurance knowledge</td>
<td>28%</td>
</tr>
<tr>
<td>Compliance view of risks and risk management's role</td>
<td>27%</td>
</tr>
<tr>
<td>Exceptional communicator</td>
<td>24%</td>
</tr>
<tr>
<td>Knowledgeable leader of innovative risk practices</td>
<td>22%</td>
</tr>
<tr>
<td>Ethical focus</td>
<td>17%</td>
</tr>
<tr>
<td>Business process/project management experience</td>
<td>16%</td>
</tr>
</tbody>
</table>

*Source: Excellence in Risk Management IX, Marsh/RIMS, April 2012*
Better integration between risk management and an organization’s strategic goals can be achieved in several ways, including adopting a formal strategic risk management process, involving risk management in early stages of strategic planning, and improving communication between risk management and senior management.

Several tools and exercises are also available to risk managers to gain a deeper view of risk management as they transition to accountable care—identifying and quantifying organizational risks and informing decisions on where to focus resources to address them. These include:

- Broad-based risk committees that look at existing and emerging risks through a wide lens, and encourage communication across the organization by including leaders from various departments and functions.
- Risk assessments, a collaborative approach involving risk managers and quality managers to identify specific financial, clinical, and operational risks and ways to mitigate those risks daily.
- Risk mapping, an interactive exercise to examine current and emerging risks facing the organization and the industry (see Figure 2).

![FIGURE 2: SAMPLE RISK MAP—ACCOUNTABLE CARE INTEGRATION STRATEGY, YEAR 1](image-url)
Ultimately, these and other steps can help risk managers meet the high expectations of senior management and drive the implementation of true enterprise risk management (ERM)—a holistic view of risk management across the organization. A more structured, consistent, and continuous approach through ERM, applied across the organization, can in turn facilitate better capital resource allocation decisions for risk managers and senior leadership, increase operational efficiency, and enhance overall governance and compliance (see Figure 3).

Source: Excellence in Risk Management IX, Marsh/RIMS, April 2012
DEVELOPING EFFECTIVE INSURANCE PROGRAMS

Risk assessments can also help to guide future decisions made by ACOs and participating organizations about their insurance programs. As coordination of patient care is improved across ACOs, many key exposures should decrease; however, temporary increases in exposures should be expected during the transition period. Many of these transition and ongoing ACO exposures can be addressed through a variety of existing insurance solutions.

Directors and officers liability (D&O) insurance, which most health care organizations already buy, provides significant coverage for many of the risks that ACOs may face, including litigation filed by shareholders and others for any number of business decisions. Other critical insurance options include:

- **Managed care errors and omissions (E&O) insurance**, which protects the health plan or network coordinator from claims brought by patients, competitors, and regulators. Many health care providers currently do not purchase such insurance coverage, but any organization that is forming or joining an ACO should consider purchasing it.

- **Provider excess loss insurance** or provider stop loss insurance, which protects the financial stability of a health care provider by limiting its exposure to catastrophic individual health claims from services it has contracted to provide to managed care plan members.

- **Cyber/data privacy insurance**, which provides coverage for data breaches, whether intentional or unintentional, including the cost of notification to affected individuals. Health care organizations have long been buyers of cyber insurance, and awareness has continued to rise through a spate of high-profile data breaches in the industry.

- **Medical professional liability insurance**, or medical malpractice insurance, which provides coverage for claims of patient injury or harm as a result of a negligence by a physician or other medical professional. Many health care providers already purchase this insurance; others set aside reserves to draw upon in the event of a loss.

Health care organizations should also consider adapting their use of captive insurance companies, which are owned by the organizations themselves and offer several benefits. Traditionally, hospitals and others have used their captives to provide insurance to non-insured physicians. Going forward, captives potentially could be used to provide insurance to network members that hospitals and others do not own—for example, nursing homes or hospice facilities. Captives could also be used as a means to share financial risk associated with capitated payments across the network.
Even if an organization already purchases these insurance products or has a captive, new accountable care models raise new questions.

- Does the existing D&O policy respond to wrongful acts from building networks, choosing care models, and negotiating payer contracts?
- Does existing managed care E&O coverage address establishing a network of providers, managing patient care, and distributing shared payments?
- Has a provider excess program been put in place to protect at-risk managed care contracts?
- Does existing cyber/data privacy coverage address exposures for affiliated providers’ access to the same patient data sources? Do affiliates have their own insurance for this exposure?

Risk managers and their insurance advisors should address these questions, along with those posed by underwriters about their ACO strategy. Underwriters have not yet reached the point of demanding to review individual contracts that insureds have with other network participants. But they have demonstrated a clear interest in ensuring that the organizations they are insuring have well-defined plans for the transition to accountable care.

Risk managers would be well-served by engaging with their underwriters to explain their strategies and objectives for accountable care. Face-to-face meetings early in the transition process can help to eliminate many ambiguities and uncertainties and ease underwriters’ doubts.

APPROACHING THE NEW FRONTIER

The new frontier of accountable care presents opportunities for the health care industry, including the promise of substantial cost savings. But times of transition often bring organizations their greatest tests and challenge leaders to rethink today’s approaches and find innovative ways to address tomorrow’s demands.

As the move toward accountable care continues, organizations must confront those demands and improve safety and service cultures, reevaluate risk exposures and insurance programs, and more closely align risk management with strategy. Those organizations that can meet this challenge will emerge as leaders in the next era of health care delivery.
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