

Health Care Leader Perspectives on State Government–Sponsored Accountable Care for Public Employees

ELAINE MICHELLE ALBERTSON, MPH; SUZANNE J. WOOD, PHD; NORMA B. COE, PHD; AND DOUGLAS A. CONRAD, PHD

ABSTRACT

Objectives: Most studies of accountable care organizations (ACOs) have focused on contracts with commercial payers, Medicare, or Medicaid. This study contributes to the literature by describing implementation of an ACO for public employees, contracted by a state government under a federally funded State Innovation Model grant.

Study Design: Over a 2-year period, we conducted 17 semistructured qualitative interviews with 20 clinical and administrative representatives of 5 participating health care systems.

Methods: We used an abductive qualitative coding approach to identify key themes in ACO implementation, with a focus on the role of state government.

Results: Interview participants discussed conditions for ACO adoption, components of implementation, likely effectiveness, and expectations about sustainability. The state government influenced ACO development by creating opportunities for innovation in care delivery, leveraging purchasing power, providing data, developing and maintaining strategic contracts, and encouraging public employees to enroll in accountable care plans. In some organizations, the ACO may have had a spillover effect, improving care for patients who were not public employees. Findings indicate that this state-led ACO shared traits with other public ACOs contracted under Medicare and Medicaid.

Conclusions: By implementing an ACO for public employees, state governments may catalyze improvements in health care and influence the direction of payment reform.

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Across the United States, health care stakeholders have formed accountable care organizations (ACOs) to reduce fragmentation and provide higher-value services.^{1,2} It has been argued that ACOs must include certain components, such as information technology, performance measures, and mechanisms for sharing financial risk.^{1,3} At the same time, evidence indicates that variation has emerged in ACO implementation.^{4,5} One important factor that varies is the type of payer or purchaser that holds providers accountable.

Studies have classified ACOs based on whether contracts were established with private payers, such as commercial insurance companies, or public payers, as with Medicare and Medicaid.⁶⁻¹⁰ One survey found that ACOs with private payers were more sustainable and efficient compared with those with public payers and that public payers can act as stewards to catalyze reform.¹⁰ However, often overlooked is the case of ACOs involving state governments, outside of Medicaid, which is jointly administered with federal government. State-led ACOs merit attention as a potentially distinct category due to the relative autonomy of states in the American federalist system and states' power as health care purchasers for public employees.

Very few studies have documented state-led ACOs. One conceptual model for evaluating ACOs included the state policy environment as a contextual factor, but it did not discuss the state as a party to contracts.⁶ Another analysis argued that states can drive payment reform through public employee insurance plans¹¹; this report listed challenges to implementing ACOs for public employees—development of data systems and new care processes, cost management, and alignment with other ACOs—but did not deeply analyze the influence of state government in implementation. To date, the only state-led

ACO for public employees that has been studied in depth is the model developed for the California Public Employees' Retirement System (CalPERS). However, descriptions of this program have mainly focused on the role of commercial health system partnerships rather than state government.¹²⁻¹⁴

We provide a new perspective by examining key factors in the implementation of an ACO for public employees in Washington state, with special attention to the role of state government. In 2014, Washington state received a \$64.9 million State Innovation Model (SIM) Round Two Model Test Award from the Center for Medicare & Medicaid Innovation to increase value-based purchasing and improve population health and care coordination.¹⁵ In 2016, the state established 2 Uniform Medical Plan Plus (UMP Plus) accountable care insurance plans available on an opt-in basis as a subset of health insurance options for public employees.¹⁶ Those who chose to participate had lower premiums and cost sharing but a smaller network of covered providers compared with the standard fee-for-service plan.¹⁶ Each UMP Plus plan offered a different set of in-network providers in different counties, although a small number of counties and providers were in both. For this study, these plans are referred to together as the UMP Plus ACO. In January 2019, there were 30,906 public employees enrolled in the UMP Plus ACO, approximately 8.1% of those eligible to enroll.¹⁷

The UMP Plus ACO represents a valuable case study for state government and health care leaders interested in accountable care for public employees. To inform future ACO development, we applied qualitative methods to explore 2 questions: (1) What factors did leaders of participating health systems identify as most significant in implementation? (2) In what ways did leaders of participating health systems believe that state government influenced implementation?

METHODS

In January-March 2017 and March-April 2018, we conducted 17 semistructured interviews using a purposive sample of 20 administrative and clinical leaders from 5 large health systems participating in the UMP Plus ACO (Table 1). Participants were asked for their perspectives on ACO implementation. Table 2¹⁸ provides sample questions. We conducted 2 rounds of interviews, 1 in each year, to assess points of consistency and changes in perspective over time. Except for a single organization that was represented only during the second year, at least 1 representative from each organization was interviewed in each round. When possible, the same organizational representative was interviewed in both years. Interviews lasted 48 to 90 minutes.

Interviews were securely stored, transcribed, and coded using Dedoose version 8.1.8 (SocioCultural Research Consultants).

Table 1. Organizations and Participant Roles Represented in Interviews^a

Organization	Description	2017 interviews	2018 interviews
Organization 1	Regional health system with approximately 300 beds in 1 hospital, participating in 1 of the 2 UMP Plus networks	n = 2 (administrative leader; clinical leader)	n = 2 (administrative leader; clinical leader)
Organization 2	Clinically integrated network of physicians including >100 practices, participating in 1 of the 2 UMP Plus networks	n = 3 (2 administrative leaders; clinical leader)	n = 3 (2 administrative leaders; clinical leader)
Organization 3	Regional health system with approximately 1500 beds in 4 hospitals, participating in 1 of the 2 UMP Plus networks	n = 2 (administrative leader; clinical leader)	n = 2 (administrative leader; clinical leader)
Organization 4	Regional health system with approximately 1400 beds in 5 hospitals, participating in both of the UMP Plus networks	n = 3 (2 administrative leaders; clinical leader)	n = 2 (administrative leader; clinical leader)
Organization 5	Regional health system with approximately 350 beds in 1 hospital, participating in both of the UMP Plus networks	None	n = 1 (administrative leader)

UMP Plus, Uniform Medical Plan Plus.

^aSeventeen interviews with 20 administrative and clinical leaders were conducted over 2 rounds in 2017 and 2018. Some interviews were conducted with multiple individuals simultaneously. Efforts were made to reinterview the same administrative and clinical leaders in each round when possible.

Table 2. Selected Questions From Semistructured Interview Guide on ACO Implementation^{18,a}

Topic	Sample question
Adoption	<ul style="list-style-type: none"> • Why did you decide to participate? • What objectives does your organization expect to achieve through accountable care program reform?
Implementation	<ul style="list-style-type: none"> • Please describe your organization's approaches for attaining objectives through what you're doing with the accountable care program and other initiatives. • What has your organization done in the past (or right now) to get ready for payment redesign? • What are the major internal organizational facilitators and barriers to your organization's attainment of its objectives from participation in accountable care program reform? (Probes were used to address each component separately.)
Effectiveness	<ul style="list-style-type: none"> • How effective do you think the accountable care program is/will be in improving population health, the quality of health care, and in reducing health care costs in Washington state? (Probes were used to address each component separately.) • Is your organization changing care just for accountable care program patients or for all patients?
Sustainability	<ul style="list-style-type: none"> • In your view, what will it take to sustain accountable care program efforts into the future?

ACO, accountable care organization.

^aSample questions from this interview guide are also provided in Wood et al.¹⁸

We used abductive coding—a combination of deductive and inductive coding—that entailed developing themes and categories to expand on existing theory.^{19,20} First, 2 researchers coded each interview using a priori codes derived from the interview guide, which was based on concepts theorized to be important in ACO implementation.^{18,21} Then, the coders used open coding to identify subthemes, allowing for new insights and theory generation. Coders discussed disagreements to reach consensus, and additional team members reviewed deidentified results to validate findings. The Washington State Institutional Review Board (project D-071416-A17.01) approved the methods.

RESULTS

Participants responded to questions about 4 key aspects of ACO development: (1) adoption, (2) implementation, (3) effectiveness, and (4) sustainability (Table 3).

Conditions for Adoption

Participants highlighted 3 main conditions that led their organizations to join the UMP Plus ACO. First, participating organizations were largely uniform in their objectives of controlling cost, improving quality, developing partnerships, and growing their organizations. At least 1 participant from each organization felt that their organization's goals and objectives aligned with those of the UMP Plus ACO, an understandable precursor to participation. Second, participants discussed the importance of organizational leadership setting a vision for accountable care. One or more participants from each organization highlighted leadership as a facilitator. Third, participants from each organization emphasized formation of interorganizational provider networks as an important step toward adopting the ACO contract. Network development included inviting providers "to be part of this journey by contracting and agreeing to the goals," and sometimes extended to creating "a formal legal entity...a joint venture" with organizations in the geographic region. Respondents reported similar conditions for ACO adoption in both rounds of interviews.

The state government encouraged adoption by creating compelling opportunities for organizations to develop in ways that participants viewed as desirable. For example, an administrative representative from organization 2 described it this way: "Seeing how the industry is shifting...we thought it was best to get in early." Although interview participants demonstrated awareness of other ACOs such as those under Medicare, most emphasized the importance of this state-led opportunity and commented sparingly on other contracts. Several participants also explained that their organizations were motivated to participate due to a perception that the state government was a large and important purchaser—thus, participating could open new business opportunities. An administrative representative of organization 1 stressed the importance of "the Health Care Authority's role as both the biggest purchaser in the state, in addition to being the policy maker." An administrative representative of organization 2 similarly described their motivation as "gaining market share."

Components of Implementation

Participants described 4 focus areas for implementation after adoption. First, nearly every participant highlighted data and information technology as critical, and there was a desire for more complete and timely data on cost, quality, and utilization. After patients enrolled in a UMP Plus ACO insurance plan, participating organizations attributed ACO members to in-network providers based on treatment history. Timely claims and utilization data thus proved essential for accurate

attribution—an important foundation for care management and attainment of cost and quality targets.

Second, at least 1 participant from each organization discussed partnership and collaboration as part of implementation. Participants considered partnerships among providers with a range of specialties to be important for providing breadth of services to attract patients to the ACO. Third, participants emphasized the need for patient engagement to improve cost and quality. Through outreach and the design of the benefits package, organizations engaged patients to keep them in-network to control costs and to encourage them to seek preventive care and manage chronic conditions. In the second round of interviews, participants from 4 of the 5 organizations placed increased emphasis on the importance of strategic benefits design for program success. Fourth, 1 or more participants from each organization discussed provider engagement. Provider buy-in was viewed as central to attaining cost and quality targets.

During implementation, participants saw an important role for the state in making real-time data available. As an administrative representative from organization 5 described, “Not getting good data in a timely fashion...makes it difficult for us to try to manage and be held accountable.” Additionally, participants saw their contracts with the state as creating both challenges and opportunities. For example, a clinical representative from organization 2 commented, “The state’s

reporting requirements and measures are exceedingly difficult, much more difficult than any other contract.” Not all participants expressed concern about the contracts, but most emphasized the importance of partnering with the state as an opportunity to improve care delivery. For example, the same participant from organization 2 noted, “We have the intention of using [the contracts] to create the integrated care, to benchmark data, the quality improvement that we know needs to happen.” Similarly, the administrative representative from organization 3 stated that “we wanted to invest in this space... the contracts gave us a reason.”

Expected Effectiveness

In both rounds of interviews, participants speculated that the UMP Plus ACO would have the strongest and most immediate beneficial effects on care quality, along with moderate but still beneficial effects on cost, population health, and patient experience. Participants viewed cost and population health improvements as a long-term endeavor that would require more time. However, they were optimistic that the program would attain these benefits eventually because of unique incentives for the state to succeed as a public agency with limited resources. For example, a clinical representative from organization 1 noted, “The state has [a] pretty tight budget...an intrinsic interest to slow down the cost growth...maybe even more so than private purchasers.” In the second round of interviews, participants

Table 3. Key Themes in Perspectives of Organizational Leaders on an ACO for Public Employees

Theme	Subthemes	
	General findings	State government influence
Conditions for adoption	<ul style="list-style-type: none"> • Aligned goals and objectives • Leadership and vision • Interorganizational network development 	<ul style="list-style-type: none"> • Creation of innovation opportunity • Influential purchaser
Components of implementation	<ul style="list-style-type: none"> • Data and information technology • Interorganizational partnerships • Patient engagement • Provider engagement • Changes to care processes 	<ul style="list-style-type: none"> • Ensuring data availability • Strategic contract development
Expected effectiveness	<ul style="list-style-type: none"> • Strong effect on quality • Moderate effect on cost • Moderate effect on population health • Moderate effect on patient experience 	<ul style="list-style-type: none"> • Spillover effect on non-ACO members
Conditions for sustainability	<ul style="list-style-type: none"> • Financial sustainability • Industry engagement • Increasing enrollment • Normalizing procedures 	<ul style="list-style-type: none"> • Continuation of contracts • Promotion of public employee enrollment in ACO

ACO, accountable care organization.

discussed the importance of population health management more than in the first round, indicating that organizations may have elevated their focus on population health outcomes.

Although the state contracted with participating organizations to deliver accountable care for public employees only, organizational representatives observed a spillover effect on care for patients not enrolled in the UMP Plus ACO. However, participants also noted that due to resource and data limitations, some care processes were restricted to enrolled public employees. For example, basic practices like checking body mass index prior to elective procedures were typically extended to all patients, whereas more intensive services like high-risk care management and certain types of customer service were available only to ACO members. A clinical representative from organization 3 commented, “Many of our care transformation initiatives affect all patients....Some...currently target [accountable care] patients only. Over time, as the transition to value-based payment continues, these programs will expand to an increasing share of the patient population.”

Conditions for Sustainability

Because the UMP Plus ACO was established under a time-limited SIM grant, an important topic was whether and how the program would be sustained after the grant ended in January 2019. Interview participants typically viewed sustainability as necessarily independent of the grant, and they highlighted 4 strategies to accomplish it. First, at least 1 representative from each organization discussed the importance of financial viability. As the clinical representative from organization 1 described, “We have to demonstrate success...[and] achieve our cost savings.” In the second round of interviews, 2 organizational participants shared their learning that success had to be demonstrated externally. For example, an administrative representative from organization 1 explained, “There has to be a leap of faith amongst payers and purchasers.... We need to publish our outcomes...of programs like this to help encourage them to implement.”

Second, and related to the emerging theme of demonstrating success to others, participants from all but 1 organization discussed how building relationships with health care stakeholders (eg, purchasers besides the state) could sustain the program. Organizational representatives expressed interest in engaging with other employers to create accountable care contracts and to align metrics across contracts. As an administrative representative from organization 4 summarized, “We’re going to need more than the state to do it, right? We’re just going to...need purchasers, we’re going to need the payers, we’re going to need the employers.”

Third, participants from 3 organizations discussed increasing patient enrollment in ACOs. Although enrollment in the UMP Plus ACO steadily increased after plans launched in 2016, interview participants noted that the number was still small relative to their overall “book of business.” This challenged sustainability by requiring their organizations to straddle the 2 worlds of fee-for-service and value-based payment. Fourth, participants from 3 organizations anticipated that accountable care would be sustained because new elements of care delivery had become formalized as standard procedures. For example, 1 respondent described the care management associated with the ACO as “hard-wired.” Another emphasized that they avoided hiring new staff just for this contract and instead were “making do with the existing resources” so that “it would be sustainable.”

Participants identified 2 primary opportunities for state government to support sustainability of accountable care in their organizations after the grant. First, many noted that the most fundamental action would be to renew and update the existing contracts. Second, participants highlighted a need for greater ACO enrollment, which could be facilitated by the state government through outreach and promotion of accountable care among public employees and other large purchasers.

DISCUSSION

This analysis fills a pressing gap in the literature by documenting the perspectives of leaders of health care delivery systems participating in an accountable care program contracted by state government. In addition to shaping the regulatory context, states can influence payment reform by offering accountable care insurance plans to public employees. Interview participants reported that by establishing the UMP Plus ACO, Washington state created a valuable opportunity for participating provider organizations to improve care. At the same time, participants viewed state government more as an initial catalyst than a perpetual source of support, and they planned to sustain the program by strengthening ties with other health care stakeholders and normalizing a value-based approach as standard procedure. These strategies appear to have been successful, as the SIM grant ended in January 2019²² and the UMP Plus ACO was still offered in 2020.²³

Results indicate that this state-led ACO for public employees shared more traits with the public ACOs of Medicare and Medicaid than with private ACOs contracted with commercial payers. For example, participant views that the state’s ACO catalyzed changes in their organizations align with prior research that described public ACOs as stewards of delivery system reform.¹⁰ Participants provide limited detail on why the state ACO program was a greater motivator than, for example, Medicare ACOs, but the perceived influence could be related to views

of the state as a large and important purchaser. Additionally, participants emphasized the need to design contracts and ACO member benefits strategically to attain success. It is possible that the state-led ACO provided more flexibility in these areas than other public ACOs. Participant concerns about cumbersome reporting requirements and difficulty accessing timely patient data also reflect prior research that public ACOs tend to score lower on indicators of efficiency than private ACOs.¹⁰ Interestingly, prior literature framed the CalPERS ACO for public employees as a commercial ACO in direct opposition to a public ACO,¹⁴ suggesting a need for clarity on how state-led ACOs for public employees are classified.

Regarding impact, participants anticipated that the UMP Plus ACO could have a stronger and more immediate effect on quality of care than on cost, population health, or patient experience. This aligns with participant reports of significant organizational efforts focused on quality improvement and with findings of other studies. One systematic review found that ACOs consistently had a positive effect on quality-related measures such as preventive care and chronic disease management but a limited effect on patient experience and clinical outcomes.⁷ Another study of hospital-based ACOs found that quality improvements were not accompanied by decreased cost growth.²⁴ It is possible that interview participants were familiar with existing literature, leading to biased results. As such, quantitative analysis could be beneficial to confirm whether this ACO truly had a greater impact on quality than other outcomes.

Participants' conservative expectations for near-term population health improvements are potentially contradictory given the finding of a spillover effect of the ACO into care for patients who were not public employees. There has been ongoing discussion in the literature regarding the ability of ACOs to affect population health, and some have argued that the effect depends on how broadly the population is defined.²⁵⁻²⁷ Our results indicate that by implementing an ACO for public employees, state governments may be able to improve care processes and outcomes for a patient population that extends beyond those enrolled. However, this high-value care still may not reach community members who lack insurance coverage or access.

Limitations

Results should be considered under several limitations. First, the focus on 1 program limits generalizability. Further research is needed to evaluate whether observed themes are present in different contexts. This is especially important given that enrollment was opt-in—provider perspectives could change if patients with different characteristics selected the ACO insurance plan. Second, although repeating data collection across years

contributed to reliability, the small sample size limits validity of results. Future studies should consider larger samples to increase depth. Third, this study relied solely on qualitative data and did not include a quantitative component. Although a qualitative approach was appropriate for our research questions, future research could be complemented by quantitative methods, to test, for example, whether participants' expectations of ACO effectiveness are correct. Fourth, we conducted interviews during early to mid-implementation. Longer-term follow-up would be beneficial, particularly because interview participants speculate that program impact could increase over time.

CONCLUSIONS

Accountable care represents an important opportunity for state governments to improve the efficiency and effectiveness of health care. This analysis provides evidence that, like other public ACOs under Medicare and Medicaid, ACO insurance plans established by state governments for public employees can catalyze potential long-term improvements for both public employees and other patients who receive services from participating provider organizations.

Author Affiliations: Jonathan and Karin Fielding School of Public Health, University of California, Los Angeles (EMA), Los Angeles, CA; University of Washington School of Public Health (SJW, DAC), Seattle, WA; Perelman School of Medicine, University of Pennsylvania (NBC), Philadelphia, PA.

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Send Correspondence to: Elaine Michelle Albertson, MPH, Department of Health Policy and Management, Fielding School of Public Health, University of California, Los Angeles, 650 Charles Young Dr S, 31-269 CHS Box 951772, Los Angeles, CA 90095-1772. Email: elalb@ucla.edu.

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