

## ACCOUNTABLE CARE ORGANIZATIONS: TO BE OR NOT TO BE?

**N**o matter what the political future holds, Accountable Care Organizations, a favorite of policy specialists of all stripes, are likely to be one of the Next Big Things in healthcare. While we will know more after the Centers for Medicare and Medicaid Services publish proposed ACO regulations, CMS is clearly prepared to push this move towards value-based purchasing.

It's not an easy move for hospital leadership to make. If successful, an ACO should improve quality of care, with benefits to your competitive position. However, that success could also reduce hospital admissions and revenue, unless you attract additional primary care physicians (PCPs). If admissions go down, how do you handle your fixed costs?

Successful ACOs will have shared savings from operations, which will partially offset any decrease in admissions revenue. But while the revenue losses will be happening in "real time", it will take one to one and a half years for the savings to be calculated and shared with the ACO. Then it's a three-way split between the physicians, the hospital and CMS, whose share is as yet undefined.

Combine these potential impacts with the need to invest significant capital in starting an ACO, and you might be thinking it best to walk away.

### THE ACO CATCH-22

An ACO is an opportunity that looks like (and may in some ways be) a threat. While it may seem safest to avoid the dangers, not pursuing the opportunity may pose its own risks.

#### **THREAT 1:** *The doctors do it themselves.*

If you don't create an ACO, a group of your physicians could decide to create one on their own. If they are successful, admissions will fall—and the hospital will not receive any of the shared savings. Just as hospitals often participated in physician-hospital joint ventures that would reduce their ancillary service revenues, partnering with your doctors in an ACO lets you keep at least a

portion of the revenue (in this case, a portion of the savings). Choose not to participate and you will lose all of it.

**THREAT 2:** *Your competitors lure away your PCP referral base. If you step away from ACOs, your competitors could use their ACO program to woo your PCPs, with negative effects on your referral patterns. PCPs are likely to find an ACO attractive, because it may provide payment for doing things they've wanted to do for their patients, but couldn't afford to do, like spending more time on patient education, or coordinating with specialists.*

### THE UPSIDE OF ACOs

Create a successful ACO and you may well experience a reduction in admissions. However, if the ACO is well-designed and executed, yours could be the hospital increasing its market share by tying in additional PCPs, and bolstering your hospital's physician alignment strategy.

One key to success lies in structuring an incentive system that will both attract PCPs and reward them for activities that will reduce overall healthcare costs for ACO members, such as managing chronic conditions. This advance against anticipated shared savings may need to meet fair market value standards to meet regulatory requirements. Or, ACO regulations may broaden the options by softening current Stark and Anti-Kick-back rules against "buying" referrals.

For hospitals and healthcare systems working to develop a fully integrated delivery system, the "upside-only" risk arrangement with Medicare may provide useful lessons in developing risk-sharing arrangements or pay-for-performance contracts with other payers.

### WHAT NOW?

Given that ACO funding will start in 2012, hospitals need to start assessing their risks and opportunities before the regulations appear. Evaluate the opportunities and risks of an ACO for your organization, and then engage organizational leadership in a fact-based discussion.

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## DGA PROFILE: JOHN M. HARRIS, PRINCIPAL



When John Harris says, "I'm thinking about ACOs just about 24/7 these days," he's not complaining. John is applying his extensive experience in advising hospitals, PHOs, IPAs, health plans and PACE programs to heading up DGA's ACO initiative.

"The issues in developing ACOs are very similar to those DGA has worked on for more than 15 years in projects from PHO development to risk contracts to pay-for-performance," John notes. "You need to understand insurers. You've got to get the doctors motivated and working with hospital leaders. Your incentives have to hit the sweet spot."

ACO planning taps John's skills as a facilitator, strategist and hard-nosed financial analyst.

"Each client situation is unique," he says, "but each lesson learned can apply to others. And our team has seen it all. That's what makes this work so interesting."

John presents frequently on ACOs, strategy and physician alignment. He is the founder of DocuBank, the nation's largest registry of advance medical directives. John holds a BA from Dartmouth and an MBA in healthcare management from The Wharton School of the University of Pennsylvania.

When not at work, John clears his head on the tennis court or Ultimate Frisbee field. With his oldest heading off to college, the other two are bracing for more attention from Dad.

ACCOUNTABLE CARE ORGANIZATIONS

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**THE OPPORTUNITY:** What assets do you have in clinical management, IT and physician engagement that will position you well for developing an ACO? Can you support the investment required? Do you have a strong PCP core, and will you be able to attract other PCPs? How much opportunity is there to reduce unnecessary utilization? Should you affiliate with another hospital/system to strengthen your position?

**THE RISK:** How likely is it that a competing hospital or a group of your physicians would create an ACO without you? What patient management assets are they able to bring to the table? How much of your PCP base might be attracted by their initiatives? What would that do to your specialty referrals and admissions?

In many markets, the ACO discussion is shaking up the competitive landscape, with hospitals/systems considering mergers or affiliations.

In developing your strategic assessment, keep in mind other strategic issues that may be triggered by ACOs. For example, to start an ACO, you may need capital for complex IT systems. In addition, consider your broader payer contracting strategy. To what extent should the ACO model be applied to your commercial payers? How would you respond to an offer to participate in a regional ACO?

While creating an ACO poses risks, hiding from the opportunity has its own perils. The market opportunities available to those hospitals that choose to pursue an ACO may be most easily realized by early entrants to the field. Now is the time to give careful consideration to the possibilities, and decide how your organization will respond.

For more on developing your ACO strategy, see [www.dgapartners.com/ACO](http://www.dgapartners.com/ACO).

DGA NEWS

The AAHDS 2010 Fall Managed Care Forum will include a two-part DGA presentation. “Financial Analysis of Health Reform Payment Innovations: Running the Numbers on ACOs and Running the Numbers on Bundled Payments Bundled Payments,” will be given by Principal John Harris and Director Jon Pearce, respectively. The Forum will be held November 4 – 5 in Las Vegas, NV.

DGA Principal John Harris, and Don Seymour, President of Don Seymour and Associates, will be presenting a webinar, “Accountable Care Organizations: the Challenge of Setting Strategy amid Uncertainty” for the Governance Institute on September 22 at 2:00 – 3:00 p.m. ET. For details: [dgapartners.com/events](http://dgapartners.com/events).

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