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solving the ACO conundrum

A hospital's ACO strategy should target market share growth to offset reduced utilization rates and to maintain fiscal strength.

Accountable care organizations (ACOs), as described in the 2010 Affordable Care Act, pose a true strategic conundrum for hospitals. On the positive side, ACOs will present hospitals with an important learning opportunity to begin to be accountable for value related to overall population healthcare costs. Yet they also are seen as being problematic from a financial perspective, in a way that can be expressed in relatively simple terms:

- > If our ACO succeeds in reducing utilization, our hospital will lose revenue.
- > If we don't set up an ACO, a competitor might, and we'll lose the revenue anyway.
- > Why can't we just skip the ACO and keep our volume?

But do ACOs truly portend lost revenue for hospitals? They certainly will have a profound effect on hospitals and physicians, but not necessarily in the way providers may think. If successful, ACOs hold the promise of enhancing alignment with physicians, improving quality, and reducing cost for the Medicare program. But before that, they will be a vehicle for strategies to increase market share.

A focused strategic and financial analysis will be needed to set the right course for developing an ACO. The stakes are high. If you are too conservative, competitors may steal your volume. Too aggressive, you could waste millions and alienate key stakeholders by promising too much. Pick the right partners, and you could solidify, or even expand, your market position; the wrong partners, and you may face years of frustration.

Another challenge is the tight time line for strategic decisions. Under the Medicare Shared Savings Program in the 2010 Affordable Care Act, ACOs for Medicare will begin operation in January of 2012. Hospitals must make key strategic decisions within months. Many have begun exploring their options, but most have not yet completed the necessary preliminary financial analysis required for such a major initiative.

Why ACOs Are Driving Strategy

At first blush, the ability to reduce costs and generate savings would seem to be the key measure of ACO success. Eventually it may be. But to get there, hospitals must focus first on deciding whether to develop an ACO, assessing their competition, securing their patient volume, partnering with physicians, and deciding whether to work with other hospitals or systems in an ACO.

Among hospitals, the greatest strategic concern raised by ACOs is their potential to shift volume. Hospitals are highly sensitive to volume for financial success because of high fixed costs. Hospitals also see ACOs as potential vehicles for addressing other strategic issues such as physician alignment, clinical integration, electronic health records (EHRs), and payer partnership

AT A GLANCE

- > Hospitals contemplating developing an accountable care organization (ACO) will be rewarded for improving quality and reducing waste, but a chief strategic concern is the fear of losing volume.
- > Hospital financial leaders considering an ACO should conduct a detailed financial analysis that examines the net impact of both shared ACO savings and hospital volume changes.
- > A key part of this analysis should be an assessment of the organization's prospects for using the ACO to increase market share.

strategies for insurance exchanges. These related and overlapping strategies complicate the strategic and financial analysis of ACO options, as it is likely that the hospital will already have some efforts under way in several areas. Untangling the cost and benefit of these different strategies can be difficult, yet it is important to do so.

Beyond these various strategic issues, however, the fear of losing volume and the hope of gaining volume continue to be the primary strategic concerns of many hospital leaders, especially with Medicare payment reductions from healthcare reform on the horizon. With Medicare typically accounting for one-third to one-half of hospital business nationwide, the prospect of shifting some of this volume to, or from, a facility is meaningful. Moreover, the stakes become higher to the extent that physicians might shift commercial volume as well.

A Shift in Mind-Set

If ACOs are implemented as policymakers hope, volume will cease to be the primary concern for hospitals. In such a circumstance, ACOs will ideally represent a paradigm shift from the focus on volume, where the concern is getting paid per service to cover high fixed costs, to a focus on population health, where the main measure of success is reducing hospital stays and other high cost services (while maintaining or improving quality).

For most hospitals today, inpatient stays and high-tech outpatient services are the economic drivers of the business model. Under the new paradigm, however, ACOs require a shift in a hospital's mind-set from caring for patients to caring for a population. Even hospitals with a strong mission of "improving the health of the community" rarely focus significant resources on this mission.

The key to success for many hospitals will be increasing market share to offset reductions in utilization rates.

Some hospitals are shifting their vision to this new paradigm and are seeking to adjust to a new economic engine—one focused on population health and value to consumers and purchasers. Other hospitals lean toward a "wait and see" strategy. To decide what is best, each hospital must wrestle with the volume/value conundrum.

In general, the best option for a given hospital will depend on its local market situation. A hospital that has a clear opportunity to increase its market share will probably want to establish an ACO. Similarly, the hospital may be compelled to pursue an ACO to defend its market position if a strong competing hospital seems likely to use an ACO as an opportunity to steal market share.

Elevated Role of the Primary Care Physician

The hospital's relationship with primary care physicians is a pivotal concern in strategic planning for an ACO. In the Affordable Care Act, beneficiaries are assigned to ACOs based on the Medicare beneficiary's use of primary care services.^a Therefore, securing the involvement of primary care physicians is a critical first step in development of an ACO. Furthermore, primary care physician affiliations present some of the opportunity while also posing some of the risk

a. For more information on the assignment of beneficiaries and other ACO program details, see Ronning, P.L., "ACOs: Preparing for Medicare's Shared Savings Program," *hfm*, August 2010.

associated with ACOs. Hospitals could see volume shift as primary care physicians choose their alignment partners.

There is an often-overlooked subtlety to this issue. ACOs under the Affordable Care Act are anticipated to be “open access,” with patients maintaining the ability to see whichever providers they wish and to choose whichever hospital they wish. Given this freedom, why would alignment with primary care physicians matter so much? Theoretically, patients could still choose your hospital even if they have chosen a primary care physician aligned with an ACO of a competing hospital.

Yet even with open access, volume will likely be steered to ACO sponsors because of the influence of the primary care physicians, enhanced care management protocols, and greater clinical IT integration. Hospitals that do not sponsor ACOs will still be allowed to care for the members of ACOs sponsored by other hospitals, but may lose volume due to this physician-driven steerage.

Additional Strategic Considerations

As was suggested in the opening paragraphs, the key to a successful ACO for many hospitals will be in its ability to increase market share to offset reductions in utilization rates. And in the previous section, we have addressed one of the key means for a hospital to increase market share, which is to seek the broadest involvement of primary care physicians that can reasonably align with the organization.

Yet hospitals should also consider additional strategies. One is to focus on retaining cases from the population that previously had been ending up in different hospitals, despite having been treated by the hospital’s primary care physicians. If a hospital can reduce such “leakage” through better management of patients in a more integrated

setting, it may offset any drops in volume resulting from reducing utilization through better care management. Retaining these leaked cases is a real possibility when patients gain confidence in the more thorough and coordinated care a hospital provides through its ACO efforts.

Some hospitals with a large base of employed primary care physicians may seek to develop an ACO with these employed physicians. After all, it will likely be easier to manage population health costs with a more tightly managed group of physicians. However, this approach could alienate independent primary care physicians, leaving them disgruntled and primed to align with competitors in an ACO. Even if 80 percent of primary care physicians referring to the hospital are employed, the remaining 20 percent still account for significant volume. Losing them could significantly harm a hospital.

If a strong physician group wants to set up an ACO, it may be best to try to partner with them. Well-managed physician groups have many of the tools needed to succeed as ACOs. For physicians, the opportunity to obtain additional funds by reducing hospital utilization is an attractive proposition. However, physician groups often lack the working capital required to invest in improving care now and then be forced to wait as much as two years for the distribution of the hoped-for savings. As a result, hospitals may be helpful partners for motivated physicians seeking ACO success.

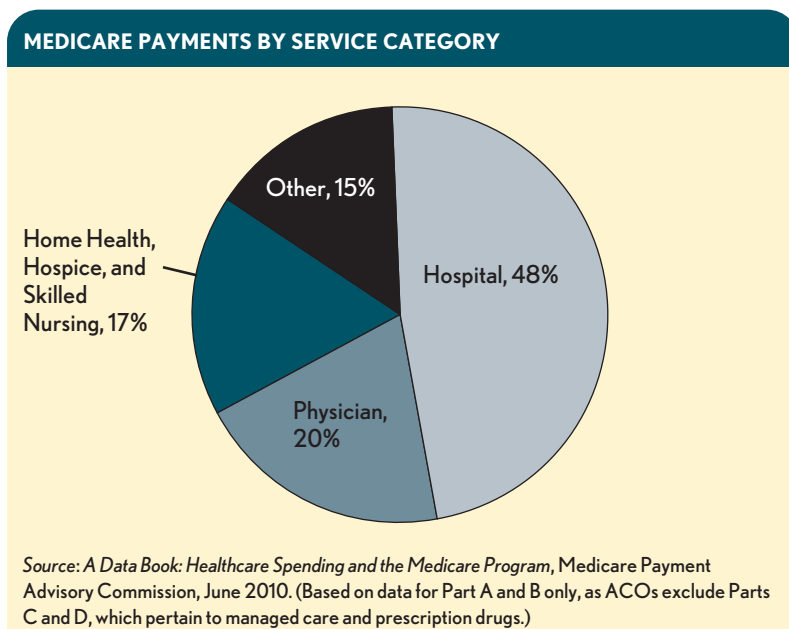
The physician-hospital partnerships inherent in ACOs also may yield additional benefits. Improved partnering with physicians could help reduce hospital inpatient operating costs. Under DRG payments, these savings accrue to the hospital. Hospitals may also improve quality of care and patient satisfaction through an increased focus on improved clinical workflow such as care coordination,

communication between physicians, and smoother transitions from hospital to home.

Assessing the Net Financial Impact of an ACO

Given the significant financial ramifications of ACO strategy, hospital CFOs should take a leadership role in evaluating ACO strategy. Hospital boards will look to CFOs for the complete picture. The financial analysis described below will help provide that picture by evaluating the ACO’s net impact, including both shared savings and changes in market share.

ACO OPPORTUNITY	
Population	290,000
Medicare Beneficiaries	45,500
Medicare Advantage Enrollees	5,500
Enrollees in Traditional Medicare	40,000
Estimate of Primary Care Physicians Who Will Align with an ACO	50%
Estimated ACO Members	20,000
Average Annual Payment per Member	\$10,000
Total Opportunity	\$200 Million



Sizing the opportunity. The first step in evaluating the ACO opportunity is to estimate the membership and total budget that would be assigned by the Centers for Medicare & Medicaid Services (CMS) for your ACO. To this end, you should first estimate the expected membership in your ACO, based on the traditional Medicare population in your market and the proportion of this volume that will be assigned to your ACO based on the participating primary care physicians.

Next, you need to know the average annual spending per Medicare beneficiary for your service area. These data are available by county from CMS (www.cms.gov/MedicareAdvtgSpecRateStats/downloads/ffs2008.zip).

A sample calculation, using hypothetical numbers to size the ACO opportunity, is provided in the top exhibit at left. For illustrative purposes, our sample assumes that the average annual spending per Medicare beneficiary is \$10,000, resulting in a total annual opportunity of \$200 million.

On average, this \$200 million is spent across several providers. Recent data from the Medicare Payment Advisory Commission indicate that about half of all Medicare medical expenses are for hospital care. Of this hospital care, researchers have estimated that approximately 64 percent is provided at the hospital at the center of a local delivery system (“Creating Accountable Care Organizations: The Extended Hospital Medical Staff,” *Health Affairs*, Dec. 5, 2006). Our sample analysis assumes 70 percent has been provided at the local hospital, because hospitals that provide more comprehensive services are more likely to seek to develop ACOs.

Estimating shared savings. With an understanding of likely membership and the total budget for your ACO, it is time to estimate potential shared savings. Start by considering utilization levels in

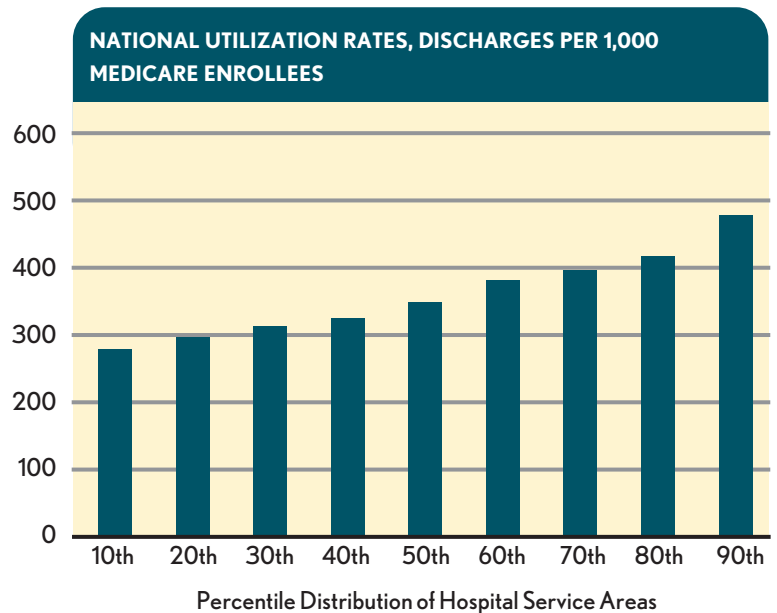
your market and compare them with benchmarks. For our example, we have focused on inpatient admission rates per 1,000 enrollees per year. Although ACOs may also generate savings in other areas, such as high-cost outpatient services, starting with the inpatient utilization is a useful proxy for overall utilization.^b

The exhibit at right indicates the level of admissions per 1,000 enrollees per year as they are distributed across the percentiles of hospital service areas (HSAs). The median is 360 discharges per 1,000 (www.dartmouthatlas.org, 2005 Medicare data). High-performing Medicare Advantage plans reportedly achieve admission rates in the 200s. Although these figures are not adjusted for the age of the Medicare population being served, comparing your local figure with this distribution can provide an initial sense of the likely potential to reduce admission rates in your market.

Our sample analysis assumes that the inpatient admission rate per 1,000 enrollees per year is 390 (see the exhibit below). We also assume that through ACO care management efforts, the inpatient utilization and related hospital outpatient

services can be reduced by 10 percent, and that any other reductions in utilization are offset by additional utilization for other services. Based on these assumptions, the ACO would generate \$10 million in gross savings by reducing hospital expenses, representing a savings of 5 percent of the total \$200 million of medical expenses.

At this point, we have intentionally provided a sample calculation with significant ACO savings because a hospital CFO's primary concern relates to the impact that a successful ACO might have on hospital profitability by reducing utilization.



b. Based on the Medicare Physician Group Practice Demonstration, the other major area for potential cost savings is hospital outpatient services. It is also important to recognize that costs may go up in certain areas as you devote additional resources to keep your ACO population healthy.

ESTIMATED CHANGE IN ACO HOSPITAL INPATIENT AND RELATED EXPENSE			
	Current	Target	Change
Admissions per 1,000	390	351	-39
ACO Members	20,000	20,000	
Inpatient Admissions for ACO	7,800	7,020	-780
Average Medicare Payment per Inpatient Admission	\$12,800	\$12,800	
ACO Payments to Hospitals	\$100 Million	\$90 Million	-\$10 Million

If your ACO can generate this level of savings, the shared savings calculation would follow the formula shown in the top exhibit below. Keep in mind that several of the key assumptions for this calculation were not available as of publication date, including the required cost reductions before savings will be shared (the CMS cushion) and the split of savings between CMS and ACOs. We have assumed a CMS cushion of 2 percent of the total budget, and a 50/50 split of savings between CMS and the ACO. As the actual figures become available in regulations, estimates of potential savings can be more precise.

We have also assumed operating costs of \$1 million for the ACO, including ACO staff and services, as well as possible payments to physicians for extra effort in managing care. These operating costs relate to the following key capabilities required for success:

- > Leadership and vision
- > Engaged provider network

- > Effective medical management (based on evidence-based medicine; chronic care focus)
- > Financial and analytic capabilities
- > IT infrastructure and reporting (to support clinical and financial efforts)
- > Administrative infrastructure
- > Capital to fund development and cash flow
- > Risk management (if assuming downside risk)

There may also be greater benefits associated with operating an ACO with greater membership. An important point to consider is that CMS has indicated that it may require a larger cushion for ACOs with a smaller population—closer to the 5,000-member minimum. CMS does not want to reward ACOs for random variations in expenses, and a larger population reduces the chance of variation leading to savings. Therefore, with a larger population, CMS can reduce the size of the cushion, making it easier for an ACO to generate savings. In addition, a larger ACO population would allow investment in adequate infrastructure and the

ACO SHARED SAVINGS ESTIMATES	
ACO Savings	\$10 Million
CMS Cushion	–\$4 Million
Amount to Be Shared Between CMS and ACO	\$6 Million
Shared Savings to ACO (if 50/50)	\$3 Million
ACO Operating Costs	–\$1 Million
Net Savings for Sharing Within ACO	\$2 Million
Shared Savings Distributed to Hospitals (if 50/50 with Physicians)	\$1 Million

ESTIMATE OF INPATIENT REVENUES AT THE HOSPITAL SPONSORING THE ACO			
	Current	Target	Change
Inpatient Admissions for ACO	7,800	7,020	–780
Percentage of Admissions at ACO Sponsor Hospitals	70%	75%	
Admissions at ACO Sponsor Hospitals	5,460	5,265	–195
Average Medicare Payment per Inpatient Admission	\$12,800	\$12,800	
Hospital Revenue for ACO Inpatient cases	\$69.9 Million	\$67.4 Million	–\$2.5 Million

spreading of operating costs over a larger population. This too would increase the chance of savings.

If your ACO pursues a richer share of savings by also accepting downside risk, the risk of penalty payments would need to be considered, as well. At that point, a more complete actuarial analysis, similar to that of an insurance product, would be needed.

Net Impact

The estimate of shared savings is only part of the financial picture. Savings to the ACO are lost revenues to the hospital or other providers. A complete financial analysis must consider the net impact on the hospital.

Some of the \$10 million in ACO savings comes from the hospital that sponsored the ACO, but

some comes from other hospitals. Again, for our example, we have assumed that 70 percent of services for the ACO membership has historically been provided by the hospital sponsoring the ACO. The remaining 30 percent has been provided by other hospitals. For the target utilization, we assume the hospital sponsoring the ACO retains 75 percent of the admissions, reducing “leakage” through a more coordinated care process. As a result, the hospital only loses \$2.5 million in revenues instead of all \$10 million the ACO has saved (see the bottom exhibit, page 6).

The \$2.5 million reduction in revenue described above is partially offset by reductions in variable costs. Our example assumes 40 percent of costs are variable, resulting in a loss of \$1.5 million of operating income for the hospital before considering the impact of shared savings. When

NET IMPACT OF ACO ON HOSPITAL

Reduction in Hospital Revenue	–\$2.5 Million
Variable Costs (40%)	\$1 Million
Impact on Hospital Operating Income Before Shared Savings	–\$1.5 Million
Hospital Share of Shared Savings	\$1 Million
Net Impact on Hospital	–\$0.5 Million

ACO NET IMPACT SCENARIOS

Scenarios	Impact of Utilization Changes on Hospital Operating Income Before Shared Savings	Shared ACO Savings to Hospital	Net Impact of Utilization and ACO Savings on Hospital
Pursue ACO, but with no gain in market share	–\$4.2 Million	\$1.0 Million	–\$3.2 Million
Pursue ACO and gain 5 percent more inpatient cases at your hospital	–\$1.5 Million	\$1.0 Million	–\$0.5 Million
Pursue ACO and gain 10 percent more inpatient cases at your hospital	\$1.2 Million	\$1.0 Million	\$2.2 Million
Pursue ACO and gain 5 percent more inpatient cases at your hospital, but without reduced utilization or shared savings	3.0 Million	–\$1.0 Million	\$2.0 Million

this \$1.5 million decrease in net income is offset by the hospital's \$1 million share of the savings, the combined net impact of the ACO initiative is a relatively modest negative \$500,000 annually (see the top exhibit, page 7).

The Strategic Discussion—Compared with What?

Strategy always comes down to judgment. In the case of ACOs, the judgment is whether you should act, how decisively, and with whom. To apply good judgment, you need a reasonable sense of what will happen under different scenarios. In other words, you must model the net impact, as described above, and then ask the question, “Compared with what?”

In the case of ACOs, it is best to compare several possible scenarios. Examples are provided in the exhibit at the bottom of page 7.

The results of the net impact scenarios underscore the importance of gaining market share. The only scenario with a significant negative net impact is the one where the hospital does not gain market share. If you gain sufficient market share, you will replace volume lost to reductions in the rate of utilization. Finally, with additional market share, even if you do not generate shared savings, you might generate a positive net impact. However, if you do not make a good faith effort to improve quality and cost-effectiveness, it is possible that CMS will not renew the ACO agreement.

Additional Considerations for Measuring the ACO Opportunity

Key elements of the financial arrangement necessary for an ACO await regulatory clarification as of the publication of this article. Watch for announcements on the savings cushion required before CMS begins to share savings with ACOs, and the split between the ACO and CMS (e.g., 50/50 or 80/20), which will be critical to determining the attractiveness of the ACO opportunity.

ACOs will also receive clearer guidance on regulatory compliance issues, including fraud and abuse, antitrust, and the regulation of risk. These clarifications will help hospitals design appropriate approaches to implementing ACOs, including establishing appropriate governance structures and providing incentives to physicians. These clarifications may also provide an implicit advantage to some hospitals based on their physician strategies (e.g., employed versus independent).

A hospital may be concerned that its primary care physicians' Medicare population is sicker, on average, than the average population. However, a sicker population should not be a disadvantage. Because the budget developed for the hospital's ACO population will be based on the historical costs for the population, the budget is already adjusted for the severity of illness in the population. The ACO's task is simply to do better than the history would suggest it should do.

Nonetheless, CMS's actuarial methodology for setting the budget for a particular population will matter. Watch closely for how CMS actuaries plan to address the concern that they will continually ratchet down the budget, which would make it progressively harder to succeed. In addition, CMS actuaries will need to address complex issues such as budgeting costs for patients without three years of Medicare history, primary care physician retirements or terminations of employment, and assigning primary care physicians to snowbirds.

With additional market share, even if you do not generate shared savings, you might generate a positive net impact.

As CMS clarifies its plans for shared savings, this financial picture may change. For example, if CMS shares 80 percent of the savings instead of the 50 percent we assumed, shared savings would have a greater positive impact on the ACO opportunity.

It should also be noted that the net impact on the hospital is only part of the strategic financial picture. Your physician partners would also share in the savings an ACO may generate. These shared savings, as well as payments to physicians for additional care management efforts, could noticeably increase physician income.

Some hospitals may consider doing nothing, hoping to be left alone. This option may not be available, as competitors may pursue an ACO, and retain more cases from current primary care physicians or attract the allegiance of primary care physicians who had supported the recalcitrant hospital. In the example above, if you are not the sponsoring hospital, but instead lose the 5 percent of cases that the other hospital retains, you would lose \$4.2 million of your bottom line.

A Tipping Point to Value

Our sample calculation demonstrates how hospitals may be able to solve the ACO volume/value conundrum. It shows how the Medicare ACO

opportunity can mark the beginning of a new set of strategies to improve quality, deliver value to purchasers, increase market share, and maintain financial strength. With success in a Medicare ACO, providers may be ready to pursue commercial insurance contracts that reward them through pay for performance or shared savings against a budget target. Providers also may build on their ACO experience to develop narrow network insurance products designed to succeed on health insurance exchanges.

In this way, ACOs may also mark a tipping point in the mind-set of hospitals and physicians toward a focus on value and population health. But this shift should be pursued carefully, with a strong focus on building market share. Accompanied by market share growth, this new mind-set can provide the foundation for financial and strategic success in a rapidly changing healthcare market. ●

About the authors



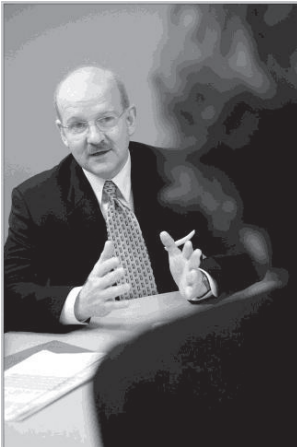
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Dan Grauman has more than 30 years experience in healthcare consulting. His clients include hospitals, healthcare providers, contracting organizations, health plans and other healthcare businesses throughout the nation. With an MBA and credentials in healthcare management, he brings a broad perspective and a unique blend of technical expertise and business acumen to consulting engagements.

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- > Providing guidance on the right physician hospital alignment strategy for organizations and developing implementation plans
- > Providing assistance with hospital-physician business arrangements and deal structuring
- > Preparing healthcare business ventures
- > Extensive background in evaluating and implementing risk contracts and provider-payer payment arrangements
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Dan is a frequent presenter for several HFMA chapters and The Governance Institute. He often publishes articles on physician alignment/employment, merger and acquisition, and provider contracting organizations.

Grauman founded DGA Partners after serving as a principal at the Raleigh Group (later Value Health Sciences). Before that, he directed the Chicago healthcare consulting practice, and served as a Principal in Philadelphia, for Laventhol & Horwath. He is a member of the AHA Society for Healthcare Strategy and Market Development, HFMA, and the American and Pennsylvania Institutes of Certified Public Accountants and several other industry associations.

Dan holds an MBA and Sloan Certificate in Health Services Administration from Cornell University, Johnson School of Management and a BA in Economics from Temple University.



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John Harris combines consulting expertise with a hands-on management background. In his 25 years in the industry, he has founded a healthcare business, run facilities and consulted to hospitals and health systems, ACOs, PHOs, IPAs, health plans, PACE programs, and other healthcare organizations.

John's experience includes:

- > Serving as an industry leader in assessing ACO opportunities and challenges, and assisting with development and implementation
- > Leading efforts in PHO development
- > Facilitating planning retreats for senior executives, physicians, and board members
- > Financial modeling in support of strategic planning, mergers and acquisitions, and new business development
- > Assisting with physician-hospital alignment strategies including employment, joint ventures, ambulatory surgery centers, and others
- > Providing expert opinions on healthcare business arrangements, and advising on strategic issues

John is a frequent speaker for various HFMA chapters and the American Association of Integrated Healthcare Delivery Systems and The Governance Institute on such topics as: ACOs, healthcare strategy, finance, and physician alignment. John's published articles often focus on physician alignment, strategic planning, and ACOs.

John spearheaded the successful launch of a leading national health information storage and access company. He has had senior operational responsibility in healthcare facilities and was a Health Policy Fellow for the US Senate's Finance Committee.

John holds a BA from Dartmouth College and an MBA in Healthcare Management from The Wharton School of the University of Pennsylvania.

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