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Should Your Hospital Develop or Join an ACO? 5 Questions to Ask

Written by Lindsey Dunn | [November 09, 2010](#)

The Medicare Shared Savings Program, also referred to as the accountable care organization program, was created by the Patient Protection and Affordable Care Act and will be effective by Jan. 1, 2012. The program will allow physicians, hospitals and other healthcare providers to join together to better coordinate care and share in cost savings created by lowering population health costs while maintaining quality. The program is significant, because it marks the first time the government has asked physicians and hospitals to manage population health costs.

Since the legislation was passed, hospitals and other providers across the country have been working to decide if they should develop ACOs in an effort to participate in the program. These entities, however, require considerable infrastructure, resources and cost, and have no guarantees of success. As such, many providers are unsure if the risk associated with developing an ACO is worth the potential payoff. While the final regulations governing these entities have yet to be released, hospitals that are considering whether they should become involved in an ACO should ask themselves the following five questions.

1. What is the hospital's relationship with its physicians? Before determining its participation in an ACO, a hospital must assess its relationship with its physicians. Success within the ACO model will require working closely with physicians to reduce costs and better coordinate care. If a hospital lacks aligned physicians, it will face more challenges in finding success within an ACO, says John Harris, a partner with DGA Partners, a healthcare consulting firm. Hospitals with integrated physicians are better positioned to be successful under this type of model.

While specialty physicians are not expected to be left out of ACOs, hospitals should focus first on their relationships with primary care providers, as these providers determine a group's ability to create a viable ACO under the current legislation.

2. Does the hospital have a large enough primary care provider base? In order to apply to join the Medicare shared savings program, ACOs must be able to care for a minimum of 5,000 Medicare beneficiaries, which means it must have enough primary care physicians involved to meet that threshold. Mr. Harris estimates this translates to about 15 to 20 primary care physicians. The recent increased use of hospitalists has left many hospitals with more distanced relationships with primary care providers, which makes meeting this minimum difficult for some facilities, he says.

Hospitals that employ or closely align with a significant base of primary care physicians are well positioned to lead an ACO, while those that lack these relationships may need to think about whether joining an ACO established by another entity is a better option. To improve alignment, hospitals should educate primary care providers about the benefits of joining the ACO and the financial and quality impacts from doing so, says Mr. Harris.

3. What other providers could be involved? In addition to hospitals and physicians, ACOs may want to align with other types of providers in their communities, such as skilled nursing facilities and home health providers. While an ACO probably does not need the involvement of these post-acute providers to become an ACO, their participation is likely to enhance an ACO's ability to coordinate care and reduce costs. As such, hospitals may want to take stock of their relationships with these providers and consider integrating them into their systems, if possible, or determine other ways to align with them, such as through contracts that ensure ACO goals will be pursued.

4. Should the hospital develop its own ACO or work with another hospital or system? A hospital may consider partnering with a larger health system or other smaller, independent hospitals to create the ACO. These arrangements allow a hospital to spread its overhead costs associated with the ACO more broadly. Additionally, Mr. Harris predicts CMS will set a higher savings threshold for smaller ACOs, making it less challenging for large ACOs to achieve the level of savings needed to receive shared savings payments.

5. How will the hospital counter the impact of reduced admissions? One of the key goals of the ACO program is to better coordinate care in order to reduce healthcare costs, which means reducing the utilization rate of the most costly services, such as inpatient admissions and complex outpatient procedures. These procedures drive up overall healthcare costs, but are also key revenue generators for hospitals. If a hospital joins an ACO, it must accept and prepare for the chance of decreased volume.

Hospitals will need to increase their market share in order to maintain volume levels in an environment that rewards low utilization. "Assume admissions from the population the hospital traditionally cares for are going to go down, which means the hospital has to reach out to a broader population base to make up for that lost volume," says Mr. Harris. Market share can be gained by aligning with a broader base of primary care physicians or by avoiding the leakage of cases to other hospitals.

"If the Medicare Shared Savings Program leads to similar opportunities with commercial health plans, it could both provide value to those health plans and their members, and it could also help shift the hospital and its physicians to a more integrated model of care," says Mr. Harris.

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