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a better outlook for ACOs?

CMS's final regulations for ACOs make an ACO strategy seem more appealing, but hospitals still will need to perform a careful assessment of their readiness to pursue this strategy.

With final regulations in hand, provider organizations must quickly evaluate the financial and strategic opportunity presented by the Medicare Shared Savings Program (MSSP) for creating an accountable care organization (ACO). The final regulations are a distinct improvement over the tight-fisted sharing formula, downside risk, tough antitrust treatment, and burdensome reporting requirements in the proposed MSSP regulations.

AT A GLANCE

- > A hospital will need to carefully consider three elements in performing their financial analyses of the ACO opportunity: CMS's calculation of ACO shared savings, the ACO's revenue statement, and the hospital's revenue statement
- > The hospital also should consider timing, size, risk, and capitalization issues.
- > Strategic issues that the hospital should consider include positioning for a new reality, positioning in relation to physicians, and positioning for the long term.

CMS recognized that providers were unlikely to participate in such an unattractive program and sweetened the deal. The final regulations provide a greater opportunity for shared savings and ACO profitability.

Sharing begins with the first dollar of savings once the minimum savings rate (MSR) is met or surpassed. ACOs do not have to take on downside risk during the first three years of operation. The regulations are more flexible and less burdensome in several areas:

- > Antitrust assessments are no longer automatic.
- > The number of quality indicators to be reported is cut in half.
- > The mandate for meaningful use of electronic health records (EHRs) by primary care physicians has been eliminated.
- > Better beneficiary assignment and data transparency improves the odds of achieving shared savings.

Related programs, such as the Advanced Payment Model, which helps physician organizations with up-front payments, are also likely to generate additional interest. As a result, more parties are probably evaluating the ACO opportunity.

Despite the sweetened deal, a hospital-sponsored ACO continues to be confronted with several key strategic questions:

- > If we succeed in driving down utilization, will it harm our financial performance?
- > Can an ACO improve our relations with physicians and increase our market share?
- > Can an ACO help us succeed in a competitive market for commercial insurance?
- > If we don't develop an ACO, will we be squeezed by tighter Medicare fee-for-service payments in the long run?

The ACO shared savings formula has more surprises than a murder mystery, and the major plot twist is the implications for a sponsoring hospital.

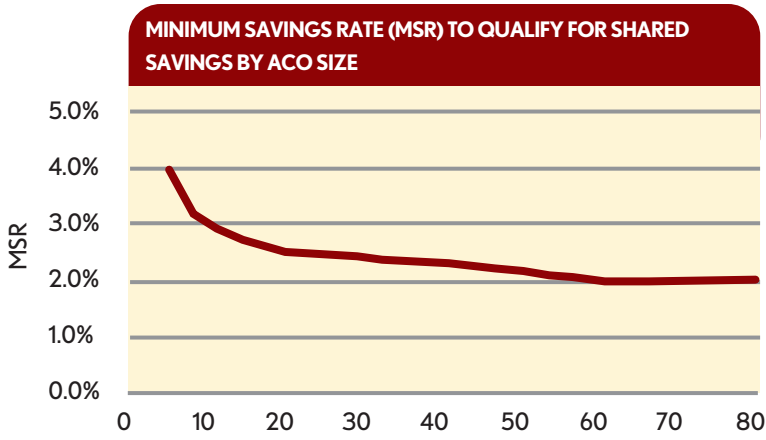
A thorough strategic and financial assessment can inform decision making on whether to create an ACO and how to succeed in doing so. The following discussion touches on some of the key considerations in completing such an assessment.

Evaluating the Opportunity

Every financial analysis has a handful of key factors that determine the outcome. The ACO shared savings formula has more surprises than a murder mystery, and the major plot twist is the

SUMMARY OF KEY CHANGES: MEDICARE ACO FINAL REGULATIONS

Area	Key Change	Implications
Shared Savings/ Risk	<ul style="list-style-type: none"> > Sharing on the first dollar of savings > No requirement to take on risk in the first three years 	<ul style="list-style-type: none"> > Greater reward for achieving cost savings > There are likely to be more ACO entrants
Quality	<ul style="list-style-type: none"> > 33 measures instead of 65 measures 	<ul style="list-style-type: none"> > Lower reporting burden > Easier to generate shared savings
Data	<ul style="list-style-type: none"> > Data shared unless patients opt out > ACOs will receive more frequent, quarterly aggregate cost reports for assigned beneficiaries 	<ul style="list-style-type: none"> > Better information about key patient groups for care management/quality improvement efforts
Electronic Health Records (EHRs)	<ul style="list-style-type: none"> > Use of EHRs is now a quality measure, not a requirement 	<ul style="list-style-type: none"> > ACOs not meeting EHR measure may still achieve shared savings
Antitrust	<ul style="list-style-type: none"> > No requirement for mandatory review 	<ul style="list-style-type: none"> > Lower start-up costs > More providers may meet requirements for compliance
Beneficiary Assignment	<ul style="list-style-type: none"> > Beneficiaries are assigned to an ACO on a prospective basis, with year-end reconciliation > Some assignment to ACOs by specialist if no primary care physician 	<ul style="list-style-type: none"> > ACO can proactively contact members and manage population health > The likelihood of greater physician interest in ACO concept
Eligible Entities	<ul style="list-style-type: none"> > Broadened participation to include Federally Qualified Health Centers and Rural Health Centers 	<ul style="list-style-type: none"> > The likelihood of more ACO entrants



A higher MSR is required for smaller ACOs, although the MSR quickly levels off once a level of 20,000 members is reached.

ACO Membership (in Thousands)

implications for a sponsoring hospital. There are many questions to be addressed. For example:

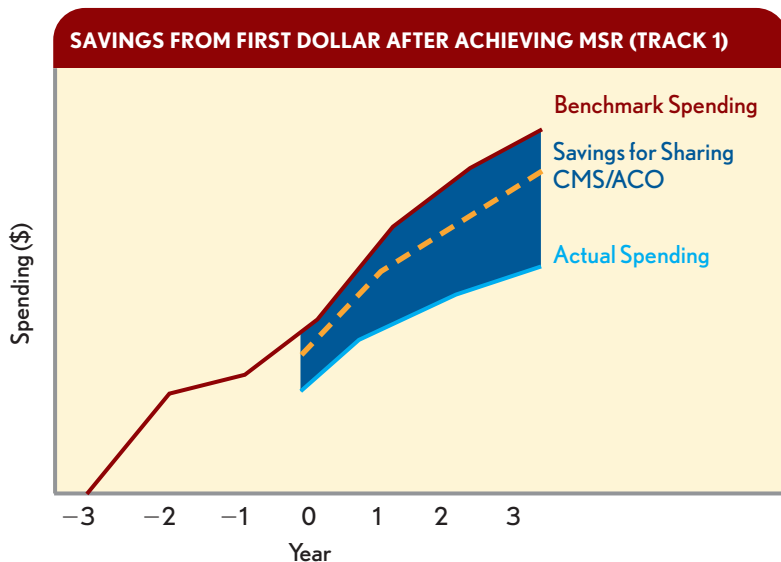
- > How important is it to hit the MSR?
- > How will quality scoring affect shared savings?
- > Will the ACO be profitable?
- > What will happen to hospital profitability?

The final rule includes a more generous sharing formula than was seen in the proposed rule. CMS shares the first dollar of savings with the ACO after the MSR is exceeded, whereas in the preliminary regulations, CMS kept the first 2 percent of savings.

In the financial analysis of the ACO opportunity, three key elements will need to be considered:

- > CMS's calculation of ACO shared savings
- > The ACO's revenue statement
- > The hospital's revenue statement

Thoroughly addressing these elements will require considerable care and diligence. Here are some of the primary considerations.



CMS's Calculation of ACO Shared Savings

The level of shared savings available to a sponsoring hospital is extremely sensitive to the ACO's ability to meet the MSR and quality reporting/performance standards.

Meeting the MSR. Shared savings are determined by subtracting actual Medicare expenses from benchmark Medicare expenses for the assigned patient population. However, *none of those shared savings are available to the ACO until it has met the CMS-defined MSR.* ACOs unable to meet the minimum savings required will not only leave money on the table, but also will invest significantly in setting up and operating the ACO without any offsetting financial return.

Depending on the size of the ACO, the MSR varies between 2 percent and 3.9 percent. Because smaller organizations have a higher MSR, it is advantageous to have a larger ACO. Once the ACO meets its MSR, it shares up to a maximum of 50 percent (Track 1) of all savings generated with CMS from the first dollar. The actual amount of shared savings will be adjusted down from 50 percent, based on quality scores.

Most successful ACOs will hit their MSR by generating savings from reduced hospital inpatient utilization. Some physician and ancillary services may increase, while others may decrease. However, the net effect of these changes is likely to be small relative to the potential savings from reduced inpatient admissions. The best opportunities to achieve the necessary decreases in inpatient admissions may be through improved chronic care treatment, smoother hospital discharges, and better coordination of care for nursing home residents.

It will be easier for ACOs to hit the MSR if they are located in markets with higher hospital utilization, where there is simply more room for reducing unnecessary utilization. The top 10 percent of hospital service areas have 70 percent higher inpatient utilization than the bottom 10 percent. Hospitals in regions with low Medicare inpatient utilization will find it difficult

to meet the MSR to generate sharable savings, and are more likely to make a quick “no-go” decision on an ACO.

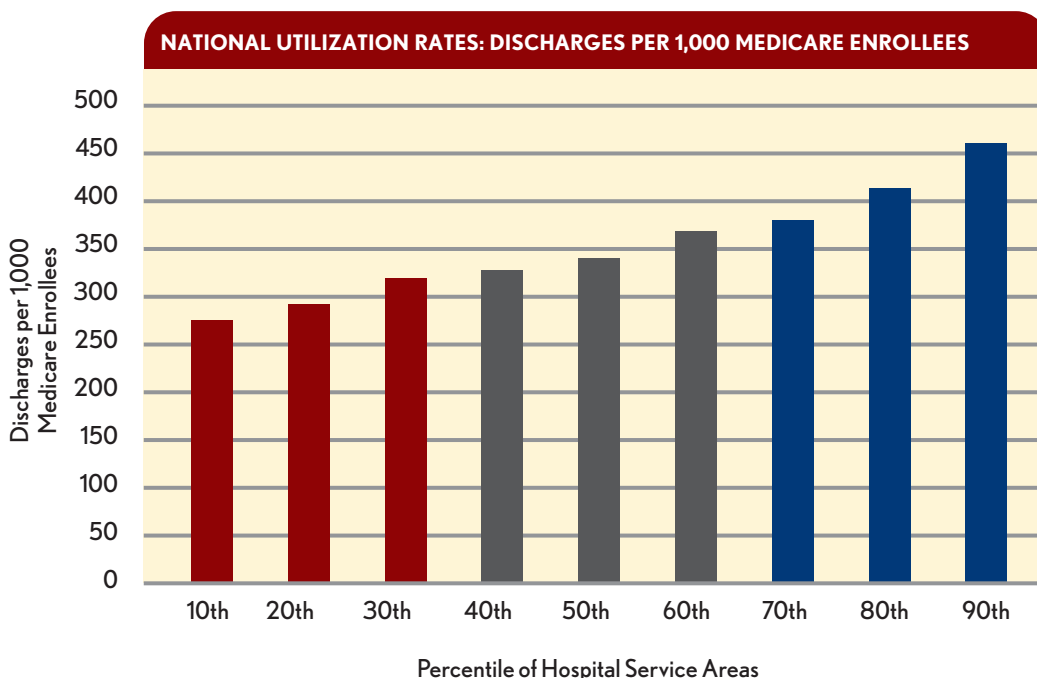
Meeting quality standards. Although the final rules simplified the quality standards, considerable effort will still be required to meet those standards. Organizations must report on 33 measures starting in the first 18 months, including many patient satisfaction and care coordination measures that providers may not currently be tracking. In 2014, 25 of the 33 measures will transition to being scored based on performance, and by 2015, 32 of the 33 measures will be scored based solely on performance.

The ACO will be eligible for some shared savings as long as it exceeds the 30th percentile on at least 70 percent of measures in each of four domains (patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk population). More information on the performance required to achieve the 30th percentile is expected in the future. If an ACO scores a zero in any of the four domains, it will not be eligible to share in any savings generated. For instance, an ACO that fails to report the percentage of primary

care physicians who have successfully qualified for an EHR incentive program payment will not meet the 70 percent threshold for the care coordination/patient safety domain, which will cause the ACO to be ineligible for shared savings.

To illustrate the key considerations in assessing an ACO’s potential financial performance, it helps to create a baseline model and calculate its level of shared savings, based on various scenarios. (For a detailed example of such an analysis, involving a hypothetical ACO participating in Track 1, go to www.hfma.org/hfm.)

ACOs that meet the MSR, but do not perform well in reporting and performance, will generate relatively insignificant shared savings—or none at all. In general, organizations that do not meet reporting or quality standards will likely not produce sufficient revenue to cover ACO start-up and operating costs or offset hospital losses due to decreased hospital utilization. Organizations that are not ready to work hard on reporting and/or performance standards should strongly consider this obstacle in deciding whether to establish an ACO.



The ACO's Revenue Statement

The amount of shared savings received back from CMS is the revenue for the ACO. The expenses are the ACO's operating costs, including incentive payments to independent and employed physicians. Spending to build care coordination and analytic and data-sharing capabilities is essential. ACOs will also need tools to manage population health, understand patient leakage, and engage the providers and patients. And spending will be required to successfully report on quality. All of these expenses will need to be taken into account.

Because the costs of improved care management and coordination are high, ACOs are not likely to make big profits. Rather, developing an ACO is a strategic initiative that will transform the organization, increasing accountability for quality and cost, while accessing some funds to help defray the start-up and operational costs. Fortunately, the benefits gained from these capabilities extend beyond the traditional Medicare population and may be applied to commercial or Medicare Advantage contracts, as well.

The Hospital's Revenue Statement

Having a profitable ACO necessarily means reducing hospital admissions. However, when admissions are reduced, the sponsoring hospital will have reduced profits, due to the high fixed costs of hospital operations. Shared savings that accrue to the hospital are not enough to make up for this lost volume.

If the hospital can gain market share, however, it can make up for the lost volume due to utilization changes. A successful ACO strategy, therefore, will be one that helps the sponsoring hospital to increase market share. Two approaches for ACOs are most likely to produce the best results:

- > Sign up new primary care physicians and primary care physicians who historically have used other hospitals and may be attracted to a more coordinated system of care.
- > Convince patients that the superior coordination of care makes it more attractive to stay within the ACO rather than seeking care outside of it.

Hospitals that are more proficient with marketing to physicians, especially willing partners, might find the former strategy easier than the latter patient-centered approach. However, gaining incremental market share each year is a key approach, and an ACO should not overlook the importance of reducing patient leakage.

Positioning the ACO

In considering whether to pursue an ACO strategy, an organization also should consider timing, size, risk, and capitalization issues.

Value of being an early entrant. Although a hospital's leaders may not feel their organization is ready to become a Medicare ACO, the risk of losing affiliated primary care physicians to a competitor ACO is a real one, and could have major impacts on medical staff and referral patterns. Competitor ACOs might attract patients through their coordinated care models, lowering the hospital's market share without providing any opportunity for shared savings.

ACO ABCs

Accountable care organizations (ACOs) are provider organizations that are clinically and financially responsible for the entire continuum of care for a given population, whether or not the care is provided under their aegis. Under the Medicare Shared Savings Program (MSSP), ACOs can be established starting April 1, 2012, and will serve traditional beneficiaries under Medicare Parts A and B. ACOs are required to make a three-year or slightly longer commitment to the program.

Beneficiaries do not choose an ACO, nor are they in any way constrained to receive their care only from ACO providers. There are no gatekeepers or preauthorization requirements. Rather, beneficiaries are assigned to an ACO if their main primary care provider participates in that ACO. Then the costs for those beneficiaries are tracked no matter where they seek Medicare covered services.

Medicare will share savings with those ACOs that reduce the aggregate cost of care for their assigned beneficiaries and demonstrate the quality of their care. ACOs that elect to take on risk will have an opportunity to gain a larger share of the cost savings, but also will have the potential to share in losses.

If there is a large physician entity with some readiness to meet ACO requirements, the physicians could form an ACO on their own, again leading to lost inpatient revenues and no compensatory shared savings. More important, physicians may start to treat the hospital as a vendor, demanding assistance with their ACO strategy with the implicit or explicit threat of encouraging patients to seek care at hospitals that are more cooperative.

Nonetheless, if a hospital has determined that it simply lacks the capabilities to form an ACO, it may decide that immediate action is not the best strategy. In such a case, it will be important for the hospital to model potential ACO losses versus potential volume losses.

Advantages of size. Size has advantages in determining the bottom line impact of an ACO. Larger organizations have a lower MSR and can spread the fixed costs of ACO operations across a larger population. Although this consideration might lead an organization to conclude that bigger is better where ACOs are concerned, strategic issues should be taken into account. Smaller ACOs, with a tighter network of providers that work together more effectively and hold each other accountable for results, may be able to more tightly manage and oversee care processes than larger ACOs. A smaller ACO may also be more able to react quickly to opportunities for improvement.

Value of taking on some risk. CMS offers a “Track 2” ACO option with more shared savings upside than Track 1 (e.g., potential share of savings increased from 50 percent to 60 percent; the MSR stays at 2 percent regardless of ACO size), but that involves sharing in losses (downside risk), as well. It may pay to take some risk (possibly softened with reinsurance) to access the greater upside. Track 2 may be the right opportunity for organizations that believe they can generate savings, but feel they will be unable to meet the MSRs required by Track 1.

The challenges of cash flow. Cash flow will be challenging for most ACOs. Even ACOs that generate

shared savings sufficient to cover their operating costs will have to wait to receive the shared savings they have earned. Because shared savings are calculated retrospectively, ACOs will need to wait about half a year after the end of each performance year to receive the shared savings.

If a hospital sponsors the ACO, it will have to tie up some capital in this effort. Physician hospital organizations (PHOs) may struggle to find this capital, particularly if physicians need to match funding from their hospital partner. However, a PHO has some organizational structure options that can address this need.

Under the Advanced Payment Model program sponsored by the CMS Innovation Center, ACOs that generate under \$50 million in revenues, are physician-based, or include only smaller inpatient facilities located in rural areas can receive advanced funding on the expectation that they will generate savings. These advance payments can minimize the cash flow challenges. In addition, some private equity sources are seeking to partner with physicians to cover these cash flow needs while bringing a set of infrastructure and operational support.

Final Thoughts

The decision on whether a hospital should establish an ACO is essentially a strategic question. Hospitals that succeed as ACOs will drive down their volume. Shared saving will not be sufficient to make up for these losses, so it's essential to build market share. If a hospital does not create an ACO but competitors do, the hospital may lose share to those competitors. A hospital that succeeds with an ACO will not make a lot of money from the ACO directly, but it may succeed in transforming its organization into a clinically integrated provider of high-quality care with a strongly aligned medical staff.

Hospitals will want to consider the following strategic issues as they evaluate the ACO opportunity.

Positioning for a new reality. Organizations that are betting on insurance exchanges and value-based

purchasing may consider ACO development as an opportunity to build infrastructure, physician engagement, patient loyalty, and payer alignment in advance of key changes. ACOs will be more likely to succeed in entering a strategic contract with a key health plan to jointly offer a competitively priced product on a health insurance exchange. Hospitals that already participate in risk-sharing arrangements with health plans may improve their results. By bringing the critical mass associated with Medicare patients into an ACO, hospitals and physicians may be able to shift to new models of care that may be necessary in a more competitive and cost-conscious environment.

There are other possible strategies besides a shift toward accountable care and a focus on population health cost and quality. A focus on efficiency and low cost for hospital services may also be a good strategy. Hospitals that are well positioned to be a low-cost provider and offer payers low rates may want to leave population health management to the health plans, and simply run efficient hospitals.

Positioning in relation to physicians. Hospitals that have traditionally been unable to engage physicians in managing quality and cost may see an ACO as a means to strengthen alignment with physicians. However, hospitals also have to be aware of the potential threat of physician-sponsored ACOs. Physician groups have little downside to creating accountable care models that drive down hospital utilization. The ACO model, like ambulatory surgery centers and other ancillary services, is another way physicians can tap into a share of payments that have traditionally been hospital-based. Hospitals should consider their physician relations and plan how to respond to any physician-led ACO initiative. In particular, hospitals should evaluate whether the share of employed primary care physicians affiliated with their organization is sufficient to protect them from physician-sponsored competitor ACOs.

Positioning for the long term. A hospital that is ready to begin work toward setting up an ACO

needs to think about the future of that ACO. As with many shared savings programs, the law of diminishing returns applies to Medicare ACOs. As a hospital improves its performance, reducing costs and utilization, its benchmark (tightened every three years) becomes harder to achieve. Less shared savings over time means less to gain from continuing as just a Medicare ACO.

If a hospital succeeds in transforming itself into a successful ACO, it may make sense for the new ACO to partner with or develop a Medicare Advantage plan in years four or seven rather than continue to operate as a Medicare ACO. Unlike an ACO, a Medicare Advantage plan is rewarded in the long run for its success in managing costs, without diminishing returns. Even if a hospital does not choose this course, Medicare payments will likely continue to evolve toward rewarding sustainable quality improvement and cost savings efforts. Building the infrastructure to manage cost and quality may be what is needed to manage the next big plot twist from Medicare, even if it doesn't mean the mystery is solved. ●

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