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ACO Value Metrics Series: Need-to-Know Basics on the Costs of Forming an ACO

The four-part *HC Topics Series: ACO Value Metrics* will consider the value metrics and capital formation costs associated with forming *accountable care organizations (ACOs)*. This first installment provides the background of the value metrics used to assess these emerging healthcare entities, and Part II will discuss the cost-benefit analysis that must be conducted in considering ACO formation. Part III will address the in-depth valuation that must be performed for prospective ACOs, and Part IV will consider the noncost-based value metrics that should also be evaluated. This *HC Topics Series* is excerpted from the book authored by HCC President, Bob Cimasi, entitled, "*Accountable Care Organizations: Value Metrics and Capital Formation*," to be published by Taylor and Francis Group later this year.

The *Patient Protection and Affordable Care Act (ACA)* places significant emphasis on the formation of ACOs, which are models of care that use clinical integration and financial incentives to attempt to improve quality while decreasing cost.[1] Under a variety of entity structures, providers receive bonuses for meeting quality and patient expenditure targets, while those who fail to meet requirements may be subject to penalties.[2] These financial incentives are expected to reduce Medicare spending by shifting some provider reimbursement away from existing fee-for-service models that reward only the *volume*, rather than the *value*, of services provided.[3] The decision to form an ACO involves a complex financial analysis that ultimately centers on whether the entity is likely to succeed, i.e., provide a significant return on investment. In determining the value an ACO is likely to provide, value metrics considers both economic and non-economic aspects of an entity, such as lower costs and community benefit, respectively. The two primary forms of ACOs are *federal* and *commercial*, and due to the variety of reimbursement and organization structures experienced in the *commercial* ACO market, this article will examine the basic financial considerations involved in the investment decision to form a *federal* ACO.

Among the different categories of ACOs, *federal* ACOs are those governed by the *Medicare Shared Savings Program (MSSP)* mandated under §3022 of the ACA, which was designed to encourage the development of ACOs for specific Medicare populations.[4] Under the MSSP, revenue generation in the federal ACO model is derived from entities' achievement of patient expenditure cost reductions that are a minimum percentage below a benchmark established by the Centers for Medicare and Medicaid Services (CMS). Each benchmark is specific to the individual ACO and is based on the entity's patient expenditures during a performance year. Although a *federal* ACO that achieves sufficient expenditure reductions will receive a shared savings payment based on the first dollar under the CMS-established benchmark, that ACO is only eligible for shared savings if its expenditures are a certain percentage below the benchmark. This percentage threshold represents the *minimum savings rate (MSR*).[5] If the ACO's expenditures are below the *MSR* threshold, then a portion of the difference between the CMS-calculated benchmark expenditures and the actual expenditures will be provided to the ACO as a shared savings payment.[6] This portion of the ACO's achieved expenditure reduction is known as the *shared savings rate*. The Medicare program retains the remainder.[7] Note: if a *federal* ACO achieves actual patient expenditures below the CMS benchmark, but not enough to satisfy the MSR, the ACO will not receive a shared savings payment, and CMS will retain all cost savings.

For entities forming a federal ACO, the MSSP offers a choice of two models through which entities may receive shared saving disbursements, based on the amount of risk assumed by the ACO: (1) the *one-sided model*; and, (2) the *two-sided model*. The *one-sided model* is a "*shared savings only*" model, meaning if the ACO's actual expenditures on patient care are above the benchmark established by the CMS, adjusted by the MSR, they are not subject to shared losses, in contrast to the *two-sided model*.[8] CMS has stated that the lack of risk sharing makes the one-sided model most appropriate for entities that are smaller and less mature in terms of their level of integration and coordination of care.[9] In exchange for greater possible shared savings payments, ACOs under the *two-sided model* are responsible for sharing any losses incurred by the Medicare program; hence, ACOs that are able to assume greater risk may be better suited for the two-sided model.[10] Although the MSSP allows ACOs to choose which distribution model is best suited to their organization, following the initial three-year contract, all ACOs must operate under the two-sided model.[11] Thus, if an organization chooses to continue operating as a federal ACO, it must eventually be able to accommodate

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some shared risk.

ACO formation is expected to require significant capital investments in order to establish the infrastructure required under the MSSP. These investments include: network development and management; clinical information systems; care coordination, quality improvement and utilization management; and, data analytics.[12] The portion of an organization's startup costs required for network development and management can vary significantly. CMS initially estimated this cost at $1.7 million and the American Hospital Association (AHA) predicted it would require an amount closer to $12 million.[13] Capital requirements for clinical information systems will be the most significant expense, as electronic health record (EHR) implementation is required for efficient data gathering and reporting, despite not being required under the MSSP.[14] For care coordination, quality improvement, and utilization management, a study of several healthcare systems found that the capital requirements for these functions will likely range from $160,000 to $250,000 annually, with more capital likely to be allocated for the first year.[15] The use of data analytics systems to track and report on quality measures may require a separate allocation of capital; however, the capital costs associated with these systems will likely be significantly less than those associated with EHR development.[16] In addition to start-up costs, ACOs must also anticipate the costs associated with each of these categories for its ongoing operation. Total ongoing costs for a small hospital will be roughly $2.9 million a year, whereas a large hospital may require roughly $5.7 million a year.[17]

Healthcare entities capable of reducing Medicare patient expenditures will share in a portion of the cost savings achieved under the MSSP, which may help to offset some of the entity's start-up or ongoing operational costs.[18] Managers of healthcare organizations contemplating investment in an ACO should carefully assess their organization's ability to achieve the required cost reduction benchmarks, as this ability is the basis of obtaining the MSSP shared payments and making the ACO a successful endeavor. The decision to form an ACO requires an in-depth analysis of the possible impacts of such an investment, and next month's installment of the *HC Topics Series: ACO Value Metrics* will consider a basic cost-benefit analysis for organizations contemplating ACO formation.

For more information on ACOs, see the following *Health Capital Consultants* publications:

- "Accountable Care Organizations: Value Metrics and Capital Formation" By Robert J. Cimasi, Saint Louis, MO: Taylor and Francis Group, forthcoming 2012.
- "ACO Final Rule: CMS Responds Favorably to Provider Concerns" Health Capital Topics News Alert, October 2011.
- "Accountable Care Organizations Series: How Are ACOs Compliant?" Health Capital Topics Newsletter, Vol. 4, No.10, October 2011.
- "Accountable Care Organizations Series: When Are ACOs?" Health Capital Topics Newsletter, Vol. 4, No.9, September 2011.
- "Accountable Care Organizations Series: Where Are ACOs?" Health Capital Topics Newsletter, Vol. 4, No.8, August 2011.
- "Accountable Care Organizations Series: Who Are ACOs?" Health Capital Topics Newsletter, Vol. 4, No. 7, July 2011.
- "Accountable Care Organizations Series: What Are ACOs?" Health Capital Topics Newsletter, Vol. 4, No. 6, June 2011.
- "Accountable Care Organizations Series: Why Do We Need ACOs?" Health Capital Topics Newsletter, Vol. 4, No. 5, May 2011.
- "CMS Issues Proposed Rule on Accountable Care Organizations" Health Capital Topics Newsletter, Vol. 4, No. 4, April 2011.
- "ACOs and the Stark Law: How to Co-exist" Health Capital Topics Newsletter, Vol. 4, No.1, January 2011.
- "Emerging Healthcare Organizations in an Era of Reform: Accountable Care Organizations" Health Capital Topics Newsletter, Vol. 3, No. 8, August 2010.
- "New Proposals for Accountable Care Organizations" Health Capital Topics Newsletter, Vol. 2, No.12, December 2009.

1 "Accountable Care Organization Provisions in the Patient Protection and Affordable Care Act" Integrated Healthcare Association, June 9, 2010, http://www.iha.org/pdfs_documents/home/IHA_PPACAACOSummary.pdf (accessed 9/20/12).
2 "Accountable Care Organizations" By David Glass and Jeff Stensland, MedPAC, (April 9, 2008), p. 4.
3 "21st-Century Health Care – The Case for Integrated Delivery Systems" By Francis J. Crosson, M.D. The New England Journal of Medicine, Vol. 361, no. 14, October 1, 2009, p. 1324; "Medicare Shared Savings Program: A New Proposal to Foster Better, Patient-Centered Care" Centers for Medicare & Medicaid Services, Medicare Fact Sheet (March 31, 2011), p. 1, Accessed at http://www.amga.org/Advocacy/ACO/FSB07.Benes.03%2031%2011.pdf (Accessed 9/20/12).
4 "Medicare Program; Final Waivers in Connection with the Shared Savings Program" Federal Register Vol. 76, No. 212 (November 2, 2011), p. 67994.
5 "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations" Federal Register Vol. 76 No. 212, (November 2, 2011), p. 67927.
6 Ibid.
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8 Federal Register Vol. 76, No. 212 (November 2, 2011), p. 67994.
9 Ibid.
10 Ibid.
11 Ibid.
12 The Work Ahead: Activities and Costs to Develop an Accountable Care Organization" American Hospital Association, April 2011, p. 11-13.
13 "Accountable Care Organizations: 10 Things You Need to Know About Accountable Care" By Eleanor Burton and Virginia Traweek, Institute for Health Technology Transformation, 2011, 24-25 http://www.fiercehealthcare.com/story/what-are-acos-start-costs/2011-10-26 (Accessed 11/17/2011).
14 AHA, April 2011, p. 8.
15 Ibid.
16 Ibid, p. 2, 10.
17 Ibid, p. 2.
18 Federal Register Vol. 76, No. 212 (November 2, 2011), p. 67994.

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Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, serves as President of **HEALTH CAPITAL CONSULTANTS** (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience in serving clients, with a professional focus on the financial and economic aspects of healthcare service sector entities including: valuation consulting and capital formation services; healthcare industry transactions including joint ventures, mergers, acquisitions, and divestitures; litigation support & expert testimony; and, certificate-of-need and other regulatory and policy planning consulting.

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Mr. Cimasi is the author of numerous additional chapters in anthologies; books, and legal treatises; published articles in peer reviewed and industry trade journals; research papers and case studies; and, is often quoted by healthcare industry press. In 2006, Mr. Cimasi was honored with the prestigious "*Shannon Pratt Award in Business Valuation*" conferred by the Institute of Business Appraisers. Mr. Cimasi serves on the Editorial Board of the Business Appraisals Practice of the Institute of Business Appraisers, of which he is a member of the College of Fellows.

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