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Accountable Care Organizations Series: Where Are ACOs?

the Medicare Shared Savings Program (MSSP), Section 3022 of the Patient Protection and Affordable Care Act (ACA) signaled the emergence of Accountable Care Organizations (ACOs).[1] ACOs are designed to coordinate patient care in order to increase healthcare quality and decrease costs.[2] Whether Federal, commercial, or both, only certain healthcare industry sectors are likely to successfully gain ACO status. The success of these healthcare organizations will likely be determined by restrictions set by the CMS proposed rules, the ability to coordinate care, and the ability to support capital requirements. In the fourth part of the Accountable Care Organizations Series, this article considers the question: *Where Are ACOs?*

Federal Limitations on ACO Formation

CMS's proposed rules for ACOs, released March 31, 2011, lists specific entities eligible to gain Federal ACO status and identifies several potential ACO participants: (1)ACO professionals in group practices (e.g., primary care physician practices); (2) networks of individual practices of ACO professionals (e.g., independent practice associations (IPA) and multispecialty physician groups (MSPG)); (3) partnerships or joint venture arrangements between hospitals and ACO professionals (e.g., integrated delivery networks (IDN) and clinical integrated networks (CIN)); (4) hospitals employing ACO professionals (e.g., hospital medical staff organizations (MSO), physician hospital organizations (PHO), and extended hospital medical staff); and, (5) such other groups of providers of services and suppliers as the Secretary determines.[3] CMS emphasizes that eligible entities must have an established mechanism for shared governance.[4]

Within the proposed rule, CMS limits the hospital definition to: (1) acute care hospitals paid under the hospital inpatient prospective payment system (IPPS); and, (2) critical access hospitals (CAH) that submit bills directly to Medicare for both facilities and professional services.[5] Federally qualified health centers (FQHCs) and rural health clinics (RHCs) were intentionally excluded from ACO eligibility due to reimbursement and compliance concerns. CAHs, on the other hand, were included due to the high number of Medicare participants in underserved and low-income populations who frequently use CAHs. Some question CAHs' ability to sufficiently integrate or raise capital to coordinate care.[6] Entities not eligible for independent ACO status (i.e. FQHCs and RHCs) may still participate in ACOs and receive shared payments through collaborations with eligible ACOs.[7]

Coordinated Care

The commercial market lessens requirements for which entities may successfully achieve ACO status. Potential ACOs can integrate on three levels: (1) fully integrated structures; (2) virtual or partially integrated structures; or (3) contractual structures.[8] While each level of integration has benefits and limitations, certain healthcare organization characteristics will restrict the level of ACO integration.

Full integration involves entities that share common ownership and employment, e.g. health systems that employ physicians through hospitals and outpatient practice locations. These organizations may be in the best position to achieve both Federal and private ACO status, as market power provides leverage in commercial payor negotiations and affords substantial financial capital necessary to invest in the coordination tools required by CMS. Having central leadership and a clear hierarchy of control may provide tighter decision-making, driving quality and cost-efficiency. While these entities may experience some legal protection due to the efficiency offered by a central administrative system, organizational size may lead to increased antitrust scrutiny and charter restrictions.[9]

Partially integrated entities are structured by joint ventures, joint operating agreements, or virtual parent governing bodies. These organizations may experience some level of financial integration, but most coordination will be clinical, due to autonomy and self-referral issues. These boundaries allow more individual practice control and greater scrutiny of financial arrangements under Stark and anti-kickback laws, representing both a benefit and a limitation of partial integration. Additionally, partially integrated ACOs may have a greater burden proving quality and cost achievements, potentially limiting their ability to become a Federal ACO.

Contractually integrated organizations will unlikely achieve sufficient coordination of care and governance to become a Federal ACO. These entities are likely to

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include physician- hospital organizations where the contract language contains elements of integration. While this structure provides the flexibility to integrate on a short or long term basis, contractually integrated organizations are less likely be large health systems, making capital requirements and quality measures harder to achieve.[10] Entities that cannot reach or maintain at least contractual integration will be unlikely candidates for ACO transition. Even those that can achieve low levels of integration may find it difficult to overcome capital requirements for ACO development.

CAPITAL REQUIREMENTS

The substantial capital needs required for a successful ACO include: clinical and administrative coordination systems, information technology needed for coordination and quality reporting, and potential increases in clinical staff and practice expansion, among others.[11] Although CMS estimates the needed Federal ACO investment to be $1.8 million, others have predicted a much higher number - $11.6 million for small ACOs, and $26.1 million for medium ACOs.[12] Additionally, the American Hospital Association has projected initial capital costs of approximately $5.3 million for small ACOs and $12 million for medium ACOs, with annual operating costs of $6.3 million for small ACOs and $14.09 million for medium ACOs.[13] As the expected payouts from CMS or commercial contracts are yet to be solidified, these substantial costs present a degree of risk that many smaller healthcare entities may be unable to, making fully integrated hospitals and health systems the most likely candidate for ACO positioning.

CONCLUSION

While the healthcare industry as a whole is generally supportive of the accountable care concept, restrictions presented by the CMS proposed rules, ability to coordinate care, and capital requirements will limit which healthcare entities are most likely to transition to an ACO.[14] In the next article Health Capital Consultants will take a closer look at the timeline under which ACO are meant to emerge to examine, *When are ACOs*?

1 "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice," Fed. Reg. Vol. 76 No. 67 (April 7, 2011).

2 "Accountable Care Organizations: A New Model for Sustainable Innovation" By Paul H. Keckley and Michelle Hoffman, Deloitte Center for Health Solutions, 2010, p. 11.

3 "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice" Federal Register, Vol. 76, No. 67 (April 7, 2011), p. 19537

4 "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice" Federal Register, Vol. 76, No. 67 (April 7, 2011), p. 19537; "Accountable Care Organizations: A Roadmap for Success: Guidance on First Steps" By Bruce Flareau and Joe Bohn, 1st ed., Virginia Beach, VA: Convurgent Publishing, LLC, 2911, pg. 45.

5 "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice" Federal Register, Vol. 76, No. 67 (April 7, 2011), p. 19540.

6 "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice" Federal Register, Vol. 76, No. 67 (April 7, 2011), p. 19540.

7 "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations and Medicare Program: Waiver Designs in Connection With the Medicare Shared Savings Program and the Innovation Center; Proposed Rule and Notice" Federal Register, Vol. 76, No. 67 (April 7, 2011), p. 19540.

8 "Constructing Accountable Care Organizations: Some Practical Observations at the Nexus of Policy, Business, and Law" By Douglas A. Hastings, Bureau of National Affairs, Health Law Reporter, Vol. 19, No. 25, June 24, 2010.

9 "Constructing Accountable Care Organizations: Some Practical Observations at the Nexus of Policy, Business, and Law" By Douglas A. Hastings, Bureau of National Affairs, Health Law Reporter, Vol. 19, No. 25, June 24, 2010.

10 "Constructing Accountable Care Organizations: Some Practical Observations at the Nexus of Policy, Business, and Law" By Douglas A. Hastings, Bureau of National Affairs, Health Law Reporter, Vol. 19, No. 25, June 24, 2010.

11 "Letter from AHA to CMS Regarding Advanced Payment Initiative" By Linda E. Fishman, Senior Vice President of Public Policy Analysis and Development, AHA, To CMS, June 17, 2011.

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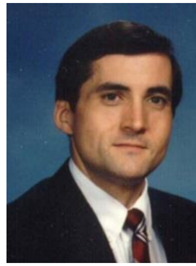

Robert James Cimasi, MHA, ASA, FRICS, MCBA, AVA, CM&AA, serves as President of HEALTH CAPITAL CONSULTANTS (HCC), a nationally recognized healthcare financial and economic consulting firm headquartered in St. Louis, MO, serving clients in 49 states since 1993. Mr. Cimasi has over thirty years of experience 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.

Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Intuition of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master Certified Business Appraiser (MCBA – Institute of Business Appraisers); Accredited Valuation Analyst (AVA – National Association of Certified Valuators and Analysts); and, Certified Merger & Acquisition Advisor (CM&AA – Alliance of Merger & Acquisition Advisors). He has served as an expert witness on cases in numerous courts, and has provided testimony before federal and state legislative committees. He is a nationally known speaker on healthcare industry topics, the author of several books, the latest of which include: "*The U.S. Healthcare Certificate of Need Sourcebook*" [2005 - Beard Books], *"An Exciting Insight into the Healthcare Industry and Medical Practice Valuation"* [2002 – AICPA], and *"A Guide to Consulting Services for Emerging Healthcare Organizations"* [1999 John Wiley and Sons].

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.

Todd A. Zigrang, MBA, MHA, ASA, FACHE, is the Senior Vice President of HEALTH CAPITAL CONSULTANTS (HCC), where he focuses on the areas valuation and financial analysis for hospitals and other healthcare enterprises. Mr. Zigrang has significant physician integration and financial analysis experience, and has participated in the development of a physician-owned multi-specialty MSO and networks involving a wide range of specialties; physician-owned hospitals, as well as several limited liability companies for the purpose of acquiring acute care and specialty hospitals, ASCs and other ancillary facilities; participated in the evaluation and negotiation of managed care contracts, performed and assisted in the valuation of various healthcare entities and related litigation support engagements; created pro-forma financials; written business plans; conducted a range of industry research; completed due diligence practice analysis; overseen the selection process for vendors, contractors, and architects; and, worked on the arrangement of financing.

Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia, and is a Fellow of the American College of Healthcare Executives. He has co-authored *"Research and Financial Benchmarking in the Healthcare Industry"* (STP Financial Management) and *"Healthcare Industry Research and its Application in Financial Consulting"* (Aspen Publishers). He has additionally taught before the Institute of Business Appraisers and CPA Leadership Institute, and has presented healthcare industry valuation related research papers before the Healthcare Financial Management Association; the National CPA Health Care Adviser's Association; Association for Corporate Growth; Infocast Executive Education Series; the St. Louis Business Valuation Roundtable; and, Physician Hospitals of America.

Anne P. Sharamitaro, Esq., is the Vice President of HEALTH CAPITAL CONSULTANTS (HCC), where she focuses on the areas of Certificate of Need (CON); regulatory compliance, managed care, and antitrust consulting. Ms. Sharamitaro is a member of the Missouri Bar and holds a J.D. and Health Law Certificate from Saint Louis University School of Law, where she served as an editor for the Journal of Health Law, published by the American Health Lawyers Association. She has presented healthcare industry related research papers before Physician Hospitals of America and the National Association of Certified Valuation Analysts and co-authored chapters in "*Healthcare Organizations: Financial Management Strategies*," published in 2008.

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