

ACO Value Metrics Series Part III: Determining an ACO's Financial Feasibility

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)*. The first installment provided the background of the value metrics used to assess these emerging healthcare entities, and Part II discussed the cost-benefit analysis that must be conducted in considering ACO formation. Part III will address the financial feasibility of potential ACOs, and Part IV will consider the monetary and non-monetary value metrics that should also be evaluated. This *HC Topics Series* is excerpted from the book authored by HCC Chief Executive Officer, Bob Cimasi, entitled, “*Accountable Care Organizations: Value Metrics and Capital Formation*,” to be published by Taylor and Francis Group later this year.

Last month's installment of the *HC Topics Series: ACO Value Metrics* discussed the cost-benefit analysis that entities considering *federal ACO* formation must perform. It is critical that such entities determine the likelihood of generating revenue under the Medicare Shared Savings Program (MSSP) sufficient to offset the prospective ACO's start-up and ongoing operational costs, and this analysis will lend itself to the initial investment decision. This month's installment will examine the process and various methodologies by which entities should evaluate the financial feasibility of a prospective *federal ACO*.

To increase the probability of success in ACO formation, prospective participants should closely examine all aspects of the investment. As additional information becomes available regarding the operating performance and capital requirements of ACO formation, the nature of the pre-investment analysis should trend toward being less of a forecast based on hypothetical assumptions and more an empirically-grounded benchmarking to normative industry data. The general tenet guiding the decision to accept or reject an ACO investment should be to only undertake projects that seek to maximize the expected value of the enterprise to its owners.

Before embarking on an in-depth analysis of the financial feasibility of ACO investment, a healthcare enterprise's leaders should first consider whether the current fiscal status of their enterprise will allow for the anticipated significant initial capital investment required to form an ACO. In order to determine if the enterprise

has a reasonable probability of obtaining access to adequate capital, a review of the enterprise's *debt policy*, along with its current *level of debt* and *debt capacity*, may be warranted. In addition, managers of the enterprise may also review the enterprise's access to equity through either *internal sources* (e.g., the *current cash flow* of the entity) or from *external sources* (e.g., *private equity*, *venture capital*, or *publicly traded equity markets*). Choosing the optimal combination of capital sources depends upon the size and make-up of the organization and what types of financing are required, as well as the tax posture of the entity. Regardless of the results of a financial analysis, access to sufficient capital is a binding constraint on investment in an ACO.

Healthcare enterprise leaders considering investing in an ACO should review the sources of revenue within the ACO model and their enterprise's ability to leverage its institutional expertise and access the necessary capital to initiate an ACO and incur initial losses. As discussed in last month's installment, under the MSSP, an ACO's revenue is derived from shared cost reductions, and healthcare entities capable of reducing patient costs to payors will share in a portion of those cost reductions, also known as *annual shared savings*. To justify the significant expense associated with ACO development and operation, a potential ACO investor should consider whether the anticipated *annual shared savings* will offset the required ACO-related capital expenditures. Given the cap on shared savings, some ACOs (primarily small ACOs) may not be able to accumulate the necessary financial benefit to offset the ACO-related costs. The annual *expected cash flow* for ACOs of each size may be estimated by assuming a “*best case*” scenario, in which an ACO achieves the *maximum shared savings*, and, therefore, the maximum *expected future cash flows* (i.e., the expected cost savings less the expected operational costs of the ACO) over the initial three-year contract term, and considering the necessary initial start-up investment.

A *cash flow analysis* first requires that a forecast be made of the potential revenue to be generated by an ACO. Using the “*best case*” scenario of revenue generated by the *anticipated shared savings* under the chosen distribution model (one-sided or two-sided), the ACO's *anticipated operating costs* are allocated between *fixed costs* (those that do not vary with the number of beneficiaries) and *variable costs* (those that vary with the number of beneficiaries). Then, assuming

that (1) variable costs will increase by a fixed amount per additional beneficiary; (2) an ACO will continue to achieve the *best case* scenario revenue for the entire term of the initial three-year agreement; and, (3) operating costs will remain constant, it can be estimated that a federal ACO under the *two-sided model* may require somewhere between 5,000 and 15,000 Medicare beneficiaries before being expected to generate *positive cash flows* (i.e., cash flows in excess of operating expenses). Under the *one-sided model* and these same assumptions, a federal ACO may achieve a *positive cash flow* with somewhere between 25,000 and 35,000 Medicare beneficiaries.

The expected cost reductions under the MSSP will be utilized as inputs into any quantitative evaluation of the financial merits of the ACO investment and may have a significant impact on the resulting *value metric* and the final investment decision. Various methodologies are available to analyze the expected value added by a prospective capital investment. Though each of these *value metrics* may be useful in assisting managers of healthcare enterprises as they decide whether to invest in an ACO, the calculation of the various *metrics* first requires an analysis of the *expected economic benefit* that will accrue to the stakeholders in the ACO project. Among the *metrics* available to analysts, the most commonly utilized include: (1) the *Payback Period* and the *Discounted Payback Period Methods*; (2) the *Accounting Rate of Return Method*; (3) the *Net Present Value Method*; and, (4) the *Internal Rate of Return Method*. Each of these methods has its strengths and weaknesses, and the merits and drawbacks of each method should be carefully considered, for every investment project, before selecting a method to utilize in the investment analysis.

The *Payback Period Method* is one of the simplest methods to calculate *value metrics* for an investment such as an ACO. This method calculates the “*expected number of years required to recover the original investment.*”¹ However, it does not consider the present value of the cash flows utilized in the analysis and, as a result, will tend to underestimate the true payback period. The *Discounted Payback Period Method* addresses this present value shortcoming by converting each cash flow into its present value equivalent by discounting at an appropriate *risk-adjusted rate*.² An alternative metric for measuring the value impact of a capital budgeting project is the *Average Accounting Rate of Return (AARR) Method*, which is calculated by dividing the average net income for the project by the initial investment cost. The *Net Present Value (NPV) Method*, defined as the discounted value of the differences over time between monetary costs and benefits in each period, is another useful metric for

evaluating a projected likelihood of increasing the overall enterprise’s value.³ Similar to the NPV, the *Internal Rate of Return (IRR) Method* attempts to determine the rate of return that would render the NPV of the project equal to zero.⁴ The IRR represents the maximum rate (in percentage) at which the project’s investors could be compensated for the project to leave the value of the enterprise unchanged.

Generation of *positive cash flow* is a requisite, but not *entirely sufficient*, condition for the expectation of *future value* attributed to investment in an ACO project. An investment project that fails to generate *positive net cash flow* will not accumulate sufficient *net economic benefit* to offset the initial investment, although it is possible that indirect benefits may accrue to the stakeholders in the ACO. An analysis using the methods described above indicates that larger ACOs have a higher probability of success, most likely due to the effect of an economy of scale, in that they can apply modest per-beneficiary cost savings across a larger beneficiary population.

Those considering an investment in an ACO must seek to determine whether this investment will maximize the expected value of the enterprise to its stakeholders, i.e., investors/owners or beneficiaries in the community served, which includes consideration of both *monetary* and *non-monetary* benefits and costs. Next month’s installment of the *HC Topics Series: ACO Value Metrics* will discuss these monetary and non-monetary aspects of ACO formation.

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

- [ACO Value Metrics Series – Part II – “A Cost-Benefit Analysis of ACO Formation.” Health Capital Topics Newsletter, Vol. 5, No. 10, October 2012.](#)
- [ACO Value Metrics Series – Part I – “Need to Know Basics on the Costs of Forming an ACO” Health Capital Topics Newsletter, Vol. 5, No. 9, September 2012.](#)

- 1 “Essentials of Managerial Finance, Ninth Edition” By J. Fred Weston and Eugene F. Brigham, 1990, Chicago, IL: The Dryden Press, p. 564.
- 2 “Corporate Finance” fourth edition by Ross, Westerfield, Jaffe, and Roberts, Canada, McGraw-Hill Ryerson, 2005, p. 942.
- 3 “The Dictionary of Health Economics” By Anthony J. Culyer, Second Edition, Northampton, MA: Edward Elgar Publishing Limited, 2010, p. 347.
- 4 “Dictionary of Health Insurance and Managed Care” By David Marcinko, New York, NY: Springer Publishing Group, 2006, p. 161.



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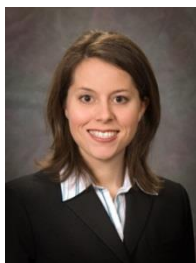
Mr. Cimasi holds a Masters in Health Administration from the University of Maryland, as well as several professional designations: Accredited Senior Appraiser (ASA – American Society of Appraisers); Fellow Royal Intuition of Chartered Surveyors (FRICS – Royal Institute of Chartered Surveyors); Master 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: *“Accountable Care Organizations: Value Metrics and Capital Formation”* [2013 - Taylor & Francis, a division of CRC Press], *“The Adviser’s Guide to Healthcare”* – Vols. I, II & III [2010 – AICPA], and *“The U.S. Healthcare Certificate of Need Sourcebook”* [2005 - Beard Books]. His most recent book, entitled *“Healthcare Valuation: The Financial Appraisal of Enterprises, Assets, and Services”* will be published by John Wiley & Sons in the Fall of 2013.

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. In 2011, he was named a Fellow of the Royal Institution of Chartered Surveyors (RICS).



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