Why Would A Hospital Want To Participate In An ACO?  
Financial Implications And Considerations

By Adam Medlin and Laura P. Jacobs

Introduction

As delegated physician organizations, CAPG members have a long history of taking risk for the cost and quality of care for a population of patients. Many would say that this qualifies them as defacto ACOs (even though the specific regulatory requirements are still pending as of this writing). While largely true, the missing link for many is a hospital "partner" that is as engaged in the reduction in costs and improvement in health. With the extinction of hospital risk pools and hospital capitation in most markets, one of the central questions for physician organizations considering ACO designation is, "How do I get more traction on the reduction of hospital costs and assurance that quality outcomes are achieved on the inpatient side if I don’t have an aligned hospital?” Or, said another way, “How do I engage a hospital in ACO discussions when all they seem to care about is the volume of admits or outpatient referrals?”

At the request of CAPG, a financial model has been developed to aid in illustrating the potential impact to hospitals of continuing with business as usual versus actively participating in an ACO with a physician group experienced in population management. The model is designed to allow assumptions to be modified to fit the essential market and economic characteristics of the proposed relationship. The scenarios that follow are one example of how a hospital can “win” in ACO participation despite a reduction in volume and length-of-stay.

Scenario Description

In our analysis, we compiled two scenarios involving a hypothetical general acute community hospital ("the Hospital"). For the first scenario, the Hospital does not participate in an ACO while a nearby competitor does ("Status Quo"). In the second scenario, the Hospital elects to participate in an ACO in collaboration with an experienced delegated physician group (i.e., CAPG member) and is first to market. In this analysis, the ACO only includes traditional Medicare fee-for-service members.

Background of the Hypothetical Hospital

The Hospital is a general acute community hospital with an average-daily-census of approximately 250 and which, in the past, has experienced limited competition. The Hospital is centered in a suburban market with a favorable payer mix with Medicare and commercial as the predominant payers. The Hospital’s payer mix and market position have contributed to a history of stable financial performance.

Scenario - Status Quo

In the Status Quo scenario, the Hospital experiences a substantial decrease in Medicare discharges as a consequence of the competitor developing an ACO and gaining market share. The Medicare average-length-of-stay ("ALOS") decreases (which helps improve Medicare profitability), but not enough to offset the loss in discharges. As Medicare discharges and ALOS decline, census drops significantly over the projected period. Although the Hospital is able to respond by flexing staff and other resources, the small increases in Medicare reimbursement and continued increases in costs begin to impact the bottom line.

Scenario - ACO

For the ACO scenario, the Hospital partners with a delegated physician group to form an ACO. The Hospital makes an equity contribution to the ACO entity, provides start-up costs, and ramps up required additional Hospital staff. By being first to market with the ACO, the Hospital is able to increase overall Medicare market share. Although Medicare admission rates for the ACO population drops, the Hospital benefits from a reduced ALOS (that is more comparable to the Medicare Advantage population) and a more aggressive reduction in readmissions, thereby significantly increasing the profitability of each ACO Medicare case. The ACO also has a “halo effect” on the ALOS of the non-ACO traditional Medicare line of business. As a result, census declines over time, similar to the levels seen in the Status Quo scenario. Shared savings generated by the ACO (primarily driven by the reduction in hospital utilization) increase with each year and are distributed equally between the Hospital and the physician group.

Under the ACO scenario, the Hospital is continued on page 21
MEMBERS SPOTLIGHT

Group Culture Is Everything

By Tom Gordon

To me, culture is everything. At Cedars-Sinai Medical Delivery Network, we spend a lot of time discussing culture. Our culture allows us to create “social glue” with each other. We value our relationships with one another, and talk about things like communication, building trust, and having emotional intelligence. By having “social glue”, we are able to create bonds that are authentic and reliable so people stay for a long time, providing continuity of care for our patients and ensuring our satisfaction and quality scores are never compromised. An overwhelming number of our physicians have been with our medical group for more than 10 years. Twenty-four percent have been with the group for more than 15 years. We value our relationships with one another and this allows us to work through the conflicts and personality differences that are a part of being “imperfect” humans. For the past 4 years, our employee satisfaction scores have been in the 99th percentile. We are committed to fostering a supportive working environment where each individual is valued and respected. We are also committed to the best quality patient care as evidenced by the fact that our quality scores are consistently high. We put in the hard, daily work of supporting each other, which results in the “social glue” that are much more than just words in our family.

In my vision, culture and true leadership will be more crucial than ever in the coming years. Today’s challenges call for leaders who are willing to navigate the uncertainties of the future and have processes in place to recognize rapidly changing demands in their marketplace. Furthermore, strong leaders are those who know how to motivate their people, ultimately enlisting the help of each individual to create and carry out a cohesive vision and a culture that rings true for everyone in the company. The only way a shared vision is accomplished is by individual people who see value in it from their own perspective. Vision and execution in our daily work, coupled with a sense of urgency for preparing for the future will be critical. The world of healthcare, as we all know, will never be the same. Therefore, core values such as culture and leadership must be strongholds upon which we can depend.

One of the ways that we install culture is to provide workshops for every level of personnel in our company. At those workshops, we role play, discuss the key differences between management and leadership, work on communication exercises, and bring everyone up to date on the strategic and financial condition of their company. One of our top goals is to maintain financial stability through turbulent times, avoid layoffs or reductions for our loyal and hard-working employees and provide a secure and meaningful environment for our family of physicians and staff. This stability allows everyone to focus on their highest privilege: to care for our patients in the best way possible and to give each patient a genuine and meaningful experience. The respect that we practice and feel for each other is carried forward into our relationships with our patients. Everyone knows to never burn a bridge because “relationships are everything”. With a culture that values relationships, people learn to embrace change, a quality that will prove to be invaluable in the future.

In building and growing our company, I have always adhered to one important management ethos that I was taught as a young manager: hire people by the size of their heart. I genuinely feel that if you hire people with heart, you can accomplish anything. People with heart instinctually care about those around them and are also passionate about what they produce. These are the types of people organizations need, especially in today’s changing world. Passion is probably the single prerequisite to cultural change, for those inclined to attempt it. If you’re not passionate about it, don’t even bother.

able from page 20

• Financial relationship between the Medical Group and Hospital (ACO investment, hospital rate concessions, split of shared savings)

This model is intended to establish a high-level starting point for discussion with potential hospital partners. It is not a replacement for thorough business planning and analysis of all of the variables at play, including Medicare Advantage impact, changes to Disproportionate Share Hospital (“DSH”) funding, Emergency Department utilization, patient access, and linkages to other care providers. But it can be a tool to engage hospitals in a meaningful discussion about how to “win” by reducing volume and costs.

Page 21