Accountable Care Organizations: Development Strategies and Capital Planning

Presented by:

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HCC
HEALTH CAPITAL CONSULTANTS

PRESENTER BIOGRAPHY

Todd A. Zigrang, MBA, MHA, FACHE, ASA, is a Senior Vice President of HEALTH CAPITAL CONSULTANTS (HCC), where he focuses on the areas of 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.

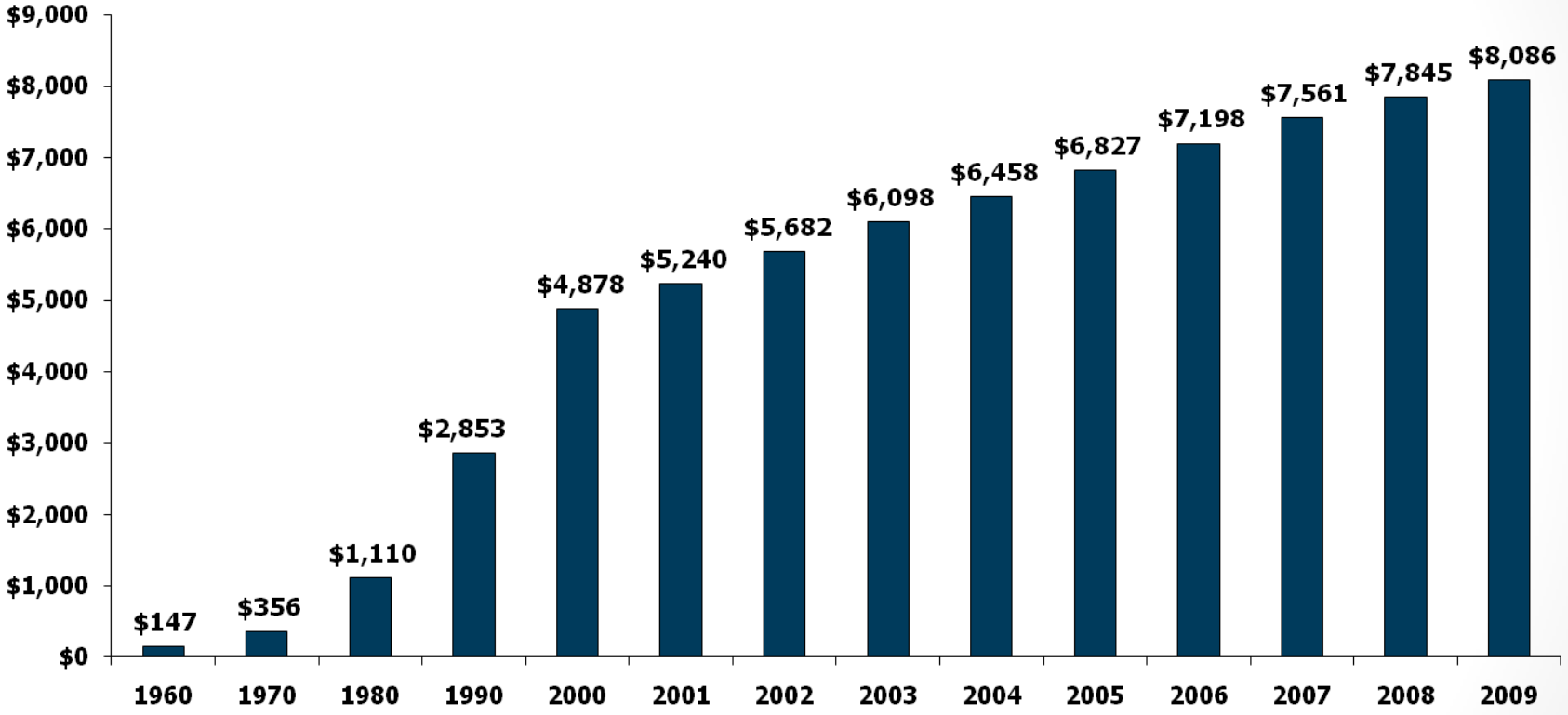
Mr. Zigrang holds a Master of Science in Health Administration and a Masters in Business Administration from the University of Missouri at Columbia. He is a member of the American College of Healthcare Executives and Healthcare Financial Management Association. He has co-authored "Research and Financial 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 has presented healthcare industry valuation related research papers before the Healthcare Financial Management Association; St. Louis Business Valuation Roundtable; and, Physician Hospitals of America (f/k/a American Surgical Hospital Association).

PRESENTER BIOGRAPHY

Anne P. Sharamitaro, Esq., is a Senior 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, and has been admitted to the Missouri Bar. She has presented healthcare industry related research papers before Physician Hospitals of America (f/k/a American Surgical Hospital Association) and the National Association of Certified Valuation Analysts and co-authored chapters in Healthcare Organizations: Financial Management Strategies, published in 2008.

An Overview of Accountable Care Organizations

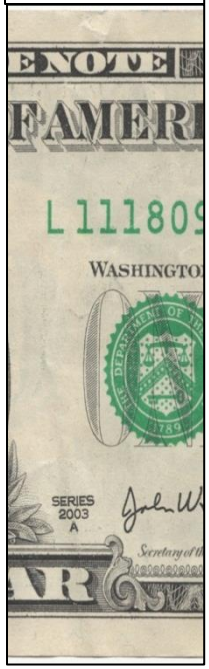
Why Accountable Care?



National Health Expenditures per Capita, 1960-2009

Source: Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; NHE summary including share of GDP, CY 1960-2009; file nhegdp09.zip).

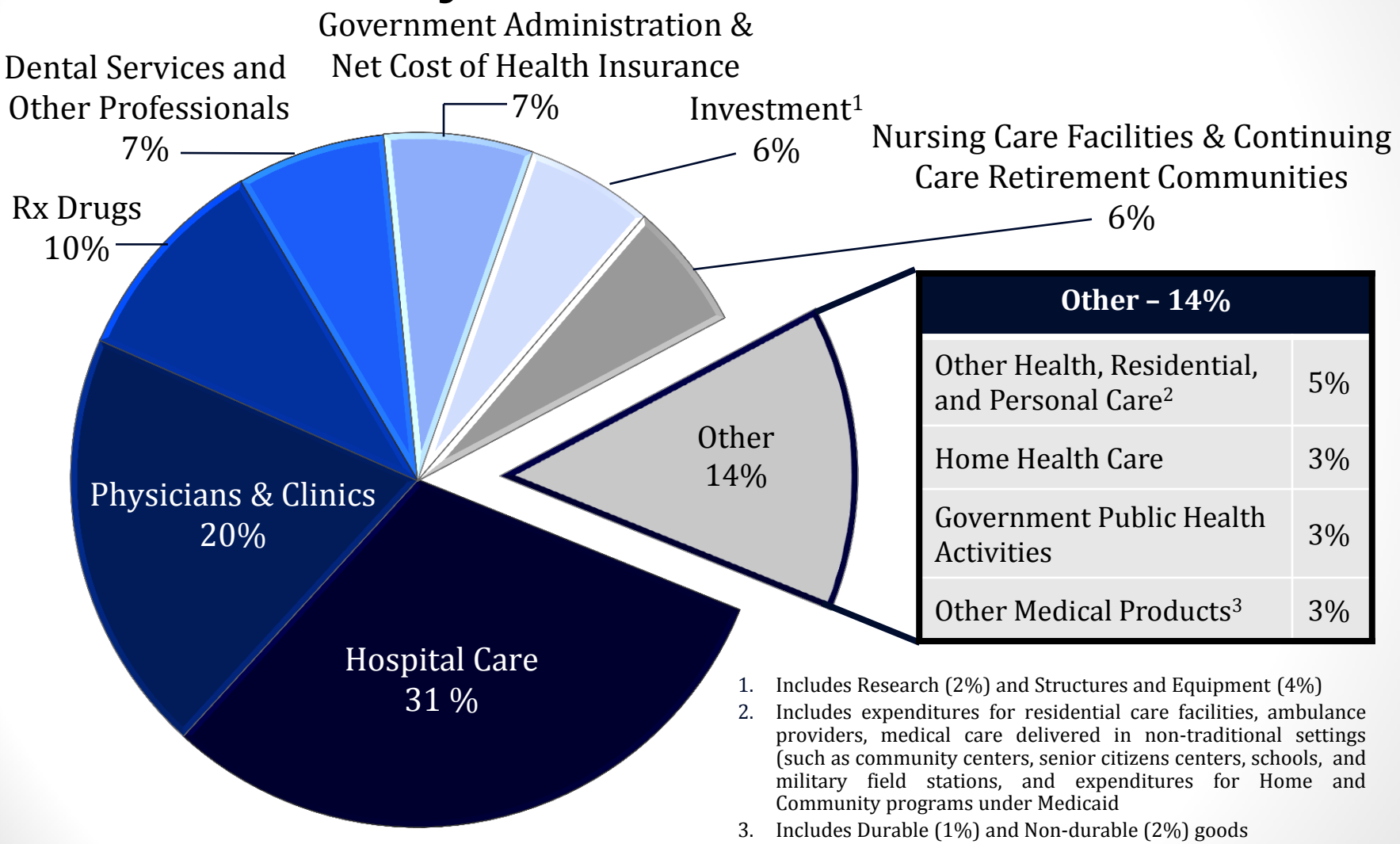
Why Accountable Care?

Hospital Care 30.5%	Physician/Clinical Services 20.3%	Other Health Spending 15.9%	Other Personal Health Care 14.9%	Rx Drugs 10.1%	Home Health 8.2%
					

*Note: Other Personal Health Care includes, for example, dental and other professional health services, durable medical equipment, etc. Other Health Spending includes, for example, administration and net cost of private health insurance, public health activity, research, and structures and equipment, etc.

Source: Kaiser Family Foundation calculations using NHE data from Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, at http://www.cms.hhs.gov/NationalHealthExpendData/ (see Historical; National Health Expenditures by type of service and source of funds, CY 1960-2009; file nhe2009.zip).

Why Accountable Care



Other – 14%	
Other Health, Residential, and Personal Care[2]	5%
Home Health Care	3%
Government Public Health Activities	3%
Other Medical Products[3]	3%

1. Includes Research (2%) and Structures and Equipment (4%)
2. Includes expenditures for residential care facilities, ambulance providers, medical care delivered in non-traditional settings (such as community centers, senior citizens centers, schools, and military field stations, and expenditures for Home and Community programs under Medicaid
3. Includes Durable (1%) and Non-durable (2%) goods

Note: Sum of pieces may not equal 100% due to rounding.
Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Statistics Group.

Path to Accountable Care

ACO

1st Generation	2nd Generation	3rd Generation	4th Generation
Managed Access	**Managed Benefits**	**Managed Care**	**Managed Outcomes**
• Emphasis on managing/restricting patient access • Administrative burdens (e.g., pre-certification, significant co-pays) • Reliance primarily on non-clinical reviewers • Physician totally outside system	• Emphasis on managing benefits • Pre-certification primary and treatment planning secondary • Cost containment emphasized over clinical management • Traditional treatment models employed • Physicians "*included,*" but their care delivery "*inspected*"	• Greater emphasis on treatment planning and quality management • Focus on most appropriate care in most appropriate setting • Patients managed through continuum of care • Clinical management of network; provider-care manager collegiality • Shift toward improving access and benefits to reduce costs	• Operational, clinical, and financial integration • Locally responsive delivery systems and services based on national standards and capabilities • Mutually beneficial partnerships with physician community • Effective use of technology to measure, report, and enhance quality and outcomes • Proof of value for patients • Full accountability for costs and quality

"The only thing new in the world is the history you don't know."

– Harry S. Truman

What is an Accountable Care Organization?

Healthcare organization with a coordinated set of providers…

- Provider mix dependent on whether federal or commercial ACO structure

Who share responsibility and accountability for the continuum of care…

- Clinical accountability – Quality of care
- Financial responsibility – Cost of Care

By providing the highest possible value of care…

- Increase quality
- Decrease costs

For financial incentives or "shared savings"…

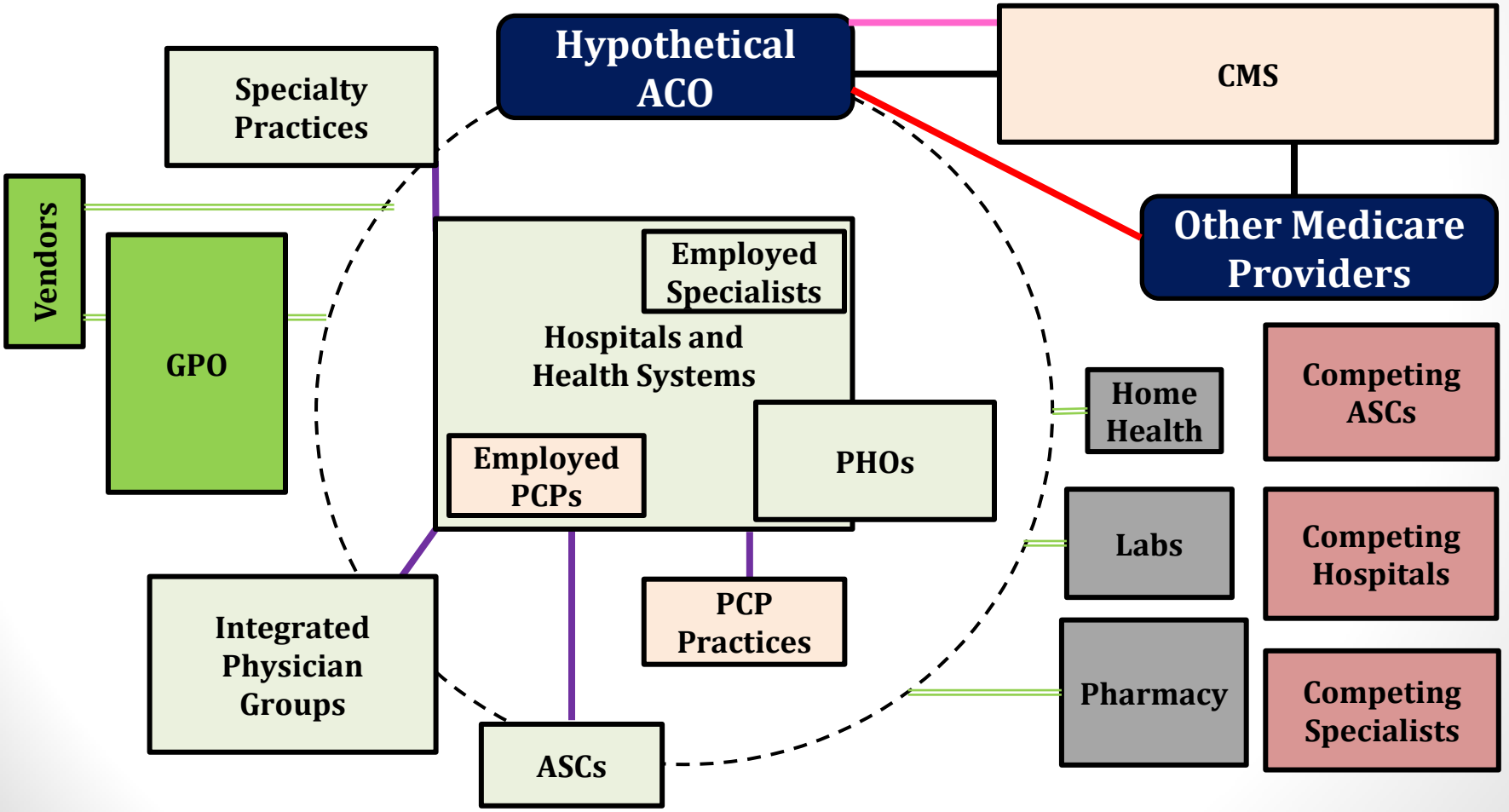
- Value-based payments
- Reimbursement for achieving cost and quality goals

From participating payors

- Public Payors (e.g., Medicare, Medicaid)
- Commercial Payors (e.g., BCBS of MA)

"The Promise of ACOs" Accountable Care Organization Learning Network, http://www.acolearningnetwork.org/why-we-exist/the-promise-of-acos; "Essential Guide to Accountable Care Organizations: Challenges, Risks, and Opportunities of the ACO Model," The Healthcare Intelligence Network, 2011.

Potential ACO Structure – *Federal ACOs*



Potential ACO Structure – *Federal ACOs*

Key

Shading

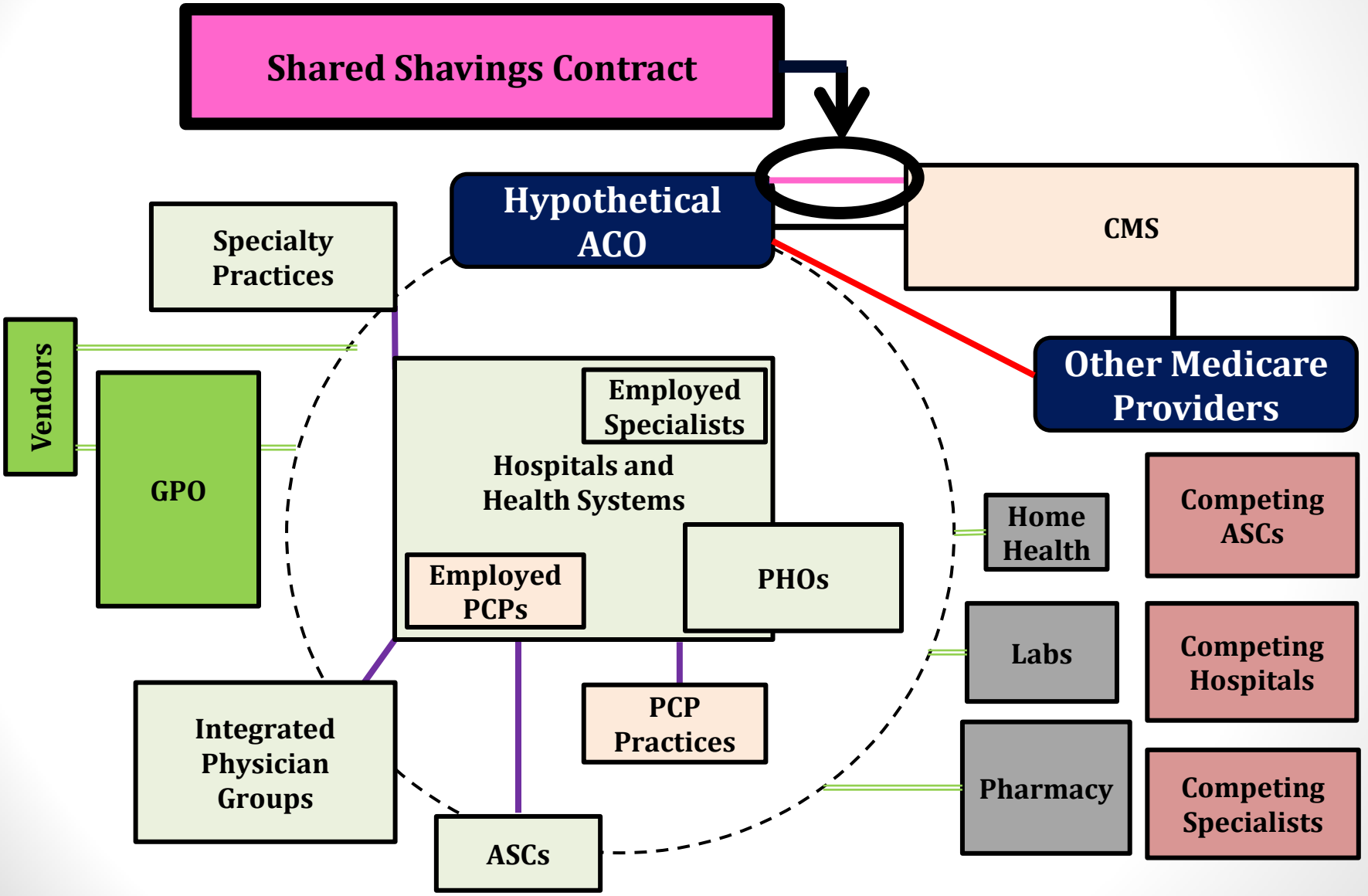
- Various entities that may partner to form an ACO under MSSP
- Dictates costs and quality measures that ACO is accountable for (i.e., PCPs and CMS)
- Not a provider (not included in MSSP)
- Competition if ACO (most likely hospital) offers similar services, but can also form mutually beneficial contracts to share MSSP payments
- Direct Competition for ACO

Size of Entity Represents Proportionate Effect on ACO Success

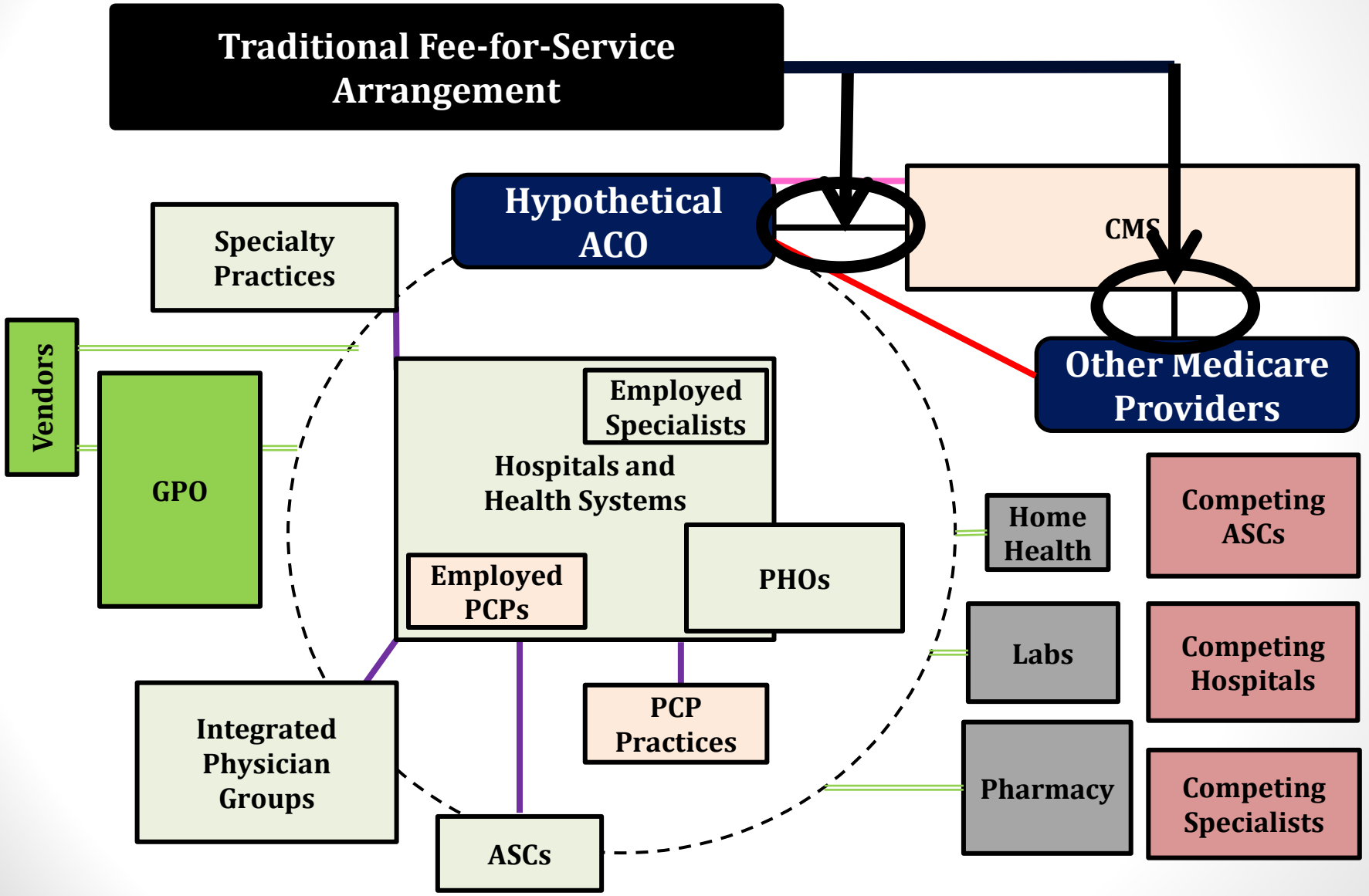
Ability to: meet capital and operational requirements, manage new reimbursement schemes, negotiate beneficial contracts, and achieve quality and cost goals

The Next Set of Slides Examines the Relationships Between Entities

Potential ACO Structure – *Federal ACOs*



Potential ACO Structure – *Federal ACOs*



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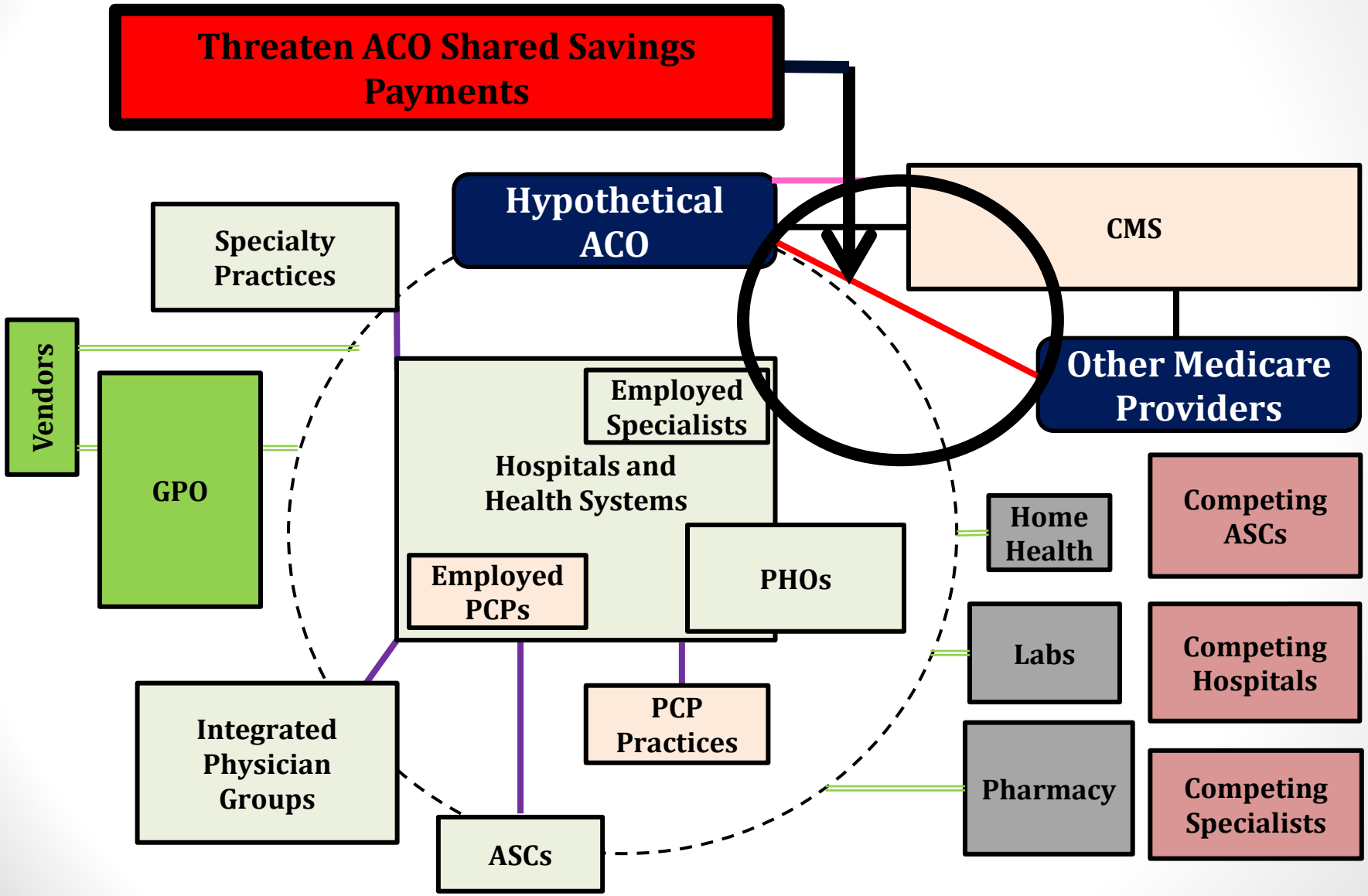

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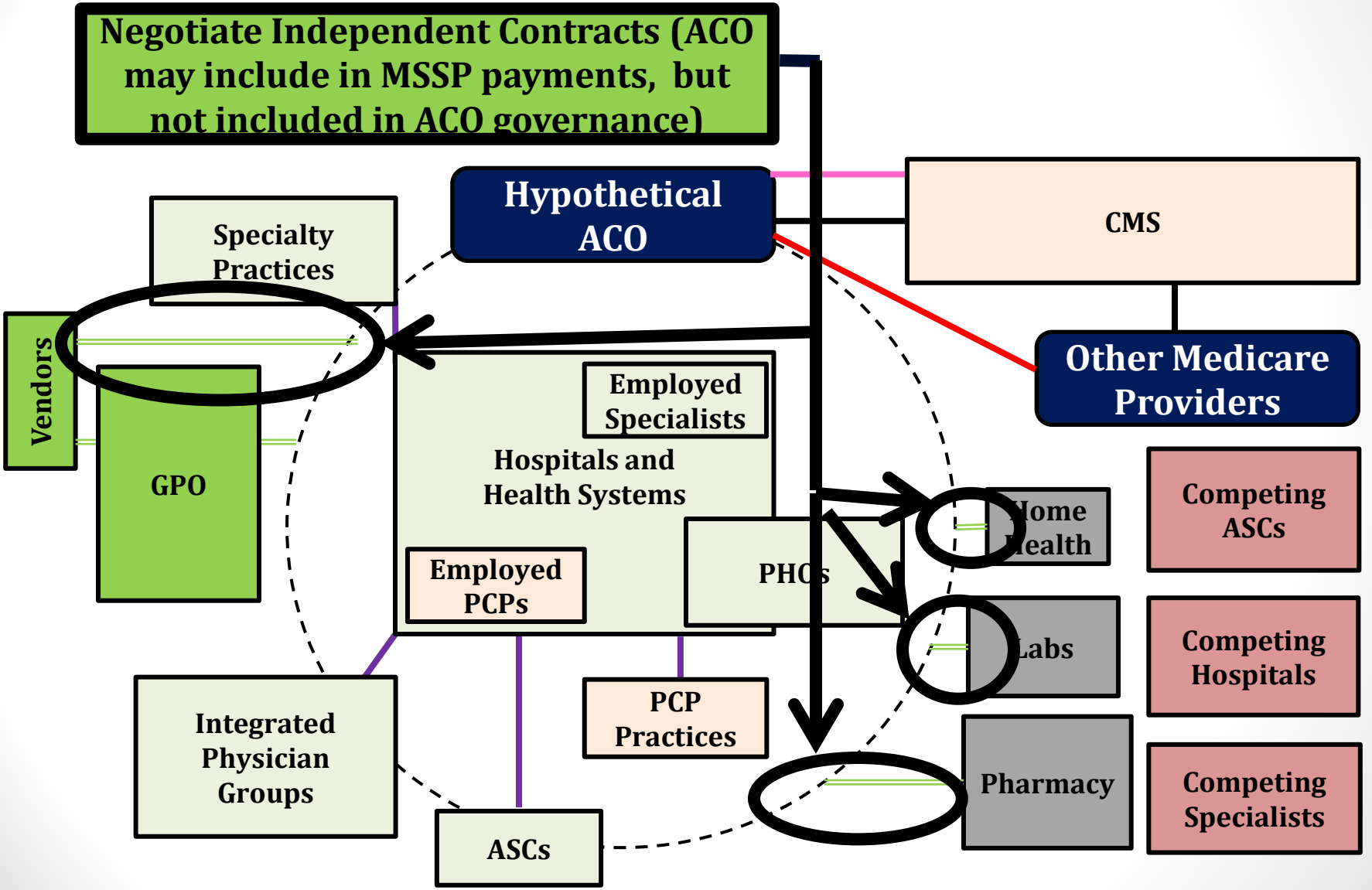
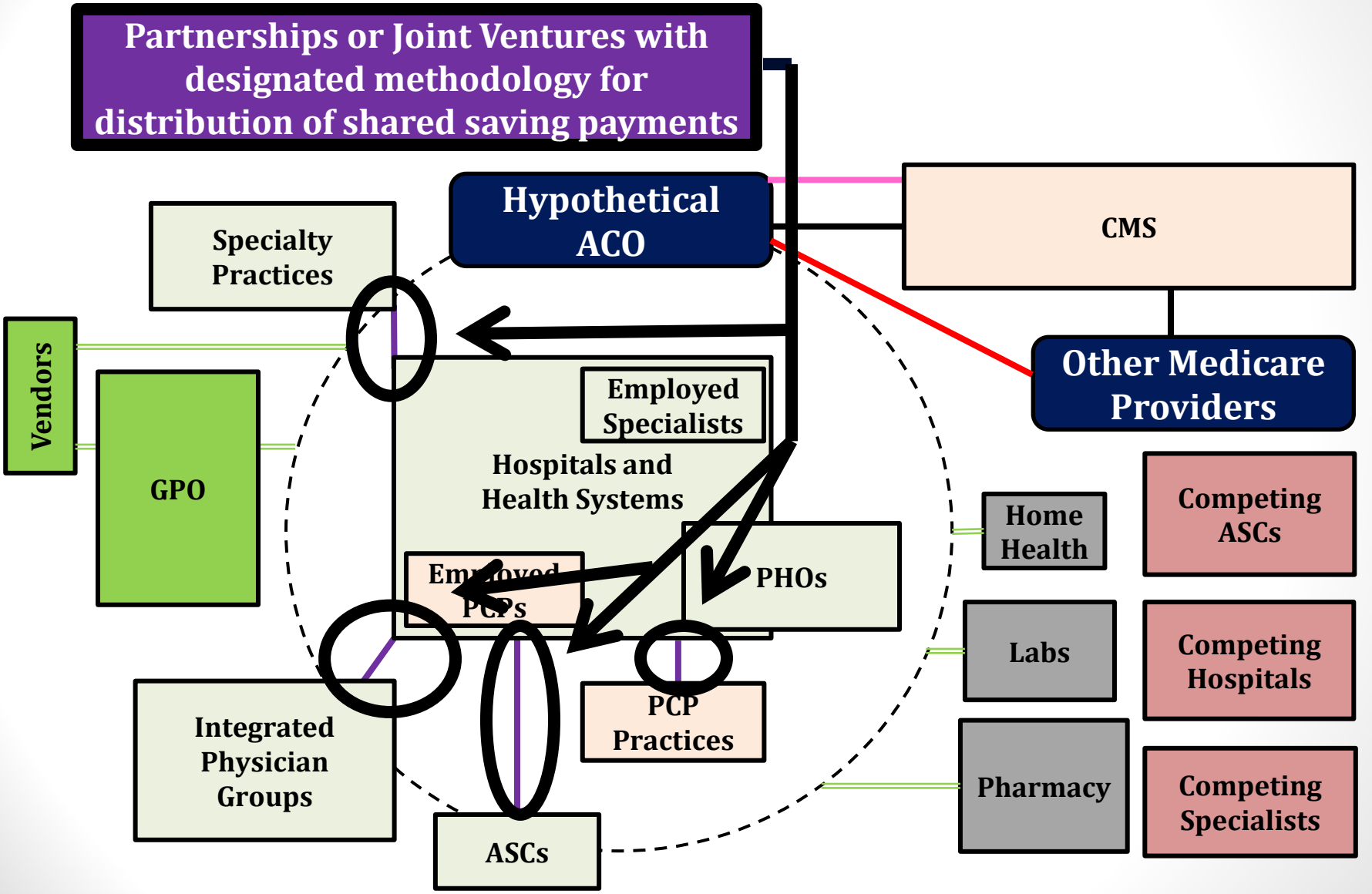
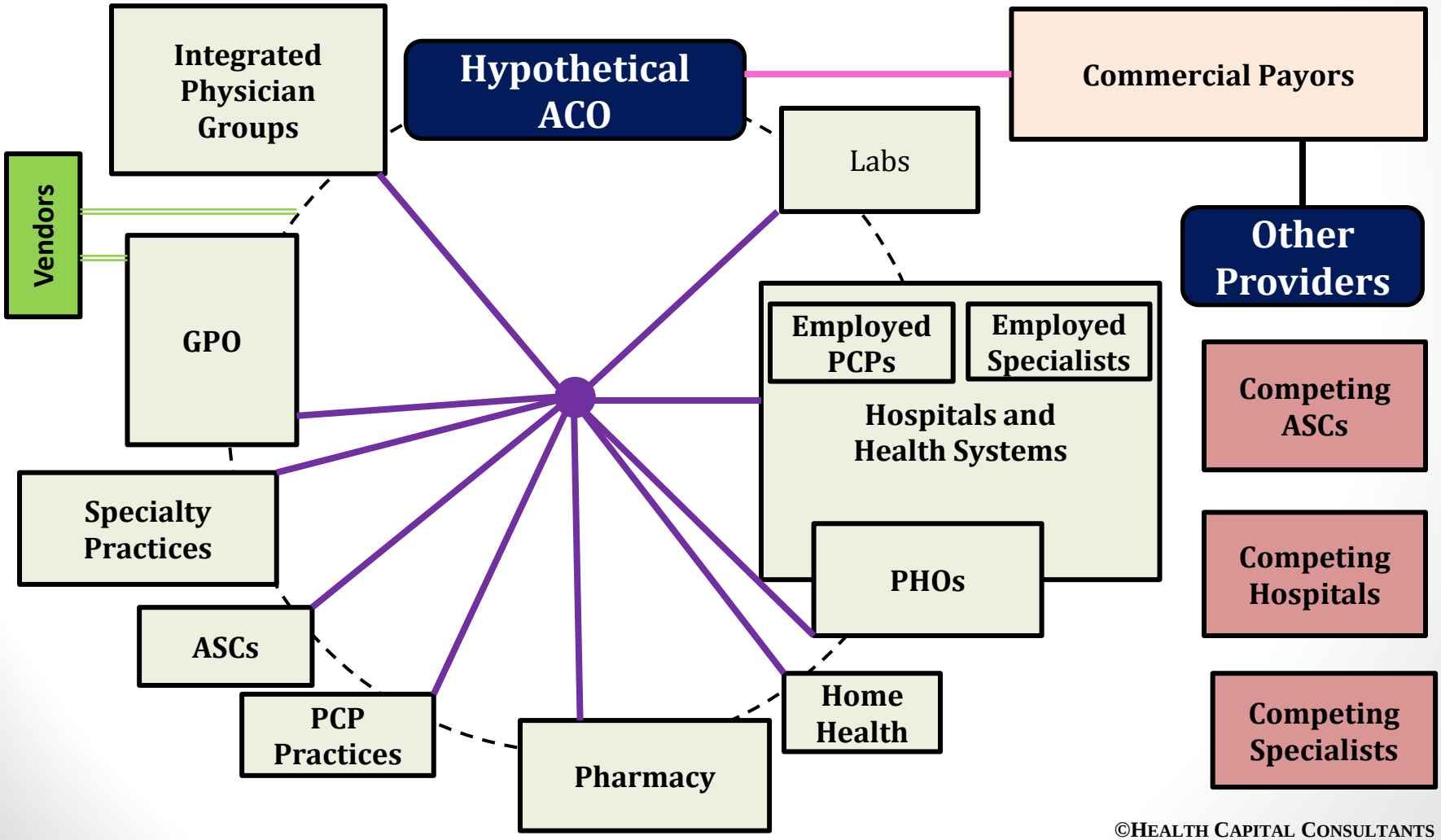


Potential ACO Structure – *Federal ACOs*



Potential ACO Structure – *Commercial ACOs*



Potential ACO Structure – *Commercial ACOs*

Key

Shading

- Various entities that may partner to form an ACO
- Not a provider (not competition, but not included in ACO risk sharing)
- Direct competition for ACO

Size of Entity Represents Proportionate Effect on ACO Success

Ability to: meet capital and operational requirements, manage new reimbursement schemes, negotiate beneficial contracts, and achieve quality and cost goals

The Next Set of Slides Examines the Relationships Between Entities

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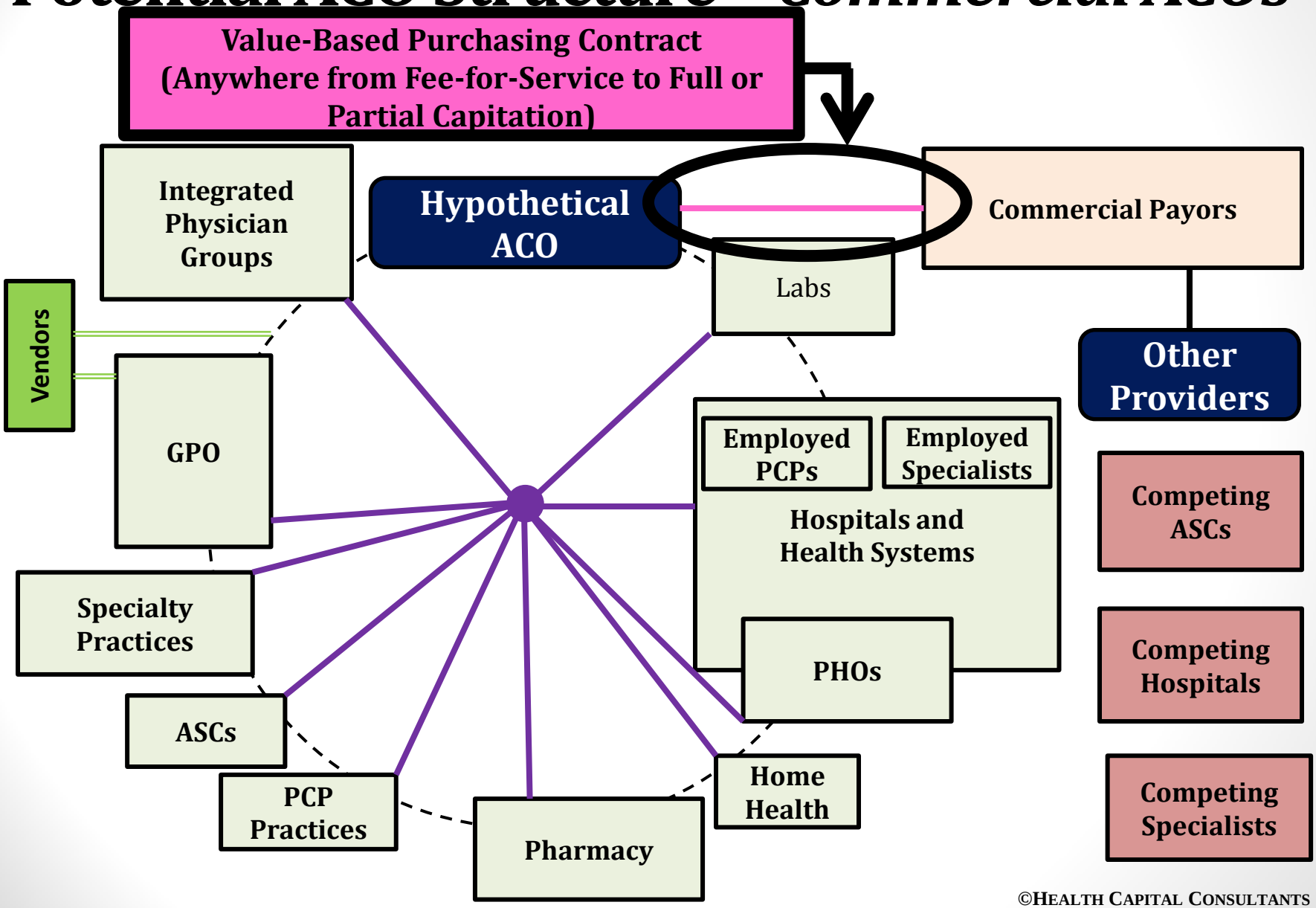
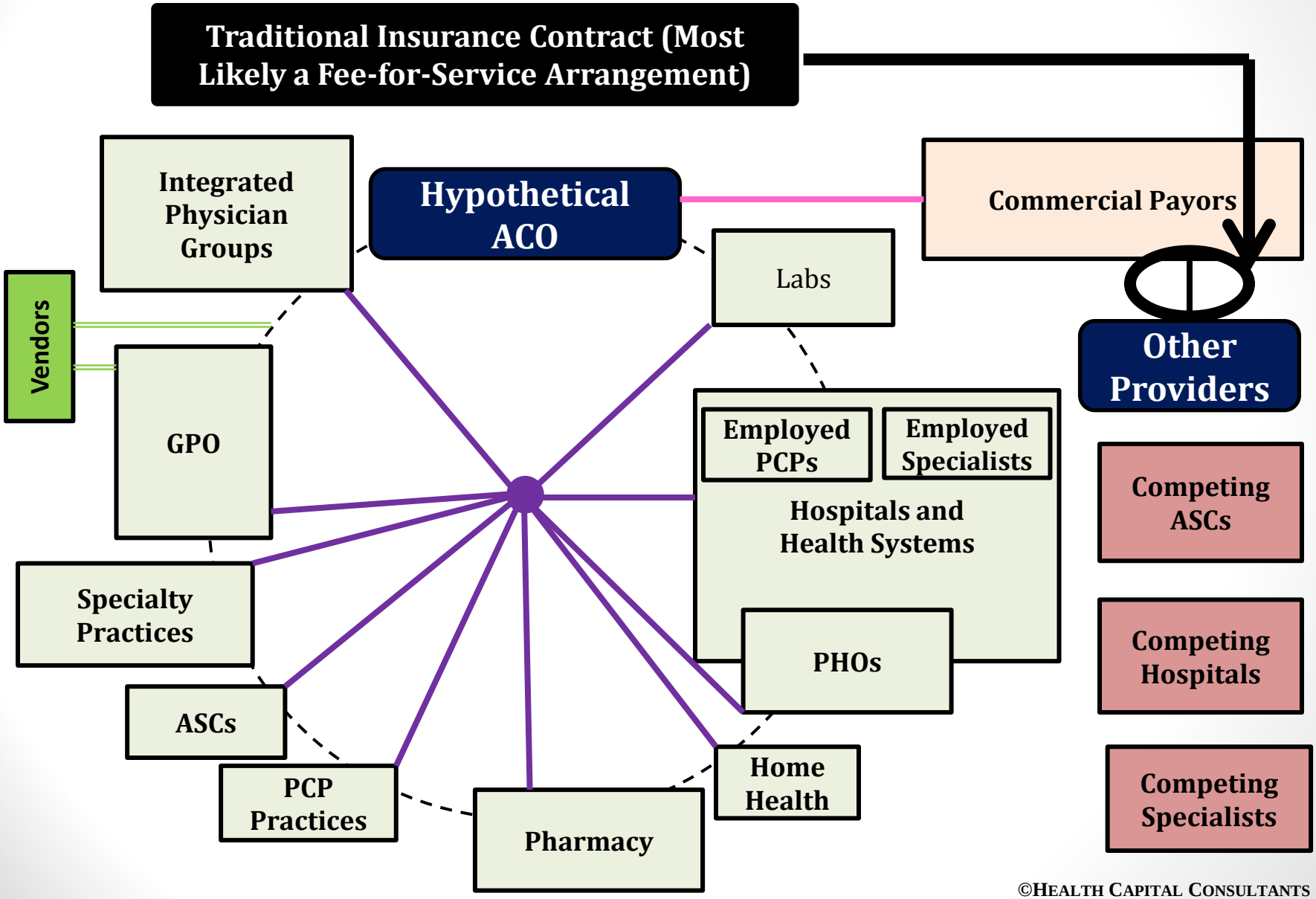


Potential ACO Structure – *Commercial ACOs*



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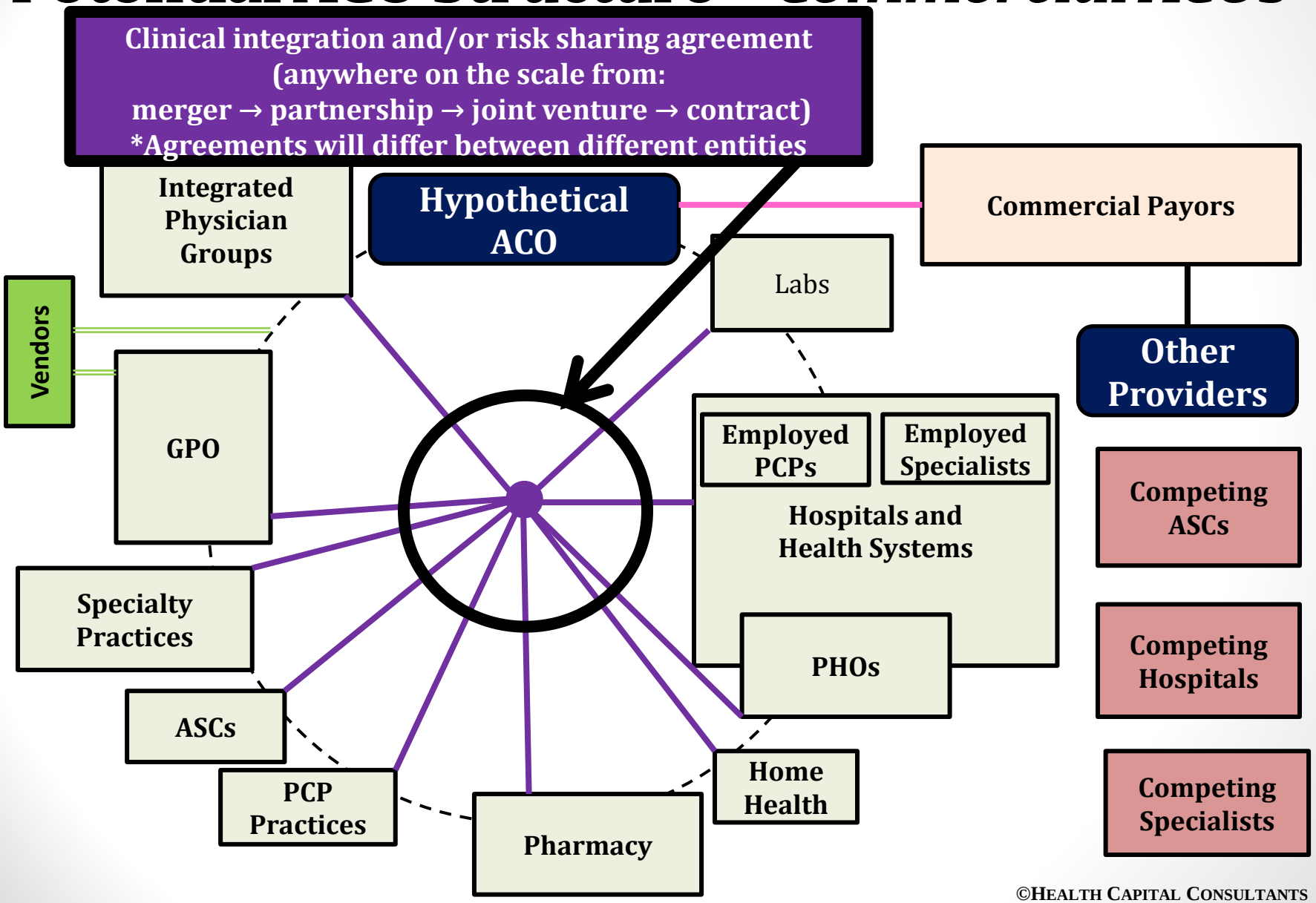
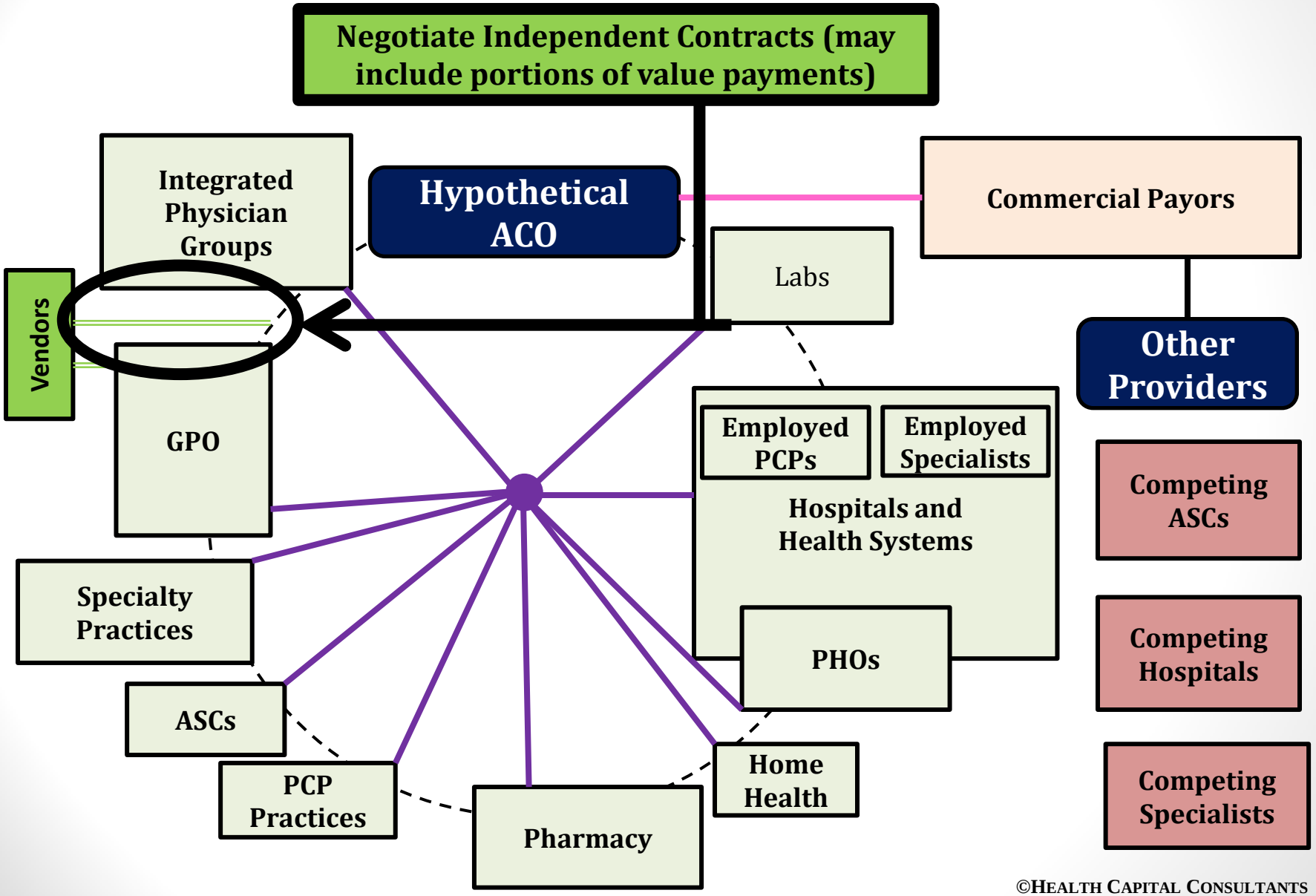


Potential ACO Structure – *Commercial ACOs*



Becoming an ACO

No

Ad Hoc

Decisions

Four Phases of Integration

Phase 1	Phase 2	Phase 3	Phase 4
Feasibility	**Review**	**Consensus**	**Implementation**
• Research healthcare market, economic and demographic conditions, physician manpower, managed care, utilization, etc. • Practice location research • Assessment of local catchment area and environment • Preliminary report / recommendations on market and financial feasibility	• Define mission, organizational structure, and capital structure • Propose organizational and governance structure • Develop revenue and expense projections • Identify the range of services • Develop business plan, budget, staffing, and timetable	• Site visit and additional research as needed • Detailed recommendations of organizational structure, governance, compensation, management and financial systems and controls, accounting and computer systems, HR, payor and vendor relationships, etc. • Assist with decision making	• Assist in coordinating HR and administrative functions • Review/analyze charge master, billing, AR, policies, reports, computer systems • Develop process flow for billing and claims resolution • Assess office space and FF&E • Perform ongoing assistance as needed
OBJECTIVE Report Preliminary Findings/ Make "go/no go" decision	**OBJECTIVE** Report Findings	**OBJECTIVE** Finalize organizational structure and governance issues	**OBJECTIVE** Closing on new practice and Commence Implementation Process
RESOURCE HCC	**RESOURCE** HCC	**RESOURCE** HCC Legal Counsel	**RESOURCE** HCC Legal Counsel

Becoming an ACO

Structures

- Formal legal organization with a governance board
- Coordination and collaboration between physicians, hospitals, and other ACO participants
- Payment model to receive and distribute any shared savings (or losses)

Systems

- Capability for patient population management and care coordination
- Capacity to measure performance, report quality, and invest in system improvements
- Adequate infrastructure and skills to manage financial risk

Leadership

- Ability to perform clinical and administrative functions
- Physician engagement and active participation
- Committed leadership and system of accountability

"AC0 Model Principles," The Accountable Care Organization Learning Network, http://www.acolearningnetwork.org/why-we-exist/aco-model-principles (Accessed 09/16/2011); "ACO Toolkit," The Accountable Care Organization Learning Network ;"How to Create Accountable Care Organizations," Howard D. Miller, Center for Healthcare Quality and Payment Reform, 2009.

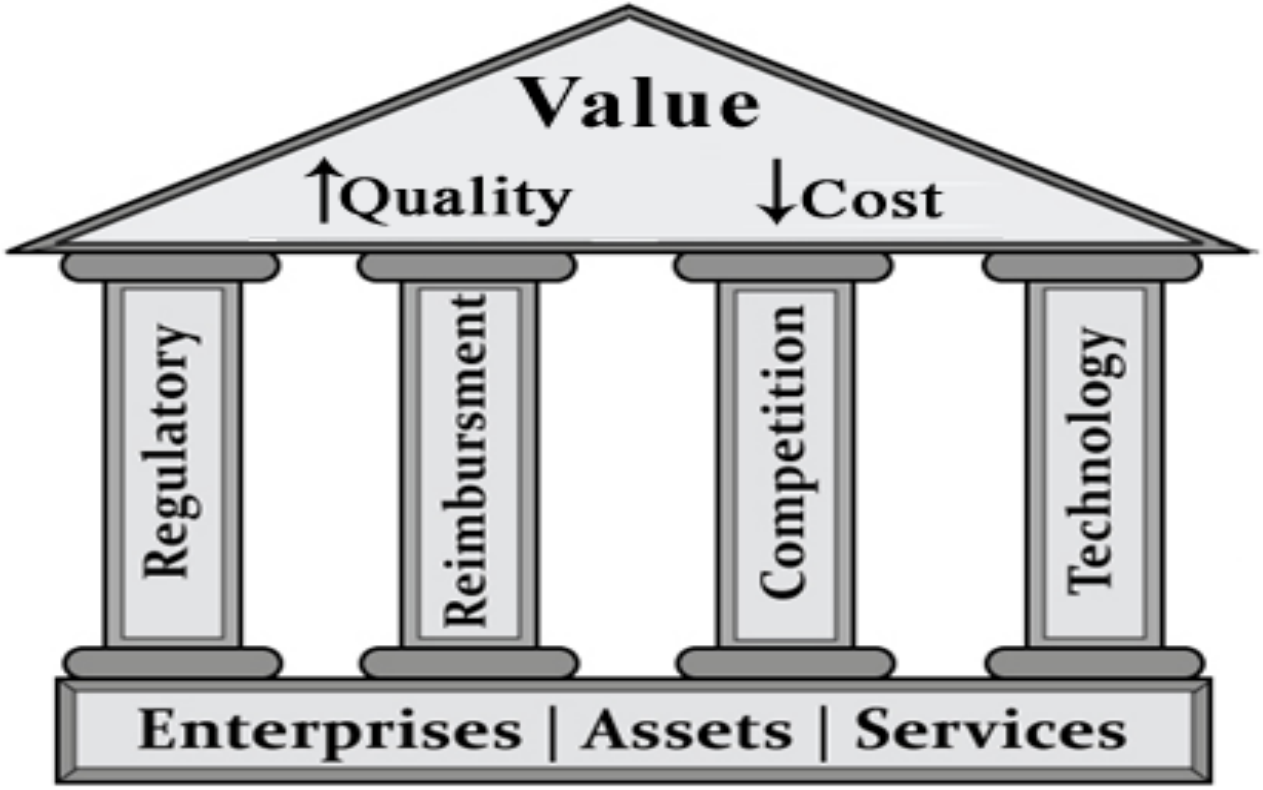
ACO Development and Implementation: Strategic Considerations

Key Strategic Considerations

- Leadership and governance: How should the ACO be governed?
- Engaged provider network : Who should the ACO include?
- Financial and analytical capacity: How should clinical and financial performance be measured?
- IT capabilities: How should IT be integrated and necessary information channels developed?
- Administrative infrastructure: How should the transition be managed?
- Start-up and operational capital: How should the ACO be financed?
- Risk management: How can risks be minimized?

"Essential Guide to Accountable Care Organizations: Challenges, Risks, and Opportunities of the ACO Model," By: John Harris, Laurel Karabatsos, Craig Samitt, William Shea, Steven T. Valentine, The Health Intelligence Network, 2010.

The "*Four Pillars*" of Healthcare
As Applied to ACOs



These four drivers of healthcare serve as a conceptual construct for strategic considerations of ACO development, implementation, and operation. They provide a framework for analyzing the viability, efficiency, and productivity of ACO enterprises, assets, and services.

Regulatory Considerations

- Federal Anti-Kickback Statute (AKS)
- Federal Physician Self-Referral Law (Stark Law)
- Federal Civil Monetary Penalty (CMP)
- Federal Antitrust Law
- Federal Tax Law
- State Regulations
  - Antitrust
  - Fraud and Abuse
  - False Claims
  - Corporate Practice of Medicine
  - Insurance Law

Regulatory Considerations – Federal AKS

Definition

Prohibition against soliciting, receiving, or paying remuneration in exchange for the referral healthcare service billed to Medicare, Medicaid, or any other federal healthcare program

ACO Implication

Current safe harbors to potentially shield ACOs from possible violations

Direct employment

Co-management arrangements

Gainsharing

"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).

Regulatory Considerations – Federal Stark Law

Definition

Prohibition against physician referrals to providers of Designated Health Services with whom the referring physician has a financial relationship

ACO Implication

Compliance with the AKS and Stark may be waived, "as may be necessary," to conduct:

Any payment model for ACOs that the Secretary determines will improve the quality and efficiency of items and services furnished under the Medicare program

The bundled payment/episode of care pilot

"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).

Regulatory Considerations – Federal CMP

Definition

Civil penalties against hospital payments to physicians for

Reducing length of stay

Reducing readmission rates

Other forms of fraud and abuse

ACO Implication

HHS has provided a waiver similar to those given for Stark Law and the AKS.

"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).

Regulatory Considerations – Federal Tax Law

Definition

Integration between providers coordinating care may cause nonprofit, tax exempt providers and for profit, taxable entities, to merge.

ACO Implication

Tax-exempt participants in ACOs should be able to remain that way as long as ACO furthers charitable purposes.

"Accountable Care Organizations: Promise of Better Outcomes at Restrained Costs; Can They Meet Their Challenges?" By C. Frederick Geilfuss and Renate M. Gray, BNA's Health Law Reporter, Vol. 19, no. 956 (July 8, 2010).

"Herding Cats? What Health Care Reform Means for Hospital-Physician Alignment and Clinical Integration," By Daniel H. Melvin and Chris Jedrey, McDermott, Will & Emery (October 13, 2010), p.38.

Regulatory Considerations – Federal Antitrust

Definition

Sherman Act, Section 1 prohibits contracts, combinations and conspiracies that unreasonably restrain trade

- Applies to independent, competing providers
- Does not apply to:
  - Physicians all within the same group
  - A hospital and its full-time, employed physicians
  - A hospital and its controlled subsidiaries

ACO Implication

FTC and DOJ released proposed rules governing mandatory antitrust monitoring, based on the percentage of market share an ACO has for any specific service line.

"Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Saving Program" 76 FR 75 (April 19, 2011), p. 21895.

Regulatory Considerations – Federal Antitrust

No Risk – "Safety Zone"

1. ACO participants provide less than 30 percent of a specific service within a single ACOs PSA
2. No participating hospitals of ASCs work exclusively with a single ACO
3. Dominant Provider Limitation – A dominate provider (offers more than 50 percent of a specific service in a PSA) within the ACO with a non-exclusive relationship, where the ACO does not restrict their payor ability, will not cause an ACO to be removed from the "*safe zone*"

Optional Risk

- ACOs that are outside the safety zone, but are not defined as high risk, may obtain an optional review.
- If they are found in violation of antitrust guidelines, they will be prohibited from entering the MSSP program.

High Risk – Mandatory Review

- ACO has greater than 50 percent share of a specific service within a single provider's PSA (If threshold is met due to a rural facilities, the Rural Exception is triggered and ACO may be in "*safe zone*")
- Must obtain permission to participate in MSSP

"Proposed Statement of Antitrust Enforcement Policy Regarding Accountable Care Organizations Participating in the Medicare Shared Saving Program" 76 FR 75 (April 19, 2011), p. 21895.

Regulatory Considerations – State Laws

- State "*Corporate Practice of Medicine*" (CPOM) laws prohibit the practice of medicine or the employment of physicians by business corporations
- A variety of care models and structures for hospital-physician relationships have been developed to comply with state statutes, which may not fit easily with the structure or goals of an ACO
- CPOM laws could prevent some ACOs from hiring physicians to work directly with provider participants in managing and better coordinating the provision of health services

"AAMC Statement on Legal Issues Related to Accountable Care Organizations (ACOs) and Healthcare Innovation Zones (HIZs)," Association of American Medical Colleges, October 5, 2010, https://www.aamc.org/download/151426/data/aamc_comment_on_legal_issues_related_to_accountable_care_organi.pdf (Accessed 09/14/2011); "Toolkit", Accountable Care Organization Learning Network, The Brookings Institute, 2010,http://www.nachc.com/client/documents/ACOToolkitJanuary20111.pdf#page=6 (Accessed 9/14/2011); "Accountable Care Organizations in California: Programmatic and Legal Considerations" By: William S. Bernstein et al., California HealthCare Foundation, July 2011, http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/A/PDF%20ACOProgrammaticLegalConsiderations.pdf (Accessed 09/14/2011)

Reimbursement Considerations

Large Health Systems May Be in Best Position to Form ACOs

- Attract more PCPs
- Vertical integration will likely aid in transition to ACO
- May easily meet quality requirements
- Greater access to capital and IT requirements

Potential Hurdles

- May need to lower cost or increase private insurers' cost to generate shared savings

"Investors Not Likely to Provide ACO Funding Under Proposed Rule, Venture Capitalist Says" By Sara Hansard, Bureau of National Affairs, Health Law Reporter, Vol. 20, No. 1026, 2011.

"Quality over Quantity" By Bryn Nelson, The Hospitalist (December 2009), www.the-hospitalist.org/details/article/477391/quality_over_quantity.html, (Accessed 2/28/11).

"Will Mayo Clinic save money as an ACO?" By Christopher Snowbeck and Don McCanne, Physicians for a National Health Program (February 8, 2011), www.pnhp.org/print/news/2011/february/will-mayo-clinic-save-money-as-an-aco, (Accessed 2/28/11).

Reimbursement Considerations

Hospitals Have Two Primary Options to Form an ACO

(1) Employ primary care physicians (PCPs), or

(2) Operate as a physician hospital organization (PHO) or independent practice association (IPA)

Fully Integrated Options Are More Likely to Pass Regulatory Inspection

"ACOs Forging the Links" By Ken Terry, Hospitals & Health Networks Magazine, Vol. 85, no. 1 (January 2011), p. 20.

Reimbursement Considerations

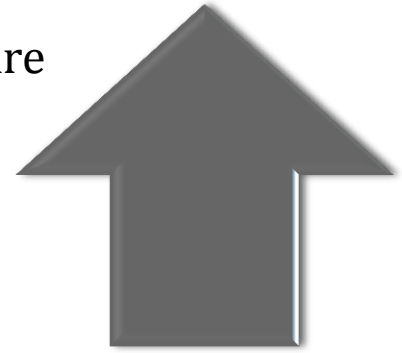
- Reduce operating expenses
- Steady salary and benefits
- Regulatory buffer
- Work-life balance
- Less financial risk

Good for Hospital

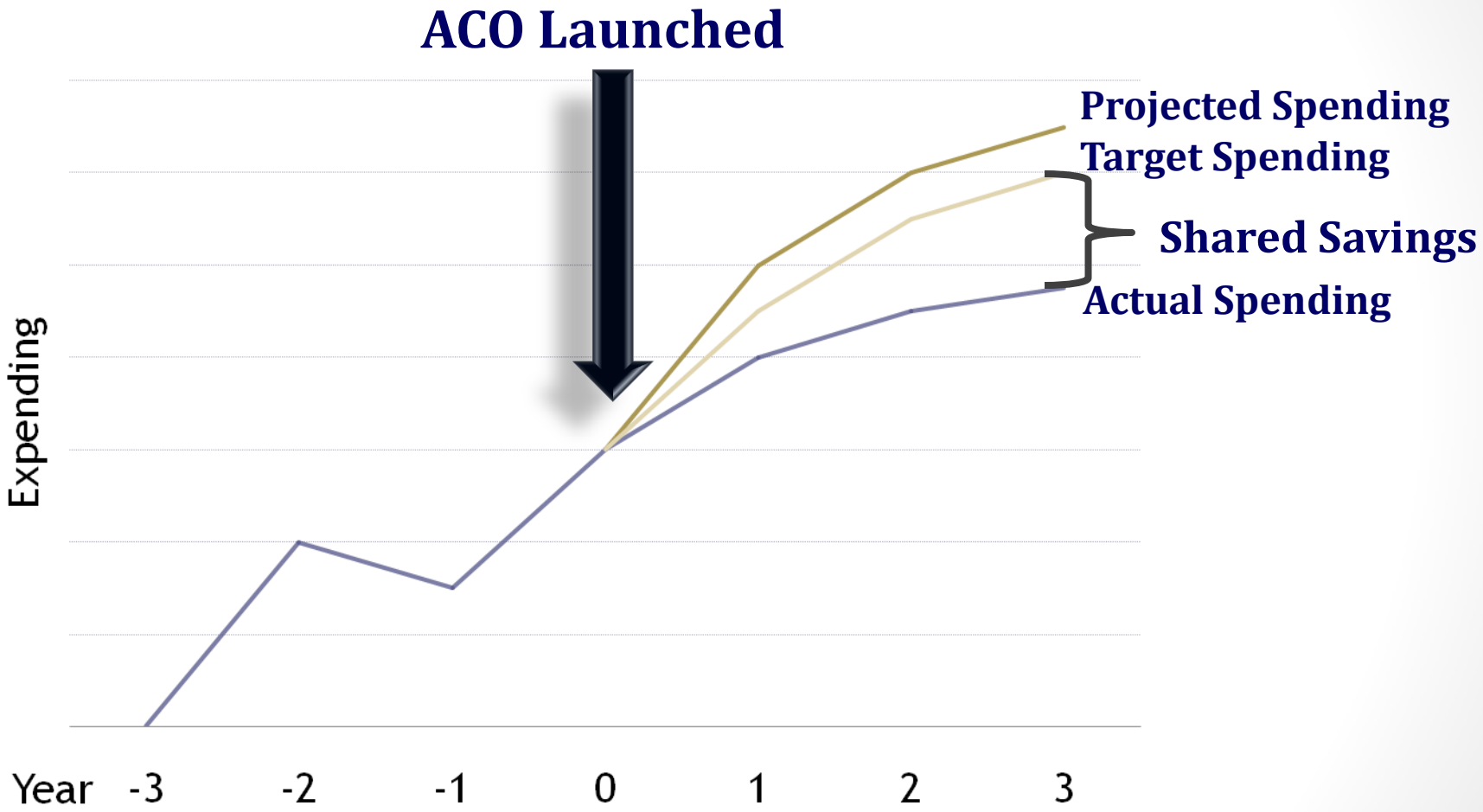
Hospital-Physician Alignment

Good for Physician

- Greater market power / market share
- Clinical integration
- ACO participation
- Quality and cost management



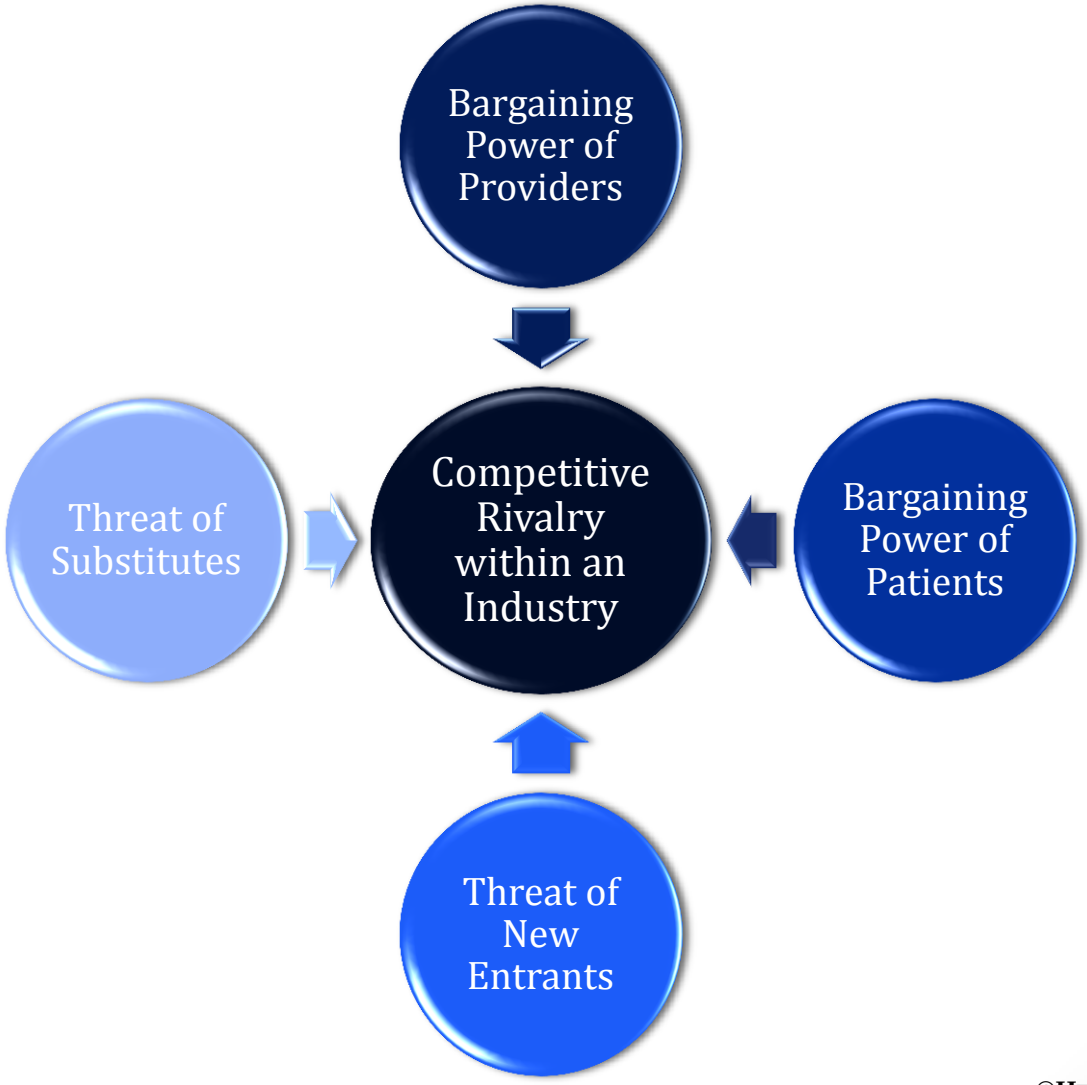
Reimbursement Considerations



Potential Savings Based on Spending Targets

"AC0 Model Principles," The Accountable Care Organization Learning Network, http://www.acolearningnetwork.org/why-we-exist/aco-model-principles (Accessed 09/16/2011); ACO Toolkit, Accountable Care Organization Learning Network ; "How to Create Accountable Care Organizations," Howard D. Miller, Center for Healthcare Quality and Payment Reform, 2009.

Competition Considerations Porter's Five Forces



Technology Considerations

- Electronic Medical Records
  - Significant cost
  - Help eliminate silos and increase continuity of care
  - Meaningful use standards

- The technological impacts on providers choosing to participate in an ACO are rooted in the primary issue of purchasing or updating an EHR system
  - Costly
  - Must meet *meaningful use* standards to be eligible for savings

- EHR integration and alignment among ACO participants is critical to ensure benefits of HIT utilization are obtained

ACO Development and Implementation: Financial Considerations & Capital Planning

Financial Considerations for ACO Development, Implementation, and Operation

- To date, many existing or developing ACOs are hospital driven, generally due to capital, financial, and operational realities
- First year start-up and operation costs for all ACOs are estimated at $132 million to $263 million
- The Government Accountability Office (GAO) reported that in 2008 that the participants in the CMS PGP Demonstration invested $1.7 million to meet the requirements of that program through the first year
- Many believe that these investments will not be recouped under the MSSP

"Managing the Risks of Accountable Care," By Max Reynolds, Healthcare Financial Management Association, http://www.hfma.org/Templates/Print.aspx?id=27518 (Accessed 9/14/11).

Financial Considerations for ACOs

Activity	Prototype A: (200 bed, 1-hospital system, 80 PCPs, 150 specialists)		Prototype B: (1,200 bed, 5-hospital system, 250 PCPs, 500 specialists)	
	Start Up Costs	Ongoing (Annual) Costs	Start Up Costs	Ongoing (Annual) Costs
Group I. Network Development and Management				
1. Providing ACO management and staff	$550,000	$1,450,000	$600,000	$3,200,000
2. Leveraging the health system management resources	$250,000	$200,000	$300,000	$250,000
3. Engaging legal and consulting support	$350,000	$125,000	$500,000	$125,000
4. Developing financial and management information support systems	$500,000	$80,000	$500,000	$160,000
5. Recruiting/acquiring primary care professionals, right-sizing practices	$400,000	$800,000	$800,000	$1,600,000
6. Developing and managing relationships with specialists	*	*	*	*
7. Developing and managing an effective post-acute care network	*	*	*	*
8. Developing contracting capabilities	$150,000	$150,000	$150,000	$150,000
9. Compensating physician leaders	$75,000	$75,000	$190,000	$190,000
Group II. Care Coordination, Quality Improvement and Utilization Management				
10. Disease registries	$75,000	$10,000	$150,000	$20,000
11. Care coordination and discharge follow-up	$150,000	$1,000,000	$300,000	$3,000,000
12. Specialty-specific disease management	-	$150,000		$300,000
13. Hospitalists	$80,000	$160,000	$160,000	$320,000
14. Integration of inpatient and ambulatory approaches in service lines	*	*	*	*
15. Patient education and support	-	$100,000	-	$100,000
16. Medication management	-	$100,000	-	$100,000
17. Achieving designation as a patient-centered medical home	$100,000	$15,000	$150,000	$25,000
Group III. Clinical Information Systems				
18. Electronic health record (EHR)	$2,000,000	$1,200,000	$7,050,000	$3,500,000
19. Intra-system EHR interoperability (hospitals, medical practices, other)	$200,000	$200,000	$400,000	$200,000
20. Linking to a health information exchange (HIE)	$150,000	$100,000	$200,000	$200,000
Group IV. Data Analytics				
21. Analysis of care patterns	$210,000	$210,000	$450,000	$450,000
22. Quality reporting costs	$75,000	$75,000	$100,000	$100,000
23. Other activities and costs	-	$100,000	-	$100,000
TOTAL	**$5,315,000**	**$6,300,000**	**$12,000,000**	**$14,090,000**

**Costs are primarily management and staff and are included in previous elements (1, 2, and 3).*

"The Work Ahead: Activities and Costs to Develop an Accountable Care Organization," American Hospital Association, April 2011.

Financial Considerations
AHA Report

Prototype A

200 bed, 1-hospital system, 80 PCPs, 150 specialist

- Total Start-Up Cost: $5,315,000
- Total Annual Costs: $6,300,000

Prototype B

1,200 bed, 5-hospital system, 250 PCPs, 500 Specialists

- Total Start-up Costs: $12,000,000
- Total Annual Costs: $14,090,000

"The Work Ahead: Activities and Costs to Develop an Accountable Care Organization," American Hospital Association, April 2011.

Financial Considerations PGP Demonstration

Note: these cost are low estimates considering that the provider systems in the demonstration project had already absorbed other integration costs before the project got under way

Average up-front payment was $489,000, plus $1.26 million in operating costs for first year

None of the 10 participants received any shared savings from Medicare in the first year

Therefore, healthcare executives should anticipate losses prior to gains in the implementation of the ACO model

"ACO Bound? Consider the Financials First," By David Lips, Health Leaders Media, December 30, 2010.

Cost for Providers Capital Requirements

Estimates Based on Risk-Based Capital Model

ACO Payment Method	Expected Costs Levels	Other Assumed Capital	2 / Company Action Level RBC
100% of ACO services are paid FFS	90% of benchmark	None	$27 million
100% of ACO services are sub-capitated	95% of benchmark	None	$11 million

Required capital is lower if all ACO services are capitated because the capitated providers are assuming the risk

"The Two Medicare ACO Programs: Medicare Shared Savings and Pioneer – Risk Actuarial Differences" Milliman, Inc, July 8, 2011

Cost for Patients
Value Metrics for Accountable Care

Value to Society

Better outcomes for individuals and populations accompanied by lower growth in expenditures

Quality of care can be measured through patient outcomes metrics (i.e., average length of stay; number of readmissions; and, patient satisfaction surveys)

Value to Providers

Shared Savings Payments; Better Medicare Reimbursement; Greater Market Power

Measured through provider expectations regarding financial returns; practice value; lower practice expenditures (achieved through administrative efficiency, coordinating patient care, and better patient outcomes)

"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), pg. 19531; "Investors Not Likely to Provide ACO Funding Under Proposed Rule, Venture Capitalist Says" By Sara Hansard, Bureau of National Affairs, Health Law Reporter, Vol. 20, No. 1026, 2011.

Providers versus Patients Costs

Provider Positives	Patient Positives
• Possible lower practice costs from increased efficiency • Greater market (negotiating) power • Possible shared savings payments	• Better quality care • More convenient care • Possibly fewer physician visits
Provider Negatives	**Patient Negatives**
• Lower patient volumes equals lower FFS payments • High IT costs • High capital costs	• Greater power of providers tends to lead to larger costs for patients • Confusing beneficiary assignment

An ACO's value, either to society or to providers, must be weighed against the prospective costs

"Rising Healthcare costs may be Impervious to Courts, Regulators" By Philip Betbeze, HealthLeaders Media, July 1, 2011, http://www.healthleadersmedia.com/print/LED-268129/Rising-Healthcare-Costs-May-be-Impervious-to-Courts-Regulators (Accessed 7/1/2011).

CONCLUDING REMARKS

Concluding Remarks

- With the MSSP receiving poor support due to ***theoretical*** savings, yet very ***real*** costs, providers looking to transition to an ACO have been doing so through the commercial market

- To succeed, ACOs will need what managed care lacked: public understanding, payor support, partnerships between physicians and hospitals, up-front financial resources, and time for integration

- Transitioning to an ACO will be financially feasible if:
  - The ACO creates system-wide cost savings
  - The ACO improves patient population quality of care
  - The ACO creates sufficient return on the substantial investment required

ACOs will demand a level of coordination never before expected of healthcare providers