ACCOUNTABLE CARE ORGANIZATIONS:

The shift from volume to value

Accountable care organizations (ACOs) are an example of new reimbursement models that replace the fee-for-service model with a so-called patient-centric model that emphasizes service value rather than service volume.

ACOs were first introduced with the Affordable Care Act as a means to improve care quality and reduce the costs of Medicare. A voluntary ACO program began in early 2012 that allowed providers and suppliers to coordinate care for their Medicare population. ACOs received upfront lump sums and modest monthly payments from the federal government for each Medicare beneficiary. ACOs that managed to lower growth in Medicare costs, while meeting certain standards of care and patient outcomes, then shared in the accrued Medicare cost savings. Minnesota-based providers Essentia, HealthPartners, Fairview and Allina Health Systems all have ACOs.

According to the Centers for Medicare and Medicaid Services (CMS), 103 ACOs held Medicare spending $926 million below their targets in 2014, earning performance payments of more than $423 million; the balance represents net savings to the Medicare trust fund.

Call it a good start, with a long way to go. Only 30 percent of all participating ACOs earned any cash bonus, according to CMS. While net savings to Medicare were $500 million, total Medicare spending in 2014 was more than $500 *billion.*

Within the health care industry, there is considerable disagreement over the staying power of ACOs and other similar value-based care models. A 2014 survey by the Physicians Foundation found "dubious acceptance" among physicians of the shift from volume to value. A Deloitte survey last year found that physicians anticipate value-based payment models equaling about half of their total compensation a decade from now, but "they are reluctant to participate, preferring the status quo, and are concerned about the consequences of financial risk."

Jerry Jurena, president of the North Dakota Hospital Association, has seen previous initiatives promising to finally get a handle on rising costs, like health maintenance organizations of the 1990s. "Is this another fad or process in how we pay for health care? I don't know," he said. "I'm for trying things, but I'm skeptical it will work."

Mike Foley, administrator and chief operating officer of the Apple Valley (Minn.) Medical Center, said the jury was still out on ACOs. "I don't think anyone has figured out how to work that yet" on a sustainable basis, he said. Many providers are involved in ACOs, "but I haven't heard anyone saying, 'Eureka, we've figured it out.'"

Others said that Medicare's involvement was a game changer. "There's no question that's what all systems are preparing for," said Terry Hill, senior adviser for the National Rural Health Resource Center, located in Duluth, Minn. "It's a done deal; everybody knows it."

Mary Brainerd, president and CEO of HealthPartners, said a lot of vertical integration is occurring under the belief that "Medicare is looking for something different ... and that powerful message is driving behavior."

Kelby Krabbenhoft, president and CEO of Sanford Health, agreed. "When Medicare will give X number of dollars to take care of a population and the risk is yours ... when that happens, the debate [about ACOs] is over. It's such a big payer."

—Ronald A. Wirtz

GRAB BAG 4
OF CONSOLIDATION DRIVERS

Federal sequestration

When Congress gets a cold, doctors and hospitals sneeze.

The Budget Control Act of 2011 created automatic budget cuts in future federal spending, dubbed sequestration. Included was a 2 percent cut in Medicare reimbursement from 2013 through 2022, and later extended through 2024.
In September, the American Hospital Association estimated that sequestration had cost hospitals $58 billion in lost reimbursements.

Compounding the matter: Because sequestration cuts are considered temporary, recommendations for annual Medicare reimbursement rate changes do not take sequestration effects into account.

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Michael Topchik, senior vice president at iVantage, a health care analytics firm.

Upgrading such facilities often becomes prohibitively expensive, given razor thin operating margins common in the industry. Many hospitals "have been happy to get by on 1 to 2 percent" net income margins, said Krabbenhoft, but that's why they have outdated facilities and equipment. The industry target now is 4 to 5 percent, Krabbenhoft said, because "no matter how hard you try, you can't get by on 1 to 2 percent margins."

In 2013, 27 percent of Minnesota hospitals had bottom-line margins of 2 percent or less, according to financial data from the Health Economics Program with the state Health Department. Another 9 percent of hospitals cleared that bar only because of other income from nonhospital operations.

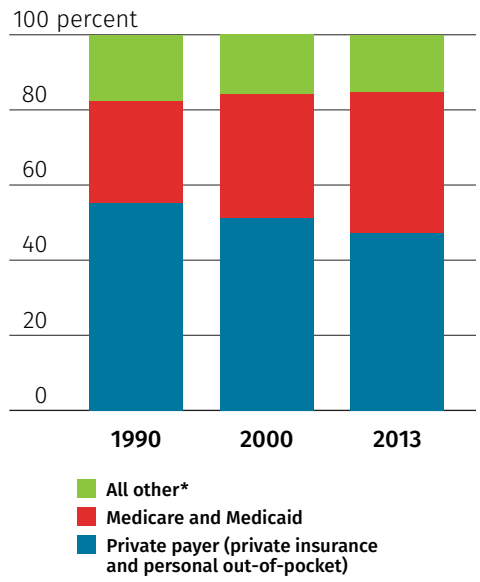
But modernizing outdated facilities is just one of the many capital mouths to feed at every health care organization—small or large, rural or urban. New technology, for example, promises increased consumer demand but comes at a steep price. "It's not that they just need a new emergency room or a new roof," said Krabbenhoft. "Now they need technology for care, and it's so, so expensive."

Cardiac ultrasound scanning systems cost an average of $158,000 in June, almost 12 percent more than a year earlier, according to the ECRI Institute, a nonprofit medical research and technology assessment organization that tracks equipment purchasing and pricing. But that's a pittance compared with the price of other big-ticket items like MRI machines ($1.5 million) or PET/CT scanners ($1.9 million). Average prices for the 10 most popular capital items rose by 7 percent in June compared with a year earlier, according to ECRI.

Still, even these costs can pale compared with those associated with federal mandates for electronic health records (EHR), systems that keep track of medical histories and provide access for any authorized user, including patients.

To insure "interoperability" among providers, EHR requires entirely new information technology systems, and

Share of national health care expenditures 6



*Includes Children's Health Insurance Program, Department of Defense, and Department of Veterans Affairs, as well as other private and public health care expenditures, including workers' compensation, Indian Health Service, vocational rehabilitation and school health

Source: Centers for Medicare & Medicaid Services

GRAB BAG 5
OF CONSOLIDATION DRIVERS

The continued shift away from inpatient visits

Hospitals nationwide are facing a long-term trend of stagnant or lower volumes of acute care admissions—historically the bread and butter of hospital revenue. This creates incentives to look for—and acquire—other growing care services. In Minnesota, inpatient admissions at the state's hospitals were down 4 percent from 2010 to 2013, according to the Minnesota Department of Health. Certain facilities are feeling a much greater pinch. At the state's 78 critical access hospitals, acute care admissions and total patient days were both down more than 12 percent over the same period.