Health Reform

Rurals at a Crossroads

ACOs are pushing hospitals to re-examine their plans for the future

By Susan Stowell and James Puiia

While reform legislation includes many provisions designed to benefit small and rural hospitals, the law also challenges these institutions to evaluate their operational strengths and weaknesses and even reconsider their independence.

Accountable care organizations aim to improve outcomes and reduce inefficiencies and expenses. For rural organizations to play a meaningful role in ACOs, they will need to assess their performance on several levels. Then, they can determine whether they should drive the creation of an ACO, participate in one that already has formed, or focus on shoring up operations to be an attractive partner in the future.

The hallmark of leadership is the ability to chart a steady course through uncertain territory. This article offers leaders of rural hospitals concrete ways to assess opportunities and to develop strategies that will enable their hospitals to remain relevant during and following the redesign of the health care delivery system.

Expanded Accountability

An ACO is made up of providers who are held jointly accountable for achieving measurable quality improvements and reductions in the rate of spending for the care delivered to a defined subset of program beneficiaries or other populations. It is liable for the quality, cost and patient experience of all care delivered across the continuum from acute episodes in the hospital to physician office visits to chronic disease management and home care.

To payers, an ACO is accountable for achieving specific spending targets and clinical outcome improvements. When it meets or exceeds these targets, an ACO is rewarded with a share of the overall savings. In some arrangements proposed by private payers, there might be penalties for failing to meet targets.

Reform legislation requires that hospitals and physicians forming an ACO have a formal, legal structure to receive and distribute shared-savings payments. These organizations must commit to the program for at least three years once it has been initiated. Leaders of these new structures will need to include both clinical and administrative personnel.

Risk and Reimbursement

To keep costs in check, an ACO will need to determine how participating providers will be reimbursed for the services they provide to members. However, the ACO's method of reimbursement may put the hospital at financial risk for the services it provides to members. Hospitals may be reimbursed on a per-case basis, such as the current diagnosis related group methodology employed by Medicare, or they may be paid for an entire episode of care, putting the hospital at additional risk for pre- and posthospitalization care and for any readmissions related to the original admission.

Critical access hospitals, which currently enjoy the benefit of cost-based reimbursement, will be particularly challenged to operate within an ACO. The per-case or per-episode reimbursement methodologies will require

CAH management to shift focus from maximizing reimbursement under a cost-based system to managing care, efficiency and cost on a patient-by-patient basis. This is a significant shift for leaders and likely will require new skill sets in the C-suite.

Keep an Eye on the Market

ACOs will be responsible for managing the overall health of the populations they serve, and they must have a minimum of 5,000 Medicare beneficiaries to qualify. To control population health and the associated risk, ACOs will need a patient base that is large enough to make population health cost-effective and to minimize financial risk. As such, they will actively reach out to grow their patient populations.

As ACOs attempt to expand their patient base, patients of rural hospitals, including CAHs, may be targets. Rural and community hospitals should investigate the initiatives under way at area competitors and track inroads into their community. They can't afford to assume that their patient base always will be there.

Because CAHs and other small, rural hospitals generally do not have the population needed to support many of the necessary elements of an ACO, they must develop an effective, forward-looking strategy that includes a hard look at market opportunities. These hospitals will need to be open to the possibility of partnering with other organizations, either through an affiliation or an acquisition, to be effective participants in ACOs.

'Make vs. Buy'

A critical step for rural health systems and physicians is determining the most effective way to gain the skills and capabilities needed to become an ACO. In many instances, this decision will come down to a "make vs. buy" judgment.

Making or developing an ACO is an option for health care organizations that already have many of its components. Mature integrated health systems, like Geisinger Health System and Kaiser Permanente, are well-positioned to become ACOs due to their networks of physicians, hospitals and internal insurance functions. Other organizations may be lacking key components, but have sufficient capital available to develop those essential pieces.

In a region served by several community hospitals, these organizations and their physicians can pool their resources to form an ACO. However, this is more difficult than having a single organization drive the ACO development.

Buying the missing components is an alternative method of achieving ACO status. Hospitals or physicians can purchase the functions from other organizations or partner with other institutions that can provide them. For example, hospitals can align or employ additional physician groups to increase the ACO's population base, lease the risk-management component from an insurance company, or purchase home health capabilities.

Self-Assessment for Rural and Critical Access Hospitals

	A PHYSICIAN ALIGNMENT	B QUALITY	C COST	D FINANCIAL POSITION	E IT PLATFORM
1	Little alignment or integration; medical staff comprises small, independent physician groups	Below state average on 95 percent of core measures	High cost per unit of service	Not able to fund current depreciation expense	No inpatient or outpatient EMR
2	Employment out of necessity; state of relationship with independent physicians is varied	Meet state average on 50 percent of core measures	Moderate cost per unit of service	Funding depreciation but operating at a loss	Inpatient EMR
3	Mix of employed and independent physicians; fragmented approach to physician alignment	Meet state average on 75 percent of core measures	At the median cost per unit of service across the region	Breaking even from operations	Inpatient EMR; private physician practices have pursued their own EMR
4	Mix of employed and independent physicians; development of strategy and consolidating body for alignment between hospitals and physicians	Meet state average on 90 percent of core measures	Respectable cost position in market	Positive operating margin of 0 to 4 percent	Inpatient EMR; systemwide IT strategy development has been started; some physician practices have integrated system
5	Full integration with physicians; have alignment organizations with physicians	Meet or exceed state and national average on 95 percent of core measures	Lowest cost provider in region	Greater than 4 percent operating margin	Systemwide IT implemented and adopted by all users

Source: Stroudwater Associates, 2011

Alternative Strategies

Understanding the size, demographics and utilization patterns of the market will clarify a hospital's options. In many cases, rural hospital leaders realize that their institutions must form a relationship with one or more organizations to achieve broader goals. Even if a hospital can't drive an ACO, it still can have a strong role in its development and ongoing operations. That role depends on a hospital's strength in areas that bring value to the ACO: integration with physicians, cost and quality positions, financial health and the extent to which it has implemented a systemwide IT platform.

Rural administrators and trustees should assess their organization's performance in the following areas to shape their strategy (see Self-Assessment for Rural and Critical Access Hospitals, page 22):

- **Physician alignment:** Cultural, strategic and financial alignment of providers is imperative to efforts to improve the quality and lower the cost of care.
- **Quality:** The hospital must meet or exceed quality-of-care benchmarks.
- **Cost:** The hospital must maintain or achieve a position of low cost per unit of service provided.
- **Financial position:** The hospital will need to maintain or achieve a healthy financial position to support physician alignment and IT implementation.
- **IT:** A fully integrated and operational IT platform will enable coordination of care and examination of quality and cost performance.

Operating in an ACO environment will require rural hospitals to embrace, develop and implement strategies and processes that improve the delivery of care to their patients and to the community while reducing costs. Hospital leaders will need to balance their fiduciary responsibilities and their desire to maintain local control with the realities of their market position.

While these decisions will carry risk, hospital leaders can optimize their positions at the bargaining table and get the most out of their new relationships by first understanding what they need and what they have to offer an ACO. T

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Where Do We Go From Here?

Rural hospitals are approaching accountable care organizations from a variety of market and financial positions. Here are four common scenarios and appropriate responses.

1 *A hospital is struggling with physician alignment, quality, cost per unit of service, financial stability and adopting information technology.*
Response: Focus on the basics. With limited capital available, the hospital will need to launch performance improvement initiatives, begin discussions with physicians around clinical integration and examine opportunities to drive cost out of the services provided. The hospital needs to focus on the basics to make itself an attractive ACO partner.

2 *A hospital has spent the last few years focused on implementing IT, strengthening relationships with physicians through employment or contracts, and building cash reserves. However, performance on quality metrics has lagged and costs are increasing.*
Response: Build on investments. Now is the time to use the investments in IT and physicians to drive quality discussions and become a low-cost provider. The hospital should look for ACO partners that will value the investments and whose strength is in providing low-cost, quality care. This organization will want to take advantage of an ACO's focus on cost and quality.

3 *A hospital has focused on improving quality and driving inefficiencies out of the system through the use of protocols and clinical guidelines, but its financial position has weakened and the physician strategy is fragmented.*
Response: Promote value. While the organization has been successful at engaging a subset of hospital-based physicians around care processes, the relationships with outpatient physicians are poor. There is no integrated inpatient and outpatient IT platform in the community and the financial position is weak. In discussions with potential partners, this hospital will want to promote its cost and quality position and look to its partners for assistance in improving relationships with physicians, adopting IT and accessing capital.

4 *A hospital has performed exceedingly well in the past few years. It has a positive working relationship with its physicians, and together they have been able to implement protocols, improve core-measures scores, reduce the cost of the services provided, and implement a systemwide IT platform. The result of these initiatives is a strong operating margin and excess days cash on hand.*
Response: Choose partners. From this position of strength, this organization can investigate multiple partnering options and select the option that affords it the most influence.—*S.S. and J.P.*

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