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E-Briefings

Strategic Benefits of ACOs: Assessing Essential Elements that Determine True Value

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The Affordable Care Act (ACA) has not only transformed the way healthcare coverage is purchased, but also how healthcare is delivered. Introduced into Medicare as part of the ACA, Accountable Care Organizations (ACOs) or, in the non-Medicare area, clinically integrated networks (CIN), are a vehicle by which health systems, hospitals, and providers accept shared responsibility for the quality, cost, and experience of an attributed population in an integrated manner across the continuum. CMS has tested multiple ACO models over 10 years, which is leading many to evaluate and quantify their efficacy. However, often these analyses exclude the benefits of ACOs outside of savings to Medicare. For hospitals and health systems, an ACO is a key strategic necessity, particularly with the fiscal pressures on the Medicare Trust Fund catalyzing CMS to move towards finding participants of any willing taker in the fee-for-service (FFS) alternative payment models (such as ACOs) to accept two-sided risk.

Common Goals, Aligned Incentives, Support Independent Clinicians

ACOs/CINs are an excellent way to formally organize both employed and independent providers around the common goal of providing integrated, cost-effective, and high-quality care. This type of integration and alignment of incentives between employed and independent providers can allow traditional competitors to work together to improve the care they provide to their beneficiaries. Health systems, especially those that do not employ large numbers of providers, who delay in implementing or participating in an ACO-like structure put themselves at risk of being able to formally integrate with their independent providers.

Medicare ACO Experience Can Translate to Commercial Value-Based Payment Arrangements

One of the strongest correlations to success in Medicare ACO models is time in these types of programs. Participation in Medicare ACO models provides for the opportunity to learn how to deliver care in an integrated fashion. The lessons learned and resources developed

Key Board Takeaways

Participation in an ACO has strategic benefits for health systems beyond financial results. Governing boards should consider questions such as the following:

- If we are not currently participating in a Medicare ACO model, do any of these strategic benefits impact the participation decision?
- If we are currently participating in a Medicare ACO model, how has our participation impacted our market position relative to competitors' efforts among the Medicare patient population?
- How can we promote greater alignment and integration among employed and independent providers, as well as with our health system?
- What additional tools, technology, and decision support capabilities should be considered to further reduce total costs of care, and improve quality and patient experience?
- Should our health system/hospital consider becoming more aggressive regarding Medicare Advantage contracts?

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from participation in Medicare ACO models can then be leveraged in other value-based agreements to improve performance across a contract portfolio. There are many opportunities across payers to contract using an integrated ACO/CIN model, including: Medicare FFS, Medicare Advantage, Medicaid, commercial, and direct-to-employers. Over the past five years, there has been an increasing trend of these types of payers contracting with integrated networks rather than individual hospitals or practices for risk-based models. The transformation from volume-based to value-based care is one that takes time and commitment. Many organizations across the country have leveraged this "halo effect" of Medicare ACO model participation into success in value-based care and payment agreements with other payers.

Benefits beyond Shared Savings: Stark, Anti-Kickback, and Civil Monetary Penalty (CMP) Waivers

The currently available Medicare models for network (ACO/CIN) entities provide several benefits to participation outside of just the potential to share in savings. One of those key benefits is access to various legal and payment waivers that simplify the process of providing integrated care across the care continuum. Access to these fraud and abuse rule waivers, specifically the Stark, Anti-Kickback, and CMP waivers that are available in all Medicare ACO models, remove the impediments in place under traditional FFS rule to value-based care. While reforms to the Stark, Anti-Kickback, and CMP regulations have been proposed, they have not been finalized as of this article. Today, Medicare ACOs are deemed to be clinically integrated and the participants have access to flexibilities that uniquely position greater opportunities for innovation to deliver integrated care over non-ACO participants.

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Market Share Growth and Reputation

Not only are there benefits for the healthcare professional/provider participants of Medicare ACO models, but also for beneficiaries. When participants can deliver care in a truly integrated manner it allows for better management of beneficiaries which leads to higher quality care. Medicare ACOs encourage cross continuum communication which has shown to greatly improve patient satisfaction. Additionally, ACOs who utilize care managers have seen increased patient satisfaction due to their hands-on support with management of chronic conditions, navigation of the ACO's various sites of care, and identification/closure of gaps in care. This increase in patient satisfaction results in enhancing the reputation of the organization.

Participation in the Medicare ACO programs provides the ACO with access to robust Medicare claims data for their assigned population. ACOs can leverage this data to support other value-based models from CMS, like the Hospital Value-Based Purchasing Program or the Hospital Readmissions Reduction Program. Moreover, this data provides great insights into utilization patterns and can be an input to identify growth opportunities, as well as to better understand out-of-network utilization patterns. Access to claims data can support market share growth.

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Competitor Threats to Revenue and Market Position

One of the primary strategic benefits that leads to model participation is the threat from competitors. These threats can manifest themselves in a variety of ways, from for-profit/venture fund-backed physician aggregators, to insurance companies and other risk-bearing entities, to other local health systems using population health as a method to expand market share. Due to the participation rules for the current Medicare ACO models, practices can

only participate in one Medicare ACO at a time. This allows health systems and physician groups to utilize the creation of their ACO as both an offensive and/or a defensive tactic relative to the competition. Maintaining alignment with both employed and independent providers allows ACOs to mitigate potential financial impacts from direct market competition and provider aggregation such as loss of patient revenue and out-of-network referrals.

Pursuing the Triple Aim

The driving principle behind the Medicare ACO models has been the Triple Aim: lowering total cost of care, improving the health of populations, and improving the patient experience of care. The first item is often challenging for hospitals considering participation in Medicare ACO models whose primary source of revenue is based on fee-for-service contracts. However, if hospitals and health systems are slow to build their own ACOs they may be at risk of being directly impacted by the total cost of care reduction efforts of their outside competitors, without having the ability to control the pacing of this demand destruction. If this occurs the hospital/health system cedes control of the rate and severity in the reduction of utilization, essentially becoming a commodity to the ACO. This can lead to significant drops in inpatient revenue without the opportunity to share in any of the savings achieved to Medicare by the outside ACO.

Do Strategic Benefits Equal (or Out-weigh) Financial Outcomes?

Since the inception of the first Medicare ACO program there have been financial benefits available to model participants, such as the ability to earn shared savings. In addition to financial benefits, participation in Medicare ACOs allows for protection from outside competition and commoditization of the hospital, access to waivers to simplify the delivery of integrated care, insights from the access to the Medicare Part A, B, and D claims data, the ability to develop population health capabilities to leverage in other value-based payment programs, and the communication channels to improve beneficiary's care experience and management. In today's rapidly changing landscape, these strategic benefits of Medicare ACO participation are becoming just as important as the financial ones.

The Governance Institute thanks Richard Doane, M.H.A, Director, Seth Edwards, M.H.A., Vice President, Bryan Smith, M.H.A., Principal, and Guy M. Masters, M.P.A., Principal at Premier Inc. and Governance Institute Advisor, for contributing this article. They provide analytics and strategic advisory on ACOs, CINs, and value-based payment models, as well as keynote presentations on trends and governance issues at board retreats and conferences nationwide. They can be reached at Richard_Doane@premierinc.com, Seth_Edwards@premierinc.com, Bryan_Smith@premierinc.com, and Guy_Masters@premierinc.com.