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ACO Value Metrics Series Part IV: Evaluating the Monetary and Non-Monetary Value of ACO Formation

The four-part *HC Topics Series: ACO Value Metrics* will consider the value metrics and capital formation costs associated with establishing and operating *accountable care organizations (ACOs)*. The first installment provided the background of the value metrics used to assess these emerging healthcare entities, and Part II discussed the cost-benefit analysis that must be conducted in considering ACO formation. Part III addressed the financial feasibility of potential ACOs, and Part IV considers the monetary and non-monetary value metrics that should also be evaluated. This *HC Topics Series* is excerpted from the book authored by HCC CEO Bob Cimasi, entitled, "*Accountable Care Organizations: Value Metrics and Capital Formation*," to be published by Taylor and Francis Group early next year.

Notwithstanding the uncertainty regarding their ultimate feasibility, there has been consistent support for the position that the ACO *concept* has value. Outside of the potential *financial return to investors* from ACO development, an ACO is also likely to have *non-direct investment-related* beneficial effects for third parties. These *external benefits*, also known as *positive externalities*, are generated when a third party has a *legitimate interest in a particular outcome*, and may accrue to any number of individuals or groups, e.g., providers; payors; and, society in general.[1] Whether operating under a *Federal ACO* or a *Commercial ACO* contract, an ACO's overall achievement of specific outcomes, once tracked and reported, may provide evidence of the creation of *value* (i.e., future economic benefit within the U.S. healthcare delivery system) in the form of *improved outcomes per dollar spent*.

VALUE TO PROVIDERS

ACO entities receive monetary value from ACO development in the form of returns on an ACO investment that result from *shared savings payments* or *improved efficiencies*. ACOs may opt to disburse *shared savings* in *excess of capital needs* to ACO providers in the form of *financial bonuses*, thereby also *disbursing the monetary value* of these achieved savings. ACOs that achieve *shared savings*, either in the Federal or Commercial market, will also likely experience greater *financial returns* from the increased efficiency of their practice, in the form of: lower administrative costs; more efficient physician time-management; and, fewer billing mistakes.[2] Providers may also experience enhanced *utility* in the form of access to a larger market share, since ACO development is often associated with mergers, joint-ventures, and other methods of market consolidation. Additionally, as physicians and hospitals in a community join together under the umbrella of an ACO, patient referrals will likely stay within that *collaboration of caregivers*.[3]

Non-monetary value for ACO participants is largely characterized by those benefits which may arise from a hospital-physician relationship, as well as the level of physician participation in governance and increased access to the expanded provider and patient network created by the ACO model. From a physician perspective, hospital employment may provide *value* through *decreased financial risk* and a more *desirable work-life balance*.[4] Whereas in the past, providers generally valued profits over personal time, today's providers are typically prioritizing a more flexible work-life balance. In addition to work-life balance improvements, ACOs may facilitate greater practice *efficiencies* by providing access to advanced levels of technology that allow physicians to access information on outcomes, which may serve as benchmarks and improve the ability of physicians to evaluate their services in greater depth than previous paper and pencil processes. These improvements in the ability to gather data for *evidence-based medicine* may also lead to the development of better *best practices*, based on the strengths and weaknesses that become apparent from comparative outcomes analyses.

In contrast to past managed care models, where physicians traditionally relinquished practice autonomy in exchange for the benefits of hospital employment, ACOs may allow physicians to maintain a greater degree of autonomy.[5] The typical ACO depends on the *independent decision-making* of providers by allowing physicians to direct care for their patients and encouraging all participants to contribute to ACO management.[6]

Buy-in to ACO governance principles for every participating physician provider may significantly influence the potential *value* offered by ACO development. However, even those physician providers who are not directly involved in governance may benefit from the expanded and closely-integrated network of providers created through ACO development.

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VALUE TO PAYORS

Payor interest in ACO development will likely be primarily monetary, focusing on the value of increased profits from shared savings and lower reimbursement expenditures. Ultimately, as ACOs *gain efficiency* and their benchmarks for anticipated patient expenditures are reduced, it is expected that payors may be able to lower their reimbursement payments to specific ACOs. Within the Federal ACO market, where CMS is the payor that contracts with an ACO, improved ACO patient outcomes may lead to fewer administrative complications regarding billing and readmissions, thereby creating additional monetary value for CMS, over and above CMS's portion of the *shared savings* generated. For more discussion on shared savings under the Medicare Shared Savings Program (MSSP), see the other installments in this *HC Topics Series*: ***Need-to-Know Basics on the Costs of Forming an ACO***, ***A Cost-Benefit Analysis of ACO Formation***, and ***Determining an ACO's Financial Feasibility***.

In addition to being on the forefront of restructuring the healthcare delivery system, ACOs have provided payors with an outlet to expand into clinical services, offering them more *control* and *greater market leverage*. While the *value of reputation* is difficult to benchmark and, therefore, difficult to quantify, the increased cooperation between providers and payors may result in the value of improved benefit to payor reputation, over time.

VALUE TO SOCIETY

The value which an ACO conveys to society may be described as the perceived future benefits that ACOs are likely to contribute to the U.S. patient population, or a sub-population thereof. Efficiencies achieved by ACOs and the effects of coordinated care may benefit society in the form of: (1) cost reductions for *patient populations*; (2) cost reductions for the *community that an ACO serves*; (3) lower overall *healthcare expenditures* as a percentage of gross domestic product (GDP); and/or, (4) slowing of the current growth of national healthcare expenditures.[7] CMS has estimated that the MSSP alone could generate $940 million in federal healthcare expenditure reductions, which may have a *significant* effect on the growth of overall healthcare expenditures.[8]

In addition, a significant contributor to the monetary value employers receive from their employees is based on *levels of productivity*, i.e., the amount of work product an employee produces in a given amount of time. If employee populations succumb to lower rates of illness, resulting in fewer *health-based losses* in productivity, employers may receive a significant benefit from ACO development. The use of healthcare information technology (HIT) and improved process management to achieve greater efficiency in healthcare delivery models may also result in *maximizing productivity rates* among healthcare employees, adding *monetary societal value*.[9]

An ACO's *non-monetary societal value* is characterized by the coordination of care leading to *improved quality outcomes* and *greater access to care*, two of the three aims of healthcare reform, and two primary purposes of ACOs. ACOs aim to create value, as measured by quality outcome improvements, through regulation of quality reporting and changes in reimbursement policy. *Societal value*, as measured by *increased population access to care*, may be most significantly affected by an ACO's ability to provide access to high quality *preventive*, *primary*, and *specialist* services to all patients across the *continuum of care*. Increased transparency through publication of reported health outcomes may provide a more accurate assessment of the societal value attributable to ACOs. Quality metrics may also be influenced and fostered by emerging trends in reimbursement within the Commercial ACO market, e.g., the transition to *value-based purchasing* models that shift a portion of the financial risk from the insurer to the provider.

CONCLUSION

Not all externalities are positive, and ACOs may produce some negative impacts. It is possible that ACOs may not reduce costs for patients if the savings generated do not trickle down past providers. While stagnant costs for healthcare services represent a neutral impact, increases in costs for patients would be a negative externality. This concern may be realized, as historically, lower costs for businesses, resulting from greater size and market leverage, have resulted in *higher costs for consumers*.[10] In addition, ACOs may reinforce *disparities* in *access to care* by funneling patients from specific ethnic groups into one ACO, and targeting patients with historically high health statuses in order to *maximize financial incentives*.[11] Understanding which situations may result in negative externalities may allow policy makers and providers to appropriately avoiding such circumstances, thereby increasing the overall value attributable to ACO development.

1 "Health Care Economics" By Paul J. Feldstein, Sixth Edition, Clifton Park, NY: Thomson Delmar Learning, 2005, p. 424.

2 "From Acquisition to Integration: Transforming a Hospital Into an ACO" By John T. Fink and Sean Hartzel, Healthcare Financial Management Association, November 2010, http://hfma.org/templates/print.aspx?id=22988 (Accessed 3/12/2012), p. 3.

3 "Referral and Consultation Communication Between Primary Care and Specialists Physicians: Finding Common Ground" By Ann O'Malley and James Reschovsky, Archives of Internal Medicine, Vol. 171, no. 1, January 10, 2011, p. 64.

4 "The New Era for Hospital-Physician Alignment" Healthcare Financial Management Association, January 2011, p. 2.

5 "What's the Difference Between an ACO and Managed Care?" Healthcare Economist, August 23, 2011, http://healthcare-economist.com/2011/08/22/whats-the-difference-between-an-aco-and-managed-care/ (Accessed 2/1/12).

6 "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, Final Rule, Federal Register, Vol. 76, No. 212 (November 2, 2011), p. 67976.

7 "A Decade of Health Care Cost Growth Has Wiped Out Real Income Gains For an Average US Family" By David I. Auerbach and Arthur L. Kellermann, Health Affairs, Vol. 30 no. 9, 2011, p. 1634.

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8 "Next Steps for ACOs: Will This New Approach to Health Care Delivery Live Up to the Dual Promises of Reducing Costs and Improving Quality of Care" By Robert A. Berenson and Rachel A. Burton, HealthAffairs, January 31, 2012, p.4.

9 "Valuing Health Care: Improving Productivity and Quality" Kauffman Task Force on Cost-Effective Health Care Innovation, Kansas City, MO: Kauffman Foundation, April 2012, p.11, 58.

10 "Accountable Care Organizations in Medicare and the Private Sector: A Status Update" By Robert A. Berenson and Rachel A. Burton, Robert Wood Johnson Foundation and Urban Institute, November 2011, p. 8-9.

11 "Accountable Care Organizations and Health Care Disparities" By Craig Evan Pollack and Katrina Armstrong, Journal of the American Medical Association, Vol. 305, No. 16, April 27, 2011, p. 1706; "Hospitals' Geographic Expansion In Quest Of Well-Insured Patients: Will the Outcome Be Better Care, More Cost, Or Both?" By Emily R. Carrier, Marisa Dowling and Robert A. Berenson, Health Affairs, Vol. 31, No. 4, April 2012, p. 827.

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