ACCOUNTABLE CARE ORGANIZATIONS:

HERE TO STAY? DOES IT PAY?
AND MOST IMPORTANT OF ALL, SHOULD YOU PLAY?
Recently, we attended an excellent conference held by The Remington Report entitled Post-Acute Population Health Management Models. Essentially, the conference focused on strategies to coordinate post-acute care in an effort to reduce costs, improve outcomes, and increase patient satisfaction (for you health care policy wonks, a derivative of the Triple Aim). Naturally, a substantial amount of time was devoted to the role of accountable care organizations (ACOs) in these efforts. Best of all, there were several presentations from real, live (and still breathing), participants in current programs – what they did, how they did it, and what kind of results they have seen.

Here are our broad – and certainly generalized – takeaways, and what they mean for a non-hospital affiliated, post-acute health care service provider.

First, for the majority of attendees, ACOs remain a riddle, wrapped in a mystery, inside an enigma.

Even four or so years after ACOs began to bubble up, displacing disease management, managed care, pay-for-performance and other flavors-of-the-week, some of the best and brightest health care executives are still struggling to get their arms (and their minds) around it. Conceptually, they know “it” should work… if only they can figure out what “it” is.

But there is good news. All of the presenting ACOs reported compelling results. The most common measure was hospital admission and/or readmission rates, and each realized significant reductions in one or both. Score 1 for society and the promise of bending the cost curve downward.

So it works….right?

Well, “kinda sorta.”

All of the ACOs were formed by not-for-profit (NFP) hospital systems (echoing NFP-heavy participation rates throughout the country). Some received grants, or tapped foundation resources, to fund massive investments in human resources, data collection and integration, patient recruitment, etc. necessary to mount an offensive into coordinated care. And as indicated above, each achieved various measures of success.

At the end of each presentation, however, after reporting a litany of encouraging results, there was an almost palpable question that the polite and respectful attendees left hanging in the air. That is, “what were the financial ramifications of these population management initiatives?”

Though largely unanswered, the implication was unavoidable. It would appear that, especially for Medicare ACOs in which payments to participating providers is largely still “fee-for-service,” what was good for society – a meaningful reduction in utilization – produced a reduction in revenues and added administrative costs (for running the ACO) that were not entirely offset by (a) shared savings, (b) margins, if any, derived from “at-risk” capitated models with private insurers or other payors, or (c) reductions in operating costs. To be sure, this does not mean all of the initiatives were financially disappointing. Nor does it mean that the programs generated losses (though they may have). But it does mean that, broadly speaking, and at least to some extent, it would seem that the ACOs weakened their sponsoring systems’ financial performance (compared to pre-ACO) – a finding echoed in other articles on the subject.

So what do we conclude from this?

First, and perhaps most noteworthy, kudos to the Boards of Directors of the many not-for-profits that have taken their missions to heart and have leaped into the great unknown to pilot programs. Their efforts have clearly succeeded in fleshing out challenges, unintended consequences, and pathways to success in coordinated care.

Second, the promise of coordinated care is real. Meaningful expense can be taken out of the system without sacrificing patient care (and in many cases, improving patient outcomes). And having just palpated the vein of opportunity, the potential benefits are enormous.
Third, **devising an optimal payment structure that properly aligns incentives remains elusive.** If the informally gauged sentiment of the attendees is any measure, the current thinking is that payments almost certainly must take the form or variant of a capitated, per member per month arrangement. Then the question will be whether or not sub-contracted providers down the post-acute care continuum – home health, hospice, pharmacy services, behavioral health, perhaps home medical equipment, and more – will, despite outcome measures to the contrary, be commoditized and hence selected on cost alone. If it goes that way, ACOs may wind up nudging capitated coordinated care perilously close to the scalpel’s edge of unsustainable margins that undermined managed care initiatives in the late 90s to early 2000s.

Fourth, how should a non-hospital affiliated post-acute provider respond to the threat (opportunity) of being excluded from (selected to fill) a sub-contract position? Certainly, this depends largely on the strength and penetration of ACOs in a given market. However, broadly speaking, it’s notable that with not-for-profit hospitals leading the charge – NFPs we might add that, for the most part, already operate entities across the post-acute continuum – non-affiliated providers may see little direct impact from the first wave of coordinated care. They weren’t getting much of the business before these initiatives, and they won’t get it post ACO. The lingering threat, however, is that as NFP driven ACOs exert more control over patients that pass through their systems, those that might have otherwise drifted into the “community pool,” will never get there. All things considered then, while we would like to think otherwise, our best guess is that the first iteration of post-acute sub-contracting under a capitated model will revolve primarily around cost (i.e. the managed care playbook of old). Accordingly, absent local market dynamics that would demand otherwise, a prudent strategy a provider might follow would be to be to resist the lure of any fleeting “first mover” advantage, and be the second (or third provider) in an ACO – at pricing that befits the real clinical effectiveness necessary to reduce a population’s global spend on health care.

Fifth and finally, regarding trepidation on being on the “bleeding edge” of ACO participation, we would be remiss if we didn’t point out the following: right now, **expectations may be out-pacing the near-term reality** regarding (a) the uptake of capitated – like ACOs, (b) the resultant push towards more community based services, (c) the potential for the most effective providers to earn exclusive subcontracting rights at pricing that reflects their value in population management, and ultimately (d) the promise of a financial windfall. Accordingly, from a purely M&A perspective, **even if the initial numbers are middling, the early movers may be able to ride the wave of expectation and capture out-sized valuation premiums.**

Faced with these conflicting strategies, how might a near-term prospective seller have their ACO and eat it too? If possible, **the best approach may very well be to aggressively seek out and initiate a limited scope, pilot-like relationship with a coordinated care organization.** In other words, rather than pursue a partnership with the dominant systems/physician groups in your market area, your best alternative may be to align with a secondary player. If it tanks, the damage will be limited, and the knowledge gained will provide valuable insights into potential future relationships. If it succeeds, you realize the “halo” effect suggested above that can boost valuations.

And, in the end, if you can solve the riddle, wrapped in a mystery, inside an enigma, well, you won’t have to wait in line for the next generation iPhone. You can just buy the company instead.
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