

The Value of Accountable Care Organizations

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Many observers view accountable care organizations (ACOs), created by the Accountable Care Act, as the current health care reform version of managed care. A payment and care delivery model, ACOs were created to coordinate health care delivery among providers, resulting in lower overall health care costs for defined patient populations, while also meeting performance standards on quality of care and other measures. Health care entities seeking to determine whether to form an ACO will typically rely on a net present value (NPV) analysis as the rational financial investment basis.

INTRODUCTION

An accountable care organization (ACO) is a health care organization characterized by a payment and care delivery model that facilitates coordination and cooperation among providers to improve the quality of care for Medicare beneficiaries and reduce unnecessary costs. A group of coordinated health care providers forms an ACO. The ACO then provides care to a group of patients for an assigned population.

The ACO may use a range of payment models (capitation, fee-for-service with asymmetric or symmetric shared savings, and so on). The ACO is accountable to the patients and the third-party payer for the quality, appropriateness, and efficiency of the health care provided.

According to the Centers for Medicare and Medicaid Services (CMS), an ACO is “an organization of health care providers that agrees to be accountable for the quality, cost, and overall care of Medicare beneficiaries who are enrolled in the traditional fee-for-service program who are assigned to it.”¹

The term “accountable care organization” was first used by Elliott Fisher, Director of the Center for Health Policy Research at Dartmouth Medical School, during a meeting in 2006 with the Medicare Payment Commission. The concept of accountable care has existed in the American health care indus-

try for decades and long before the emergence of ACOs. Most notably, the managed care boom of the 1990s promised similar objectives of accountable care, including lower costs and higher quality outcomes for patients.

Managed care gained more prominence and bears resemblance to the health maintenance organization (HMO), a prepaid health plan model which used provider networks with a system of primary care gatekeepers and capitated provider reimbursement incentivizing a reduction in use and increases in the efficiency of care for HMO members.

The Patient Protection and Affordable Care Act (ACA) contains provisions surrounding the establishment of ACOs under the Medicare Shared Savings Program (MSSP).

Under the final rule issued by CMS in October 2011, ACOs will coordinate care and share in certain savings or losses for Medicare beneficiaries assigned to it in an attempt to improve results for patients with original (fee-for-service) Medicare—Medicare Parts A and B programs. The rule does not cover Medicare Advantage plans, Medicaid, or private insurers.

The MSSP will reward ACOs that lower health care costs for Medicare beneficiaries (by allowing the ACO to share in certain savings) while also meeting performance standards on quality of care and other measures. ACOs also will have to share

certain losses for failing to provide efficient, cost-effective care.

QUALITY STANDARDS

To address the goal of improving health care quality, CMS has established four domains in which to evaluate the quality of an ACO's performance. Also, there are approximately 33 quality measures that are monitored for an ACO. These quality measures fall into the following domains:

1. Patient/caregiver care experiences
2. Care coordination/patient safety
3. Preventative health
4. At-risk population

GROUPS OF PROVIDERS ELIGIBLE TO PARTICIPATE

The following groups of physicians, facilities, and health care professionals are eligible to participate as an ACO under the MSSP:

1. ACO professionals in group practices
2. Networks of individual practices of ACO professionals
3. Partnerships or joint venture arrangements between hospitals and ACO professionals
4. Hospitals employing ACO professionals
5. Critical access hospitals
6. Such other groups of providers of services and suppliers as the Secretary of Health and Human Services (HHS) determines appropriate

Those entities ineligible for ACO status may still participate in the MSSP and shared savings payments by partnering with an established ACO. However, those entities are not regarded as an ACO themselves.

PARTICIPATION REQUIREMENTS

Physicians, facilities, and health care professionals must meet certain eligibility requirements to participate in an ACO under the MSSP. These requirements include the following:

1. The ACO will be willing to become accountable for the quality, cost, and overall care of the original Medicare plan beneficiaries assigned to it.

2. The ACO will enter into an agreement with the Secretary of HHS to participate in the MSSP for not less than a three-year period.
3. The ACO will have a formal legal structure that would allow the organization to receive and distribute payments for shared savings to participating providers of services and suppliers.
4. The ACO will include primary care ACO professionals that are sufficient for the number of Medicare beneficiaries assigned to the ACO.
5. The ACO will have, at a minimum, at least 5,000 beneficiaries assigned to it in order to be eligible to participate in the MSSP.
6. The ACO will have sufficient information regarding participating ACO health care professionals as the Secretary determines necessary to support beneficiary assignment and for the determination of payments for shared savings.
7. The ACO will have leadership and management structure that includes clinical and administrative systems.
8. The ACO will define processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care, such as through the use of telehealth, remote patient monitoring, and other such enabling technologies.
9. The ACO will demonstrate that it meets patient-centeredness criteria specified, as determined by the Secretary.
10. The ACO participant cannot participate in other Medicare shared savings programs.
11. The ACO entity is responsible for distributing savings to participating entities.
12. The ACO will have a process for evaluating the health needs of the population it serves.

TYPES OF ACOs

There are two types of ACOs:

1. Federal ACOs
2. Commercial ACOs

Both types share similar structural components and overall goals. Unlike the federal ACOs, no formal law or statute governs the commercial market,

although the various individually negotiated contracts between self-proclaimed ACOs and private payers provide the structure and management for ACOs by providing incentive payments, similar to those seen in the MSSP.

Each market enables a body (i.e., a CMS or a private payor) to act as a supervisor in the terms of managed competition.

Given the nature of the contracts between ACOs and private payers, some view there being greater flexibility regarding ACO formation in the commercial market as compared to the standardized contracts between ACOs and CMS under MSSP. It should be noted that one of the most restrictive components of the MSSP is that a federal ACO must be a legal entity in its entirety, identified by a unique tax identification number.

Within the meaning of the term “value,” as it relates to the federal ACO market, CMS has used the following three-part aim to determine the value gained from ACOs:

1. Better care for individuals
2. Better health for populations
3. Lower growth in Medicare expenditures

Similarly, corporate ACOs are beginning to adopt this three-part approach to defining value. Premier, Inc., established a definition of value for its ACO to include the following:

1. Population health status
2. The patient’s care experience
3. Total cost of care²

Whether developed in the federal or commercial markets, an ACO’s overall achievement of this three-part aim provides the basis for its claim on adding value (i.e., future economic benefit to the U.S. health care delivery system), in the form of improved outcomes per dollar spent, for society as a whole, for ACO providers, and for ACO payers.

The future benefits that an ACO will contribute to the population as a whole comprise the value an ACO presents to society. These benefits can be categorized as either monetary or nonmonetary. Measures of comparison, such as benchmarking the results to industry norms and historical trends, must be in place in order to begin to quantify the value added by an ACO.

Benchmark comparisons of patient populations, on an ACO regional or national level, are useful in

determining the existence of statistically significant evidence of improved patient outcomes as an indication of whether an ACO truly added value.

Whether participating in the MSSP, or participating under private contracts between providers and payers, an ACO uses defined measures to assess the quality of care the ACO’s beneficiaries are receiving from the ACO’s providers. As noted previously, there are 33 identified and mandated quality measures to be collected by federal ACOs under the MSSP, which are consistent across all participating federal ACO providers.

In contrast, within the private sector, the required quality measures are established and agreed to, by contract, between the ACO and the private payor, and may vary from ACO to ACO. Despite potential differences in the value metric used between the federal and commercial ACO markets, all ACOs are responsible for regional and national reporting under current regulated transparency initiatives.

UPSIDE AND DOWNSIDE VIEW OF ACOs

Upsides

Presented below is a list of items that reflect upsides regarding the formation of ACOs:

1. Although ACOs are not directly linked to current initiatives attempting to increase health care access (i.e., expanding Medicare coverage or increasing the number of insured), they may have a significant effect on patients’ access to primary care and specialist referrals through their focus on coordinated care. (See “Health Care Reform: The Impact on Academic Health Centers” in this *Insights* issue.)



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Additionally, as ACOs become more efficient, it is anticipated that they should be able to handle larger patient volumes, allowing for improved patient care.

2. CMS has estimated that the MSSP alone could generate \$940 million in federal health care expenditure reductions over the next four years.
3. ACOs that achieve shared savings, either in the commercial or the federal markets, are likely to experience greater financial returns from increased efficiency in their respective practices (i.e., lower administrative costs, more efficient physician time-management, and fewer billing mistakes).
4. Although ACOs are related to HMOs, the ACO model does not incorporate the requirement that physicians seek pre-approval before prescribing treatment to their patients—a requirement common among HMOs.

An ACO depends on the independent decision making of the providers by allowing physicians to direct their patients' care and encouraging all participants to contribute to the management of the ACO.

The ACO essentially shifts the coordination of care from administrators to doctors and patients, as the physicians are frequently on the front line when a patient seeks help.

5. The MSSP began accepting applications for establishing future ACOs on January 1, 2012, and established commencement dates on April 1, 2012, and July 1, 2012. As of July 2012, there were approximately 153 organizations participating in Medicare shared savings and more than 2.4 million beneficiaries were receiving care from providers participating in Medicare shared savings initiatives. This indicates that there is certainly interest across the country in forming ACOs, which is a positive trend going forward.

Downsides

Presented below is a list of items that reflect downsides regarding the formation of ACOs:

1. While technology investment is not required for either commercial or federal

ACO development, the reality is that an ACO is unlikely to succeed without it. Without various technology enhancements, an ACO may not be able to reach the level of integration required for the requisite coordination of patient care and is unlikely to be able to effectively measure results and provide quality reporting measurements.

2. Concerns have been expressed that the ACOs favor large, urban health care providers and that they are very similar to HMOs which received significant attention in the 1990s.
3. One of the biggest concerns is whether or not there is sufficient potential to create innovative ways to improve quality and decrease costs. Some critics may be concerned that the program will hinder physicians' autonomy to make important clinical decisions and that financial incentives could potentially hinder overall medical progress by restricting innovation.
4. There are a few concerns regarding fair market value issues that arise relating to the formation of ACOs, including provider compensation, valuing assets contributed, return on investment made by ACO members, and the distribution of savings (income) to member owners.

ACO providers will expect compensation that reflects their contribution to professional services rendered, quality of care, and cost savings. As the typical physician compensation models—emphasizing quantity of service as opposed to quality of service or outcomes—may not be relevant in the ACO environment, models will need to migrate to payments based on different performance measures and not solely on productivity measures.

These compensation models will need to comply with Stark and Anti-Kickback Statutes. Stark Law generally is referred to as the federal statute dealing with physician self-referral. Under this law, if a physician or a member of a physician's immediate family has a financial relationship with a health care entity, the physician may not make referrals to that entity for the furnishing of designated health services under the Medicare program.

The law essentially governs physician self-referral for Medicare and Medicaid patients. The federal Anti-Kickback Statute is a criminal statute that prohibits the

exchange (or offer to exchange), of anything of value, in an effort to induce (or reward) the referral of federal health care program business.

The Anti-Kickback Statute establishes penalties for individuals and entities on both sides of the prohibited transaction.³

Currently, it is not entirely clear regarding how these statutes will express authority for physicians within ACOs, which will most likely be resolved in the near future. Until clearer guidance is in place, the potential costs savings to the government within ACOs may be less defined.

Participants that invest in an ACO by supplying start-up capital and other assets will expect a return on their contribution. The assets contributed may include cash, working capital, intangible assets, or an income-producing ancillary. The value of the asset contribution will be important in determining how any income or savings is allocated among the ACO participants.

The risk-adjusted, calculated value of each participant's contribution would be helpful in determining its percentage of the shared savings or the income available to each participant.

5. Lastly, ACOs risk being accused of violating certain antitrust laws if they are perceived to drive up costs through reducing health care competition while providing lower quality of care.

The U.S. Department of Justice has offered a voluntary antitrust review process for ACOs to address this issue, but there most likely will be hurdles along the way with getting the review process established.

STARTING AN ACO AND AN ANALYSIS OF CAPITAL

For health care entities seeking to determine whether or not to form an ACO, a net present value (NPV) analysis provides a financial investment basis for determining whether to accept the decision to form an ACO or not. The NPV of an investment project is the value of the differences over a period of time between benefits and costs.

Health care entities use NPV analyses to determine the ACO project's potential impact on the organization's financial standing and on its needs for total available capital and the allocation decisions related to utilization of existing capital.

Health care entities need to determine if the additions to the net cash flow from operations that would be generated from forming an ACO would exceed the initial start-up and maintenance costs of the project after consideration of the organization's cost of capital and the likelihood of obtaining a return on, and a return of, invested capital.

To be valuable, an acquisition of capital and an investment in an ACO should add to an entity's net cash flow. Determining whether or not this economic threshold is achievable is the first step in evaluating a capital acquisition. The other step is to determine the projected after-tax net cash flow from the proposed capital acquisition over the expected length of investment time.

In using NPV analysis, the sum of the present value equivalents of the expected net cash flow less the initial investment in the project equals the project's net present value.

If the net present value is positive, then the net cash flow produced by the acquisition will be adequate to cover the costs of acquiring and financing the project. Ideally, the projected return on investment would be at least equal to the after-tax weighted average cost of capital (WACC).

Whether a project is net present value positive or negative most often will determine if it would be economically possible for an entity to accept or reject a decision to acquire capital for an ACO project. Using estimated start-up and operation cost data, the MSSP, and examples of ACOs of varying sizes, a NPV analysis may be prepared to forecast potential financial benefits from ACO investments.

Models for Shared Savings

The ACO's financial incentive payments will be determined by comparing the organization's annual incurred costs relative to CMS-established benchmarks. These benchmarks will be based on an estimation of the total fee-for-service expenditures associated with management of a beneficiary based on fee-for-service payment in the absence of an ACO.

CMS will update benchmarks by the projected absolute amount of growth in national per capita expenditures as well as by beneficiary characteristics. CMS also will establish a minimum savings rate (MSR) that will be calculated as a percentage of the benchmark that ACO savings must exceed in order to qualify for shared savings. The MSR will account for normal variation in health care spending.

While Medicare will continue to offer a fee-for-service program, ACOs can choose either a one-sided model (lower reward and lower risk) or

“To justify the significant expense associated with ACO development and operation, a potential investor should consider whether the anticipated shared savings will offset the required capital expenditures.”

a two-sided model (higher reward and higher risk) based on the degree of risk and potential savings they prefer.

Initially, a one-sided model ACO shares in savings for the first two years and savings or losses during the third year. The maximum sharing percentage for this model is 50 percent. In a two-sided model, ACOs share in savings and losses for all three years. In both cases, the ACO savings must exceed 2 percent in order to qualify for shared savings. The maximum sharing percentage for the two-sided model is 60 percent.

In both models, there is a shared loss cap of 5 percent in the first year, 7.5 percent in the second year, and 10 percent in the third year. Aspects regarding financial risk and shared savings would be altered in the final regulations.

After the initial set of regulations released in March 2011, CMS received feedback regarding streamlining the governance and reporting burdens and improving the potential financial return for ACOs willing to make the necessary, and often substantial, investments to improve care.

In October 20, 2011, the final regulations for the MSSP were released. The final regulations allow for broader ACO governance structures, reduce the number of required quality measures, and create more opportunities for savings while delaying risk bearing.

Under the new regulations, providers' financial incentives were increased. Under the one-sided model, providers have the opportunity to engage in ACOs and to share in any savings above 2 percent without any financial risk throughout the three years.

Under the two-sided model, providers assume some financial risk, but will be able to share in any savings that occur (there is no 2 percent benchmark before provider savings accrue). In addition, the quality measures required were reduced from 65 to 33.

Limitations and Expenses to Be Considered

The worst case scenario for any ACO occurs when the organization exceeds its calculated benchmark

by a sufficient amount to be responsible for the applicable cap on shared losses. An ACO will be responsible for a portion of shared losses once the 2 percent buffer is reached and up to the designated cap for the given year.

Under the one-sided and two-sided models, ACOs are also responsible for the supplementary start-up costs and operational expenses related to the ACO.

To justify the significant expense associated with ACO development and operation, a potential investor should consider whether the anticipated shared savings will offset the required capital expenditures. Given the cap on shared savings, some ACOs may never be able to accumulate the required financial benefits to offset the ACO related costs.

In a best case scenario, an ACO will achieve the maximum shared savings available and, therefore, the highest expected future cash flows over the initial three-year contract term.

Considering the required initial start-up investment, an NPV analysis can be used to determine at what size (i.e., the required number of beneficiaries) an ACO would be capable of providing sufficient future cash flow to offset the expense of the initial ACO investment.

Limited data on actual ACO costs and success rates creates an additional level of uncertainty regarding the feasibility of potential ACOs, especially in the commercial market. ACOs that do not meet the 33 regulated quality performance measures will realize lower shared savings and will negatively impact the NPV of the ACO.

VALUATION APPROACHES

There are three generally accepted business valuation approaches:

1. Income approach
2. Market approach
3. Asset-based approach

There are three generally accepted asset valuation approaches:

1. Income approach
2. Market approach
3. Cost approach

Income Approach

The income approach measures the value of an asset by the present value of its future economic benefits. These benefits can include earnings, cost savings,

royalty savings, tax deductions, and proceeds from the asset's disposition.

When applied to a business, value indications are developed by capitalizing current benefits or discounting prospective cash flow to a present value at a rate of return that incorporates the risk-free rate for the use of funds, the expected rate of inflation, and risks associated with that particular investment.

The capitalization and discount rates selected generally are based on rates of return available for alternative investments of similar type and quality as of the valuation date. This approach assumes that the income derived from a business or asset will, to a large extent, control its value.

Market Approach

The market approach measures the value of an asset through an analysis of recent sales or offerings of comparable assets that recently have been acquired in arm's-length transactions. The market data are then adjusted for any significant differences, to the extent known, between the identified comparable assets and the asset being valued.

A benefit of the market approach is its simple application when comparable transactions are available. This circumstance is most commonly found when the acquired asset is widely marketed to third parties. Under these circumstances, the market comparable method represents the most appropriate method for estimating the fair market value of the subject asset.

The primary drawback of the market approach is often the scarcity of data regarding comparable transactions within a relatively recent period upon which to establish fair market value.

When applied to the valuation of a business, consideration is given to the financial condition and operating performance of the company being valued relative to the performances of publicly traded companies operating in the same or similar lines of business.

The publicly traded companies or merged and acquired companies are assumed to be affected by industry and economic risks in a similar manner as the subject company, and are therefore considered to be reasonable investment alternatives.

Cost/Asset-Based Approach

The cost approach measures the value of an asset based on the cost to reconstruct or replace it with another of like utility. Historical costs are often used to estimate the current cost of replacing the asset or entity valued. In doing so, adjustments for physical, functional, and economic obsolescence are taken into account.

When applied to the valuation of a business, value is based on the net aggregate fair market value of the entity's underlying assets. This asset-based approach analysis involves a recasting of the balance sheet of the subject company in which the fair market values of its assets and liabilities are substituted for their book values.

CONCLUSION—VALUE RECONCILIATION

Although ACOs represent a new form of operating entity, a valuation analyst should consider each of the generally recognized valuation approaches as a starting point in attempting to estimate the value of these potentially complex organizations.

After considering the relevant valuation factors, it may seem most reasonable for an independent valuation analyst to rely on the indications of value provided by a single valuation approach. In some situations, multiple valuation approaches and multiple valuation methods produce similar results and can be relied on by all interested parties.

As a starting point in the valuation process, and based on consideration of the newness of ACOs and the information provided herein, a valuation analyst estimating the value of an ACO may need to understand the following issues:

1. The structure
2. Groups and providers involved
3. Assets contributed
4. Location and type
5. Shared savings model

Using a combination of an income approach (i.e., a discounted cash flow method or an after-tax net cash flow using the NPV analysis discussed previously) along with a cost/asset-based approach, a valuation analyst should be able to estimate the value, or a range of values, for an ACO and its related assets.

In other words, the valuation of the ACO involves the same generally accepted valuation approaches and methods as the analyst would use in the valuation of any other operating business (health care or non-health-care related), physician practice, hospital, or group of assets.

Notes:

1. www.cms.gov.
2. www.premierinc.com.
3. 42 U.S.C. § 1320a-7b.

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