emerging ‘Super ACOs’ fill unique needs

Super ACOs aim to maintain the local character of independent hospitals while meeting increasing cost and quality requirements.

A proliferation of health system mergers and consolidations has garnered attention since the global recession of 2008–09 and the enactment of the Affordable Care Act (ACA). What has been less noticed is a separate push by health systems to coordinate clinical services with other organizations to lower costs of care and improve care quality and population health.

Health systems increasingly are forming partnerships to obtain some of the advantages that physician-led accountable care organizations (ACOs) have garnered from coordinating patient care across a variety of providers.

For many health systems or large providers, an effective strategy is to form their own ACOs. A health-system-led ACO, or “Super ACO,” has the potential to obtain the patient care improvement and cost-savings benefits that many high-profile physician-led ACOs have achieved without the need for a formal merger.

**Breaking New Ground**

Forming or joining a Super ACO can provide a health system with a range of benefits. For instance, small systems may gain economies of scale in their population health management capabilities, infrastructure, and contracting. Other advantages include:

- Expanded geographic coverage to meet the needs of a larger population
- Enhanced ability to focus attention and resources on high-priority gaps in care delivery that contribute directly to performance
- Reduced competition

Forming a Super ACO also enables organizations to avoid the complexity and costs that come with ownership and governance changes under formal mergers.

AT A GLANCE

Hospitals and health systems exploring the idea of forming or joining a “Super ACO” should consider several key factors:

- Pace of change and partnership opportunities in their market
- Market concentration and the organization’s size relative to larger competitors
- Whether the organization is financially strong enough to participate
- How prepared the organization is for accountable care and population management
- Whether the organization is equipped to care for new patient populations
But Super ACOs are not appropriate for every system and situation. Health systems should assess their markets and capabilities before deciding whether to form or join one.

Health systems that opt to form a Super ACO should focus primarily on which partners would best complement their organizations and what goals the Super ACO should pursue. Ideal Super-ACO partners are other health systems and providers with similar missions and strategies. Other important points to consider are whether the potential Super-ACO partner system exhibits the following characteristics that are essential for a successful partnership:

**What Is a “Super ACO”?**

Healthcare industry activities related to the Affordable Care Act are accelerating as the Jan. 1, 2014, launch of coverage through the state health insurance exchanges and expanded Medicaid programs draws near. However, the lingering effects of the recession are stressing hospital and physician financial performance. Such uncertainty is spurring complex competition that crosses industry lines between insurers, hospitals, and medical groups.

The pressures of competition, slower revenue growth, and greater risk are generating a wave of mergers and acquisitions as smaller health systems seek safe harbors and larger systems struggle to gain share to maintain revenues as payment flattens. But mergers and common ownership are not the only way to increase integration with other providers. Many small health systems aiming to remain independent are working to develop accountable care organizations (ACOs), called “Super ACOs,” with their clinicians to help deliver higher-quality, more affordable health care and improve population health. Moreover, some progressive systems have gone beyond their own organizations to collaborate with other health systems. These initiatives have the same population-health-management focus of standard ACOs, but the economies of scale these small systems are able to achieve results in their achieving Super-ACO status.

Coordination of physician services is a necessary component of Super ACOs, but it is not sufficient to achieve the quality and cost-control outcomes sought by these organizations. Other important components that may need to be added over time are healthcare IT infrastructures (e.g., registries, data analytics, reporting systems), shared services (e.g., case management, patient-centered medical homes), and joint go-to-market vehicles (such as jointly owned health plans).

Emerging examples of Super ACOs include a Northern California coalition between Dignity Health, Hill Physicians, and the University of California, San Francisco, called “Third Way.” In 2010, two members of this coalition (Dignity Health and Hill Physicians) worked with Blue Shield of California to win a large “narrow network” contract for CalPERS in Sacramento covering 41,000 lives. In the first year they lowered costs for that group by 1.6 percent—compared with a 9.9 percent increase for CalPERS members not in the group. Over two years, annual cost increases for CalPERS members in this plan were 3 percent, or half their previous rate.a

Other examples include the 2010 Florida alliance between Orlando Health and University of Florida to link physicians, collaborate on clinical program development, and build compatible electronic health record and quality information systems.

In July, three regional health systems in Eastern Pennsylvania—Abington Health, Aria Health, and Einstein Healthcare Network—announced they are forming a jointly owned limited liability corporation to manage the health plans of their more than 30,000 employees and dependents. They also will develop a “health management platform” for other self-insured employers.

Also in July, 23 Georgia hospitals from 13 independent health systems—led by Central Georgia Health System in Macon and Tift Regional Health System in Tifton—formed a clinically integrated nonequity partnership called Stratus Healthcare to manage regional population health.

Any of these or other Super ACOs eventually may evolve into integrated systems as their partners find more areas in which to collaborate. Many of the nation’s largest health systems began as loose federations of hospitals that demonstrated value from integration and deepened their collaboration and integration until local resistance to merging assets melted away.

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*a. Markovich, P., “A Global Budget Pilot Project Among Provider Partners and Blue Shield of California Led to Savings in First Two Years,” Health Affairs, September 2012. This “proof of concept” has become a template for other “narrow network” initiatives with large books of business across the state.*
A compatible culture
A willingness and ability to collaborate
A relatively low cost position
A strong brand
Sufficient scale to generate economies of scale
Moderate market overlap
Experience in accountable care or risk contracting
Committed leaders who will stay on long enough to ensure the Super ACO is successful

A Super ACO can substantially improve its prospects for success by selecting initial goals that are concrete, tangible, and easily understood. Better and quicker outcomes may come from the pursuit of “market facing” initiatives, such as development of a joint management plan for the collaborating systems’ employee health plans, launch of a jointly owned Medicare Advantage plan, or development of a “narrow network” contract with a group of large employers. However, joint market-facing initiatives also can carry regulatory risks, especially if health systems have extensive market overlap. Super ACOs also may draw regulatory attention based on the way they are structured.

Super ACOs are less likely to encounter legal risks if they focus on joint investments in IT, case management services, or other infrastructure. However, collaborations that focus on these objectives may take longer to pay off.

Health systems looking for implementation partners should remember that wide variation in Super-ACO designs and goals exist. The initiatives the Super ACO undertakes should fit the unique conditions of its market and the specific strategic goals of each partner organization.

’Super ACO’ Candidates
Health systems usually form or join a Super ACO to strengthen their competitive position and grow their patient base. But other reasons organizations form Super ACOs include a desire to better organize community health resources and avoid duplicating accountable care resources. In relatively small markets with one or two health systems, Super ACOs are a vehicle for planning community health and rationalizing care delivery. In larger markets, similar goals may lead highly specialized providers—such as children’s hospitals—to join together.

Forming or joining a Super ACO may offer health systems several advantages over building their own ACOs or merging with other systems:
> Economies of scale can reduce each partner’s investment in accountable care and population health management, including the cost of developing physician networks and IT infrastructure.
> Super ACOs allow development of joint-venture health plans and other “go to market” vehicles.
> Super ACOs can expand the partners’ geographic coverage to access a larger population base.

Super-ACO Readiness: Self-Assessment Questions for Health Systems

<table>
<thead>
<tr>
<th>Assessment Questions</th>
<th>Considerations (Partial List)</th>
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<tbody>
<tr>
<td>How “advanced” is our market, and how fast is it moving?</td>
<td>Markets with significant risk contracting (e.g., Boston, Los Angeles) are ideal for Super-ACO development, because experienced partners are plentiful.</td>
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<tr>
<td>How concentrated are health systems in our market, and what is our relative strategic position?</td>
<td>In markets with a relatively low provider concentration, a Super ACO could be a powerful consolidation tool.</td>
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<tr>
<td>How strong is our system’s financial position?</td>
<td>Weak health systems may need to merge with other systems to protect their assets rather than join a Super ACO.</td>
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<tr>
<td>How “ready” is our system for accountable care and population health management?</td>
<td>Financially sound health systems can use Super ACOs to strengthen their strategic position with less capital than it would take to build their own ACOs.</td>
</tr>
<tr>
<td>Do we want to grow?</td>
<td>A Super ACO can help an organization that has little experience with risk contracting gain experience and build capabilities at relatively low cost.</td>
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<td></td>
<td>An organization may have specific skills or programs that can be leveraged in a Super-ACO partnership.</td>
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<td>Super ACOs can help a health system access patients in new geographic locations.</td>
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Super ACOs can focus management attention and resources on closing gaps in care delivery that contribute directly to performance shortfalls.

Retaining separate health system ownership avoids the complexity and costs associated with changes in health system ownership and governance.

On the other hand, Super ACOs are not appropriate for all health systems. For example, health systems that are financially weak may benefit more from pursuing mergers than from forming a Super ACO.

Health systems weighing whether to form or join a Super ACO should first assess the dynamics of their market and their strengths and weaknesses. Leaders of health systems that can answer “Yes” to at least four of the self-assessment questions in the exhibit on page 3 should seriously consider forming or joining a Super ACO.

**Forming a Super ACO**

Once a health system decides to pursue a Super-ACO strategy, the next steps are to determine the best partners for the Super ACO and what initiatives the Super ACO should pursue. For providers with established relationships, the decision to form a Super ACO may precede the process of identifying its goals. In other instances, health systems may start by identifying high-priority initiatives and then pick Super-ACO partners best positioned to help them achieve those goals. Most existing Super ACOs are arranged around initiatives they decided to undertake.

Health systems forming a Super ACO should evaluate potential partners using the following criteria.

**Aligned strategic goals.** Super-ACO partners should ensure their mission and strategic visions are aligned. Although some competition between partners is acceptable, organizations focused on growing shares of the same markets will have difficulty collaborating. Similar conflicts also are likely to arise if the partner organizations have significantly different risk tolerances.

**Compatible cultural values.** The adage “Culture eats strategy for lunch” reflects the importance of cultural compatibility as a criterion for any partnership. Most health systems and their medical staffs have a sense of whether another system shares their values, but health system leaders should test these perceptions because they occasionally are inaccurate.

**Willingness and ability to collaborate.** Super-ACO partners should place a high value on collaboration and have a long-term commitment to working together to improve clinical outcomes, population health, and financial performance.

**Relatively low costs.** Reducing the cost of care is a major goal of the ACA, and hospitals and health systems that have relatively low-cost positions in their markets (adjusted for acuity and severity of the patients they treat) will generally make better Super-ACO partners than their relatively high-cost, high-priced competitors.

**A strong brand.** Collaborating health systems will be offering new products to their markets, so the brands previously established with customers by their Super-ACO partners will affect the brand of the new Super ACO.

**Potential for scale.** Many accountable care initiatives are subject to significant economies of scale, and the further a Super ACO moves along the spectrum toward population management, the greater the potential economies. Larger partners can help build scale faster than smaller partners.

**Moderate market overlap.** In general, a moderate level of market overlap is best for Super-ACO collaborations. However, if the overlap is too great, competitive forces will prevent a Super ACO from forming or pull a loose affiliation apart. In addition, if the combined market share of Super-ACO members is substantial (e.g.,
to 50 percent), the Super ACO could attract scrutiny from regulators.

**Experience with accountable care and population health management.** Health systems and other providers that have built population health management capabilities and infrastructure can be valuable Super-ACO partners. In particular, primary-care-driven medical groups and independent practice associations experienced with global capitation or other forms of risk contracting can provide knowledge as Super-ACO partners.

**Strong leadership tenure.** When it comes to implementing partnerships of any kind, sustained leadership is critical. A Super ACO’s leaders should be committed to remaining in place for at least one or two years to avoid potential problems during implementation.

**Identifying Super-ACO Initiatives**

A critical strategic decision for Super-ACO partners is to identify the first initiative on which they will focus. A poor initiative choice will squander management time and resources and could prevent the Super ACO from ever gaining traction. Failure could similarly stem from launching too many initiatives.

Super-ACO leaders juggling the complexities that arise when starting such an entity should limit their inaugural initiatives to one or two goals.

The list of potential Super-ACO initiatives is long, but experience has shown that some carry more advantages than disadvantages.

New Super ACOs may benefit most from the use of tangible initiatives with short-term benefits. Given the complexity of health systems’ strategic agendas, Super ACOs must compete for management time, attention, and capital, which can create difficulties if the ACO is pursuing many different initiatives. Concrete, easy-to-understand initiatives that produce “quick wins” are the best way to generate excitement and build management support.

Similarly, market-facing initiatives are a good focus for new Super ACOs because they allow the ACOs to demonstrate unequivocal success. Market-facing initiatives include development of a narrow network for an existing health plan or large employer or launching a provider-sponsored Medicare Advantage plan. If successful, such initiatives may pay off well in one to two years.

**DETERMINING POTENTIAL SUPER-ACO INITIATIVES**

* HIE OHP = Health insurance exchange qualified health plan.
† MSSP ACO = Medicare Shared Savings Program accountable care organization.
Established Super ACOs can undertake more complex initiatives, such as joint infrastructure development projects. However, the partnership’s leaders should carefully design these projects to avoid political controversies and add value quickly. Healthcare IT systems and infrastructure—either built or purchased—often require substantial investments that may require a long time to provide an investment return.

A clinically integrated network (CIN) of employed and independent physicians is an essential component of any Super ACO, and collaborating on the development of a CIN is a critical step in Super-ACO development. Such an effort requires resources, but in most markets, it also carries relatively low risk and relatively high probability of success (except in certain markets such as Los Angeles, where a CIN could be seen as being competitive with other organized medical groups).

**Regulatory Issues**

Participation in a Super ACO also requires consideration of possible regulatory issues. Regulators such as the Federal Trade Commission and the U.S. Department of Justice have issued a number of rules and opinions on appropriate ways for independent physicians to work together in CINs, but they offered relatively little definitive guidance for independent health systems trying to collaborate in delivering accountable care.

Based on the principles underlying regulators’ rulings, wherever possible, Super ACOs should:

- Work directly with clinically integrated physician networks to align hospital services with the CIN’s activities
- Invest in clinical integration infrastructure (for example, clinical performance management systems, protocol development, quality and value reporting) and use performance on metrics as the basis for determining resource allocations and bonus distributions
- Contract with existing health plans on a nonexclusive basis (as exclusivity provisions are a red flag for regulators)
- Share financial risk (for example, through joint ownership of a new health plan product)
- Avoid driving up the cost of care to buyers

**Implementation**

After health systems have assembled their partners and decided which initiatives to pursue, a plan for implementation should be established. A large and growing group of accountable care service organizations have sprung up to help with initiatives such as building CINs, developing contracts, and starting health plans. These service organizations include private payers that have been motivated by the ACA to restructure their relationships with providers. They also include a growing number of independent third parties that offer front-office and back-office services to help build population health management capabilities.

Although many of these companies have expertise, management systems, and customized tool kits, unless a Super ACO has a tailored approach to its market and partners, as well as shared goals among the partnering health systems, no amount of assistance will enable it to survive.

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