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Developmental Strategies and Challenges of Rural Accountable Care Organizations

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Purpose

This policy brief shares insights gained from site visits in 2013 to four Accountable Care Organizations (ACOs) serving rural Medicare beneficiaries. Initial strategic decisions made and challenges faced as the ACOs were being developed can inform development of other rural ACOs.

Key Findings

- The rural ACOs we studied were formed as a step toward a value-driven rural delivery system, recognizing that ACO participation may or may not have a short term return on investment.
- Common rural ACO strategies to increase health care value include care management, post-acute care redesign, medication management, and end-of-life care planning.
- Access to data is an important enabler of population health management, care management, and provider participation.

Introduction

Section 3022 of the Patient Protection and Affordable Care Act of 2010 created the Medicare Shared Savings Program (MSSP), which “promotes accountability for a patient population ... and redesigned care processes for high quality and efficient service delivery.”¹ As of December 5th, 2014, Centers for Medicare and Medicaid have certified 356 Medicare Accountable Care Organizations (ACOs),^{2,3} of which 117 have a presence—at least one provider—in rural (nonmetropolitan) counties, including 8 that operate exclusively in rural counties.

The overarching ACO goals of improving clinical quality and reducing per capita costs (i.e. increasing health care *value*) can be approached in several ways. Early ACO studies by Larson and colleagues⁴ and Sillow-Carroll and Edwards⁵ found that ACOs often base their activities on developing and using health information technology (HIT) and implementing care management, as well as on other activities and strategies, including performance measurement, physician engagement⁴, practice standardization, community partnerships, medication management, nursing home transfers, and patient engagement⁵. Although literature on the experiences of ACOs is starting to appear, we found no literature describing the strategies and challenges of ACOs operating in rural areas, and whether they were different from their urban counterparts.



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Methods

From the population of Medicare shared savings ACOs with a rural presence, a convenience sample of four was drawn (one from each census region) to learn from experiences in different areas of the country. Semi-structured interviews were conducted with key ACO leaders and representatives (e.g., board members, physicians). Interviews were recorded and transcribed, and two coders independently extracted key information regarding ACO history, governance, management structure and operations, financing, emerging health care delivery models, lessons learned, legislation/regulation, and general ACO characteristics (e.g., organizations involved, geographic coverage, attributed patients). This brief draws predominantly from the interview sections that addressed management structures and operations, emerging healthcare delivery models, lessons learned, and general ACO characteristics.

Findings

All four ACOs recognized that payments in health care will transition from fee-for-service to value-based payment plans. To engage in this transition, the formation of an ACO was seen as an opportunity to more actively engage ACO providers and work with other providers in the area to develop value-based care processes along the continuum of care. An ACO model was also seen as compatible with other initiatives, such as meaningful use, patient-centered medical home, and quality improvement activities. Thus, formation of an ACO served as a trigger and a framework for discussions around value, appropriate care settings, and population health management. As such, ACO strategies do not necessarily represent unique actions, but reflect an underlying approach to care delivery that these organizations are adopting and refining.

While financial sustainability was important to the four ACOs studied, they recognized that the financial implications of ACO program participation would not be clear in the short term. However, the ACOs agreed that financial sustainability would require clinical care redesign. Below we describe key value-oriented strategies employed by the four ACOs.

Using Data to Improve Performance

The population health management strategy at all four ACOs included access to clinical performance and cost-of-care data. Data analysis¹ allowed the ACOs to identify high-risk patients and to manage their care. Three of the four ACOs emphasized the importance of redesigning care processes and integrating HIT into provider workflow, which served two important functions—improving documentation to increase data reliability and efficiency, and improving performance by providing clinically relevant patient information to the provider at the point of care. Sharing performance data and developing HIT practice support tools also increased physician participation in population health and performance improvement efforts. Centralizing analytical efforts enabled constant improvement in data reporting, including site visits by central staff to support on site reporting and sharing results as actionable information.

Care Management

All four ACOs developed care management programs. While the ACOs used different program descriptors (e.g., care coordination, care navigation, guided care) and differed in some program elements, common care management elements included the following:

- Identifying the high risk population, often defined as the 5 percent to 10 percent of patients with the most comorbidities and/or high utilization and spending
- Providing care coordinators with access to the relevant patient information (through the HIT system), as well as information regarding resources available in their community
- Directing patients to the most appropriate services and service providers (advice provided by physicians and/or care coordinators)

¹ Data analyses are performed either by the ACO or a contractor, depending on ACO's HIT capabilities and experience

Two ACOs reported that their care coordinators visit patients at home to ensure a safe environment and to provide further assistance (e.g., medication reconciliation). They also identified these visits as opportunities to engage the patients in their own health and health care.

Other Opportunities

Several other opportunities to enhance healthcare value emerged from the ACOs' experiences:

- **Post-acute care.** All four ACOs identified post-acute care redesign as a value-enhancing opportunity, which entailed reassessing the relative value of various post-acute care services. One approach they adopted was finding common goals with post-acute care providers (e.g., avoiding readmissions, medication reconciliation). Another approach was reducing post-acute care spending by encouraging providers to direct patients to high-value care settings.
- **Medication management.** Three of the four ACOs redesigned medication practices, such as improving medication reconciliation (either through care coordination or through data sharing) and increasing generic drug utilization.
- **End-of-life care.** Two ACOs identified end-of-life care planning and advance directives as an important opportunity to improve care and reduce cost by ensuring that patients get the care they want and avoiding unnecessary care. One ACO reported that care coordinators would play an important role in this strategy by identifying appropriate patients, completing necessary patient eligibility requirements, and preparing patients and providers for end-of-life planning conversations.

Discussion and Implications

The ACO strategies and challenges reported in this brief can inform the early development of rural ACOs and help other rural providers and organizations assess their readiness for ACO participation. Certain structures and processes, such as enhanced HIT capability and expanded care management capacity, are fundamental to ACO operations, yet can be costly to acquire and to implement. To support the financial investment required for ACO development the Centers for Medicare and Medicaid Innovation (CMMI) has used two special programs to assist MSSP ACOs. The Advance Payment Demonstration Program offered up-front and monthly capitated payments for physician-based and rural ACOs during two cycles of ACO approval.⁶ The ACO Investment Model, which began with applications in the last quarter of 2014, offers prepaid shared savings for ACO formation in rural and underserved areas⁷. For rural ACOs to succeed, our four case studies revealed several challenges that need to be addressed.

Challenges common to all ACOs face in their strategies to succeed may manifest differently in rural settings. For example, the four ACOs in our study implemented strategies to redesign care delivery both within and between providers and organizations. Doing so in these rural environments requires coordinated action and may also require repurposing certain resources (e.g., facilities and professionals) as new opportunities and needs arise (for example, a hospital may become a community health hub) to remain relevant in a value-based healthcare system. Repurposing is especially important in communities where health care represents a large economic base, as is common in rural areas. ACOs can facilitate and coordinate necessary healthcare system changes, but must match health care redesign with program incentives; that is, health care redesign must result in shared savings if ACOs are to be economically viable.

ACOs must also design care systems that are compatible with specific local circumstances, yet still achieve optimal cost and quality results. As an example of the rural context for implementing this strategy, one ACO recognized that the geographic dispersion of its patients and providers required a tradeoff between an adequately sized patient panel and provider coordination. A larger service area allows greater opportunity to spread risk across a larger population, but it challenges effective partnering and coordination between providers. A well-functioning health information exchange would reduce the impact of geography on communication and coordination. In another example, splitting Medicare beneficiaries among multiple Medicare initiatives, specifically creating a Medicare MSSP ACO in the same rural area as an active Medicare Advantage plan, may fragment an already small population. If incentives align (e.g., financial reward for savings generated through care management)

the same local rural practice may see a sufficient return on investment. However, this assumes that both the MSSP ACO and the MA plan share savings and/or the cost of investing in new programs with provider organizations. Advance planning to align the efforts is an important action. Further, as the programs evolve the managers in our sites where both exist suggested examining, and potentially redesigning, the incentives built into public policies for both efforts, perhaps even finding ways to merge them such as assigning MA beneficiaries to ACOs under contractual arrangements between the MA plans and the ACOs.

¹ Joint Committee Print. *Compilation of Patient Protection and Affordable Care Act as Amended through November 1, 2010*. Washington D.C.: U.S. Government Printing Office. November, 2010: p 313.

² Medicare Shared Savings Program Accountable Care Organizations. Available at <https://data.cms.gov/ACO/Medicare-Shared-Savings-Program-Accountable-Care-O/ay8x-m5k6>. Accessed December 5th, 2014

³ Pioneer ACO Model. Available at <http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/index.html>. Accessed November 30, 2014

⁴ Larson BK, Van Citters AD, Kreindler SA, Carluzzo KL, Gbemudu JN, Wu FM, Nelson EC, Shortell SM and Fisher ES (2012) Insights from transformations underway at four Brookings-Dartmouth accountable care organizations. *Health Affairs*, 31(11):2395-2406. doi: 10.1377/hlthaff.2011.1219

⁵ Sillow-Carroll S, and Edwards JN (2013) Early Adopters of the Accountable Care Model: A Field Report on Improvement in Health Care Delivery. *The Commonwealth Fund*. Available at <http://www.commonwealthfund.org/publications/fund-reports/2013/mar/early-adopters-accountable-care-model>. Accessed November 20, 2014.

⁶ Advance Payment ACO Model. Available at <http://innovation.cms.gov/initiatives/Advance-Payment-ACO-Model/index.html>. Accessed December 1, 2014.

⁷ ACO Investment Model. Available at <http://innovation.cms.gov/initiatives/ACO-Investment-Model/index.html>. Accessed December 1, 2014.