Understanding the Use of Accountable Care Organizations in Rural Health Care Settings

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Context of Change

- Increasingly intensive focus on cost
- New models rolling out – ambulatory
- System expansion/growth
- Mergers, acquisitions, affiliations
What It All Means

- A rural community focus
- What is needed?
- What do we have?
- How do we play in a way that sustains essential local services?
Buzzwords of the day

- Value
- Patient-centered
- Choice
- Savings
Health Care Organizations of the Future

- Accepting insurance risk
- Focus on population health
- Trimming organization costs
- Using the data being captured (e.g., electronic health records)
- Health care as retail business
Implications

- Transitions have to be managed
- First do no harm
- Relationships among strange bedfellows (urban and rural, systems and independents, institutions and community-based providers)
- Value, value, value proposition is critical
- Flexibility in business plans means flexibility in policy models
Welcome to the World of ACOs

- Not just a buzz word
- Is a new model, built on use of data systems and management strategies
- Provider systems focused on health
They’re Here .................

- Private started before Medicare
- Medicare Pioneer, MSSP, Advanced Payment
- Almost daily stories on more being formed
- And they are in rural places (the first 59 Medicare ACOs)
Accountable Care Organizations

Pioneer and Shared Savings ACOs, Western Census Region
Accountable Care Organizations

Pioneer and Shared Savings ACOs with rural coverage, Western Census Region

Legend:
- Metropolitan county
- Non-metropolitan county
- ACO coverage area

Logos:
- RUPRI (Rural Policy Research Institute)
- University of Iowa
Accountable Care Organizations
Pioneer and Shared Savings ACOs
Midwest Census Region

Metropolitan county
Non-metropolitan county
ACO coverage area
Accountable Care Organizations

Pioneer and Shared Savings
ACOs with rural coverage,
Midwest Census Region

[Map showing the coverage areas of ACOs in the Midwest Census Region, with circles indicating metropolitan and non-metropolitan counties.]
Accountable Care Organizations
Pioneer and Shared Savings ACOs
with rural coverage,
South Census Region

Metropolitan county
Non-metropolitan county
ACO coverage area
Accountable Care Organizations

Pioneer and Shared Savings ACOs
Northeast Census Region
Accountable Care Organizations

Pioneer and Shared Savings ACOs with rural coverage, Northeast Census Region
32 Pioneer ACOs
116 MSSP ACOs
20 116 are Advanced Payment
221 private sector ACOs
ACO DISTRIBUTION BY STATE

ACO DISTRIBUTION BY HOSPITAL REFERRAL REGION

ACOs in Region C


- **IN**: 2 Hospital System, 1 Insurer
- **KS**: 1 Insurer
- **WI**: 7 Hospital System, 2 Physician Group, 1 Insurer
- **IA**: 3 Hospital System, 2 Insurer
Continued

- **IL**: 2 Hospital System, 1 Physician Group, 1 Insurer
- **NE**: 2 Hospital System
- **MI**: 8 Hospital System, 3 Physician Group, 1 Insurer
- **MN**: 4 Hospital System, 2 Physician Group
- **OH**: 8 Hospital System, 1 Insurer
- **MO**: 3 Hospital System, 1 Insurer
Colorado Accountable Care Collaborative: began pilot in 2011
New Jersey Medicaid ACO Demonstration: authorizing legislation passed in 2011
Oklahoma Accountable Care Organization for Dual Eligibles: PCCM program, contemplating Medicare ACO
Continued

- Oregon Coordinated Care Organization Plan: authorizing legislation enacted in early 2012; implementation underway
- Utah Accountable Care Organization Program: Pending CMS waiver approval
Are Rural Challenges Being Met?

- Preserving rural autonomy
- Adapting rural practice design
- Adapting to low rural volumes
- Baseline against historical rural efficiency
Are Rural Challenges Being Met?

- Meeting urban motivations in regional design
- Addressing urban provider cost structure
- Overcoming legal and regulatory barriers
- Accelerating learning curves for rural leaders
Positioning Rural Providers

- Developing networks: exclusively rural, regional collaboratives, rural participation in large systems – best positioning for rural providers
- Understanding motivations of parties to negotiations: rural-urban, urban-rural, public-private, private-public
- Adopting best practices in patient care and clinic management
- Developing performance measures
Considerations for Continued ACO Development in Rural Places

- Provider readiness/support
- Flexibility in design
- Effects on payment and revenue
- Part of the move to pay for value
For Further Information

The RUPRI Center for Rural Health Policy Analysis

http://cph.uiowa.edu/rupri

The RUPRI Health Panel

http://www.rupri.org
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