

Fitting the ACO Model to Rural Circumstances

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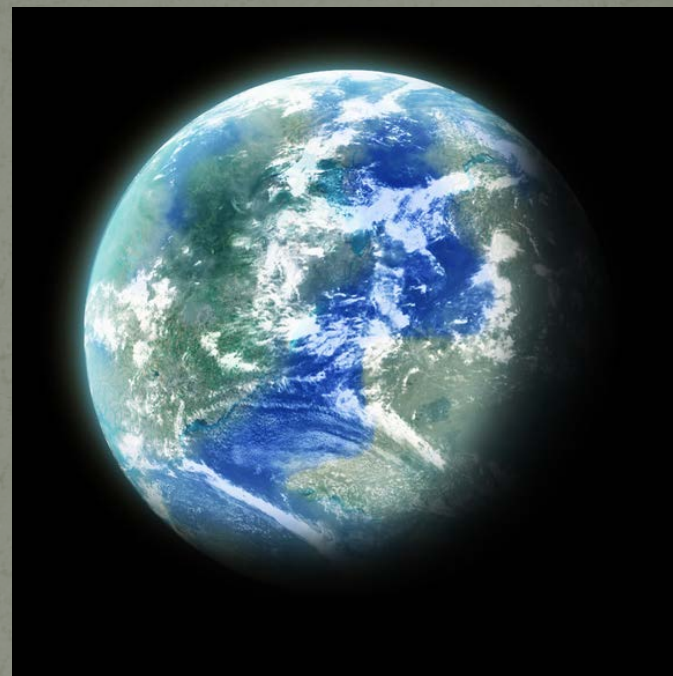
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The Brave New World

- Volume to Value in Payment Systems
- New Goals for Savings
- Public and private payers, but the lead is coming from Medicare



Speed and Magnitude: Goals for Medicare Payment

- 30 percent of Medicare provider payments in alternative payment models by 2016
- 50 percent of Medicare provider payments in alternative payment models by 2018
- 85 percent of Medicare fee-for-service payments to be tied to quality and value by 2016
- 90 percent of Medicare fee-for-service payments to be tied to quality and value by 2018

Parallel in Commercial Insurance

- Coalition of 17 major health systems, including Advocate Health, Ascension, Providence Health & Services, Trinity Health, Premier, Dartmouth-Hitchcock
- Includes Aetna, Blue Cross of California, Blue Cross/Blue Shield of Massachusetts, Health Care Service Corporation
- Includes Caesars Entertainment, Pacific Business Group on Health
- Goal: 75 percent of business into value-based arrangements by 2020

Source: <http://www.hcttf.org/>

Evolution of Medicare Payment Through Four Categories

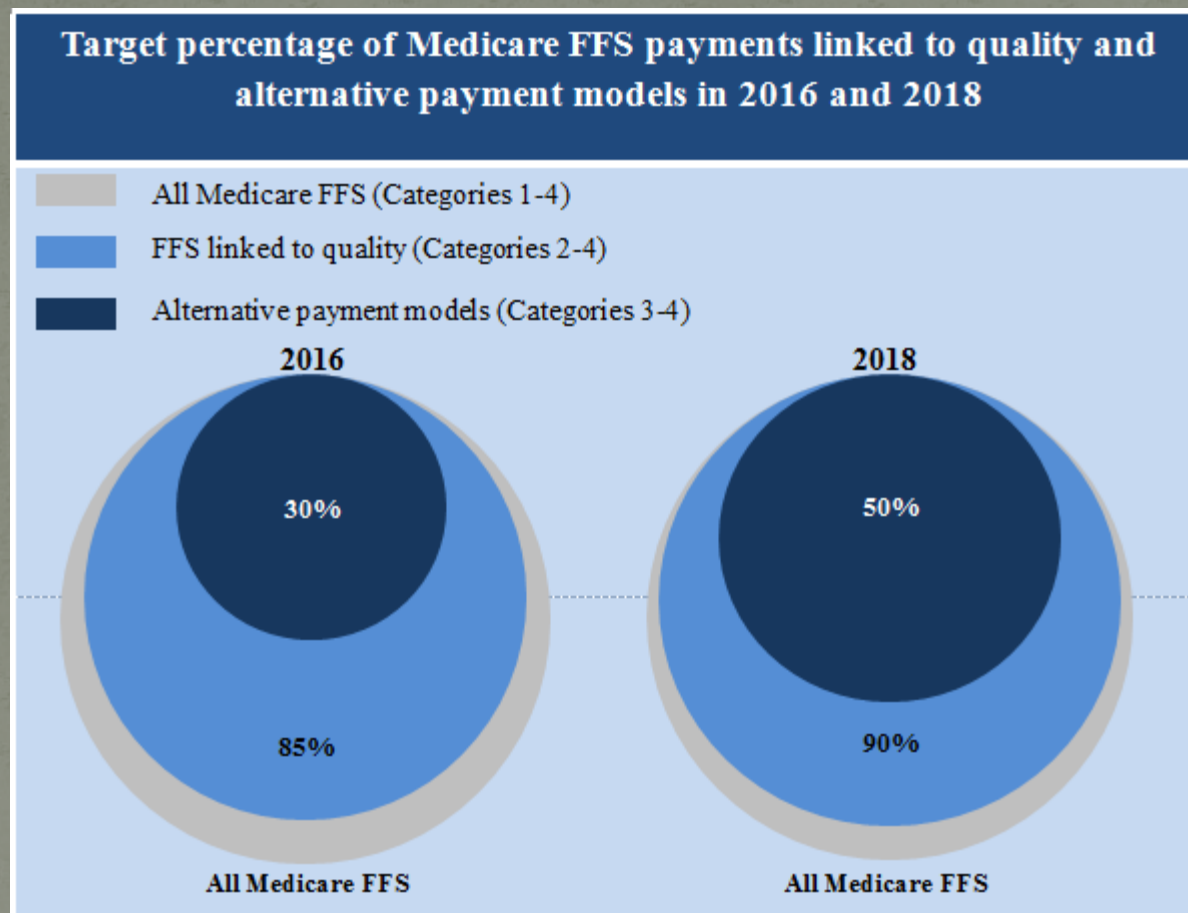
- Fee-for-service with no link to quality
- Fee-for-service with link to quality
- Alternative payment models built on fee-for-service architecture
- Population-based payment

Source of this and following slides: CMS Fact Sheets available from [cms.gov/newsroom](https://www.cms.gov/newsroom)

Illustration of Move to Population-Based Payment

Payment Taxonomy Framework				
	Category 1: <i>Fee for Service—No Link to Quality</i>	Category 2: <i>Fee for Service—Link to Quality</i>	Category 3: <i>Alternative Payment Models Built on Fee-for-Service Architecture</i>	Category 4: <i>Population-Based Payment</i>
Description	<i>Payments are based on volume of services and not linked to quality or efficiency</i>	<i>At least a portion of payments vary based on the quality or efficiency of health care delivery</i>	<i>Some payment is linked to the effective management of a population or an episode of care. Payments still triggered by delivery of services, but opportunities for shared savings or 2-sided risk</i>	<i>Payment is not directly triggered by service delivery so volume is not linked to payment. Clinicians and organizations are paid and responsible for the care of a beneficiary for a long period (e.g. ≥ 1 yr)</i>
Medicare FFS	<ul style="list-style-type: none"> Limited in Medicare fee-for-service Majority of Medicare payments now are linked to quality 	<ul style="list-style-type: none"> Hospital value-based purchasing Physician Value-Based Modifier Readmissions/Hospital Acquired Condition Reduction Program 	<ul style="list-style-type: none"> Accountable care organizations Medical homes Bundled payments Comprehensive primary care initiative Comprehensive ESRD Medicare-Medicaid Financial Alignment Initiative Fee-For-Service Model 	<ul style="list-style-type: none"> Eligible Pioneer accountable care organizations in years 3-5

Shrinking Band of Traditional Payment



CMS Slogan: **Better Care,** **Smarter Spending, Healthier People**

- Comprehensive Primary Care Initiative: multi-payer (Medicare, Medicaid, private health care payers) partnership in four states (AR, CO, NJ, OR)
- Multi-payer Advanced Primary Care Initiative: eight advanced primary care initiatives in ME, MI, MN, NY, NC, PA, RI, and VT
- Transforming Clinical Practice Initiative: designed to support 150,000 clinician practices over next 4 years in comprehensive quality improvement strategies

CMS Slogan: Better Care, Smarter Spending, Healthier People

- Pay for Value with Incentives: Hospital-based VBP, readmissions reduction, hospital-acquired condition reduction program
- New payment models: Pioneer Accountable Care Organizations, incentive program for ACOs, Bundled Payments for Care Improvement (105 awardees in Phase 2, risk bearing), Health Care Innovation Awards

CMS Slogan: Better Care, Smarter Spending, Healthier People

- Better coordination of care for beneficiaries with multiple chronic conditions
- Partnership for patients focused on averting hospital acquired conditions

A New Tidal Wave: ACOs

- Boost in number and momentum from the Medicare program
- But also in the Medicaid program
- And through commercial contracts (including Medicare Advantage plans)



Tally Sheet

- ✓ 700+ public and private ACOs
- ✓ 405 Medicare ACOs
- ✓ 19 Pioneer ACOs
- ✓ 35 are Advance Payment
- ✓ Medicare ACOs located in 48 states (and DC and Puerto Rico)



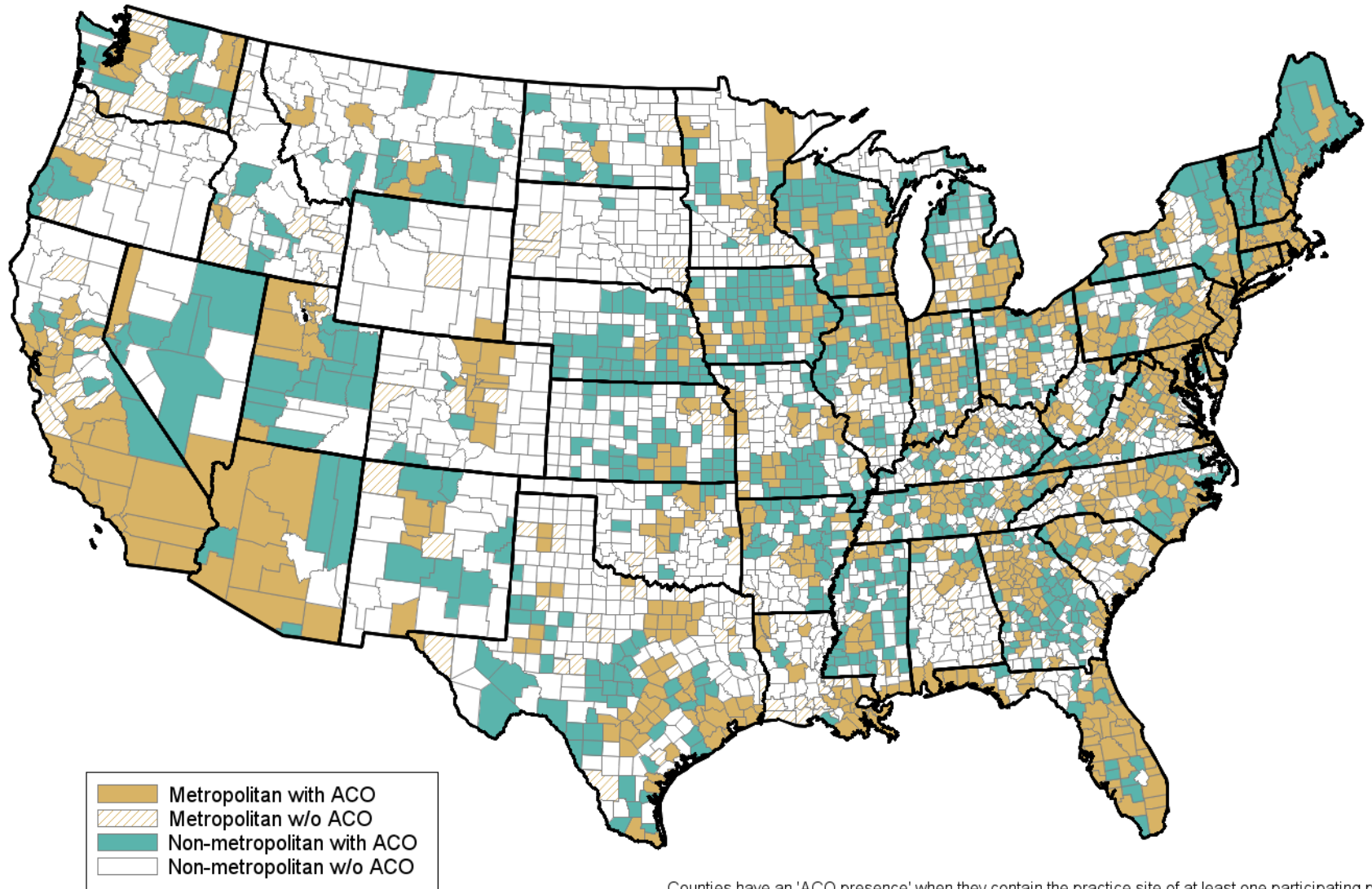
ACO's in Rural Places

- 113 ACOs operate in a combination of metro and non-metro counties
- 92 ACOs are “mostly metro” but include rural
- 7 ACOs operate exclusively in rural areas, including 1 such ACO in 3 of the 4 census regions
- Growth in consortia, systems with rural providers

Source: RUPRI analysis of data obtained from public sources and ACOs

County Medicare ACO Presence

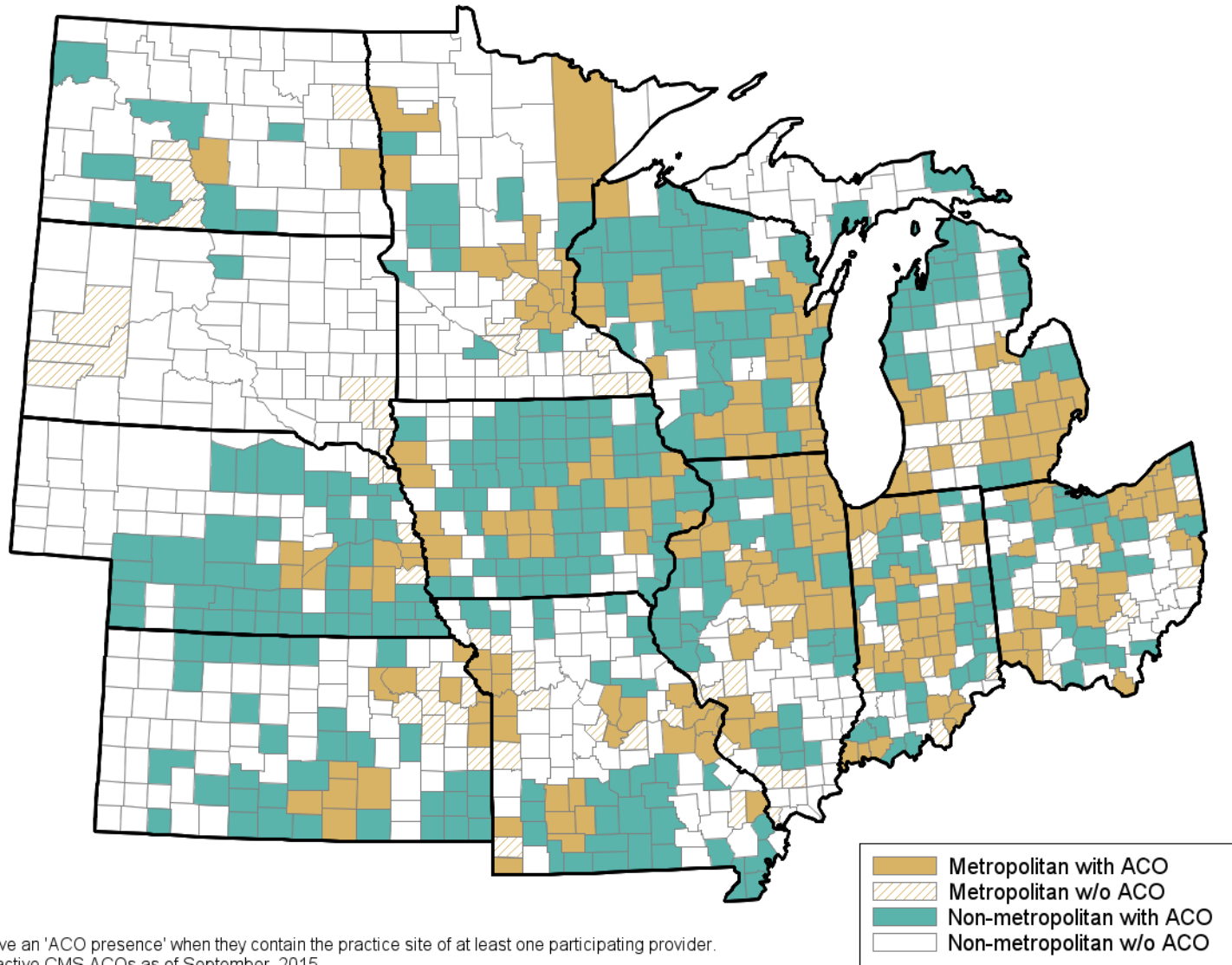
Continental United States



Counties have an 'ACO presence' when they contain the practice site of at least one participating provider.
Includes all active CMS ACOs as of September, 2015.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2015.

County Medicare ACO Presence

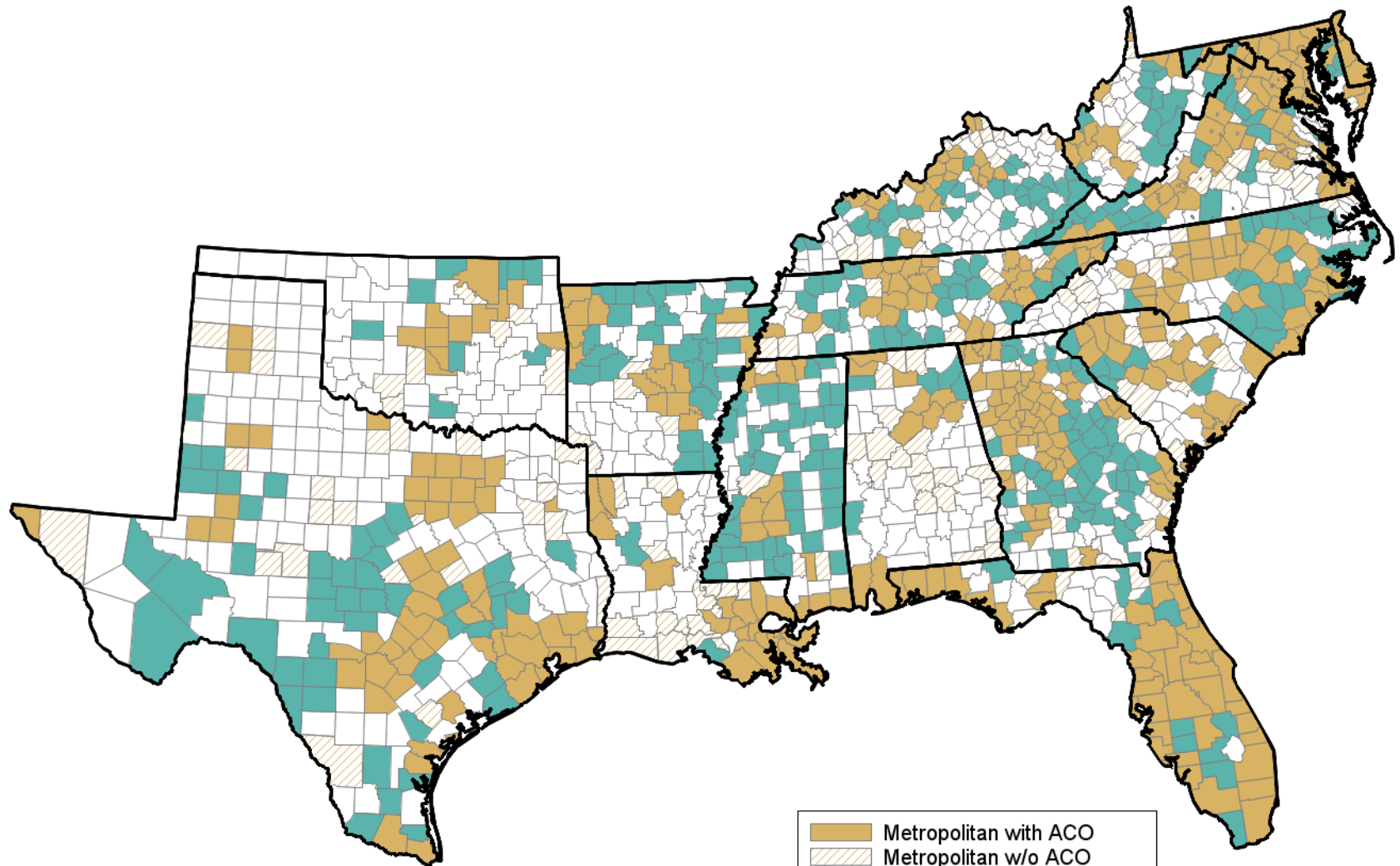
Midwest Census Region



Counties have an 'ACO presence' when they contain the practice site of at least one participating provider.
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County Medicare ACO Presence

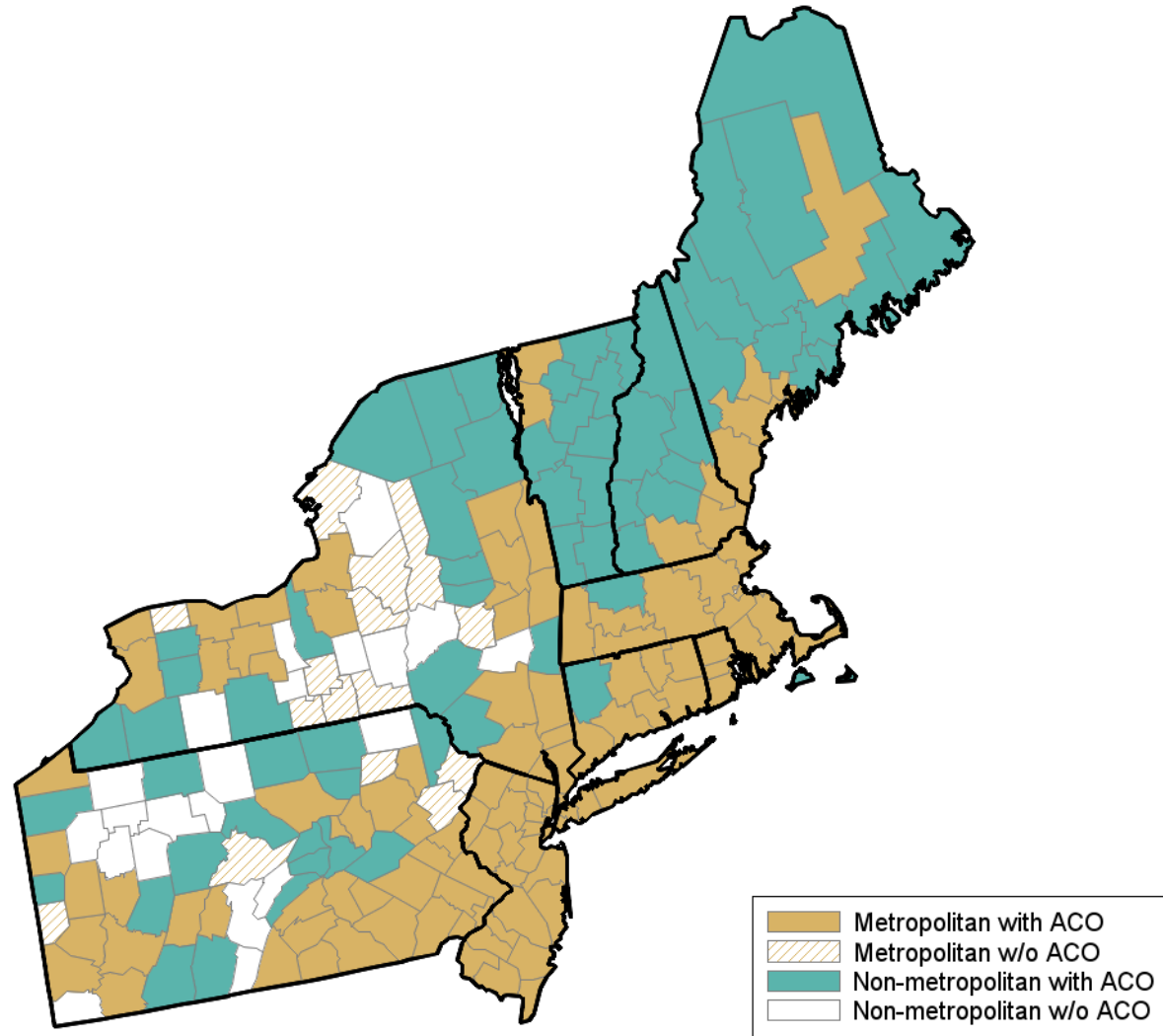
South Census Region



Counties have an 'ACO presence' when they contain the practice site of at least one participating provider. Includes all active CMS ACOs as of September, 2015. Produced by: RUPRI Center for Rural Health Policy Analysis, 2015.

County Medicare ACO Presence

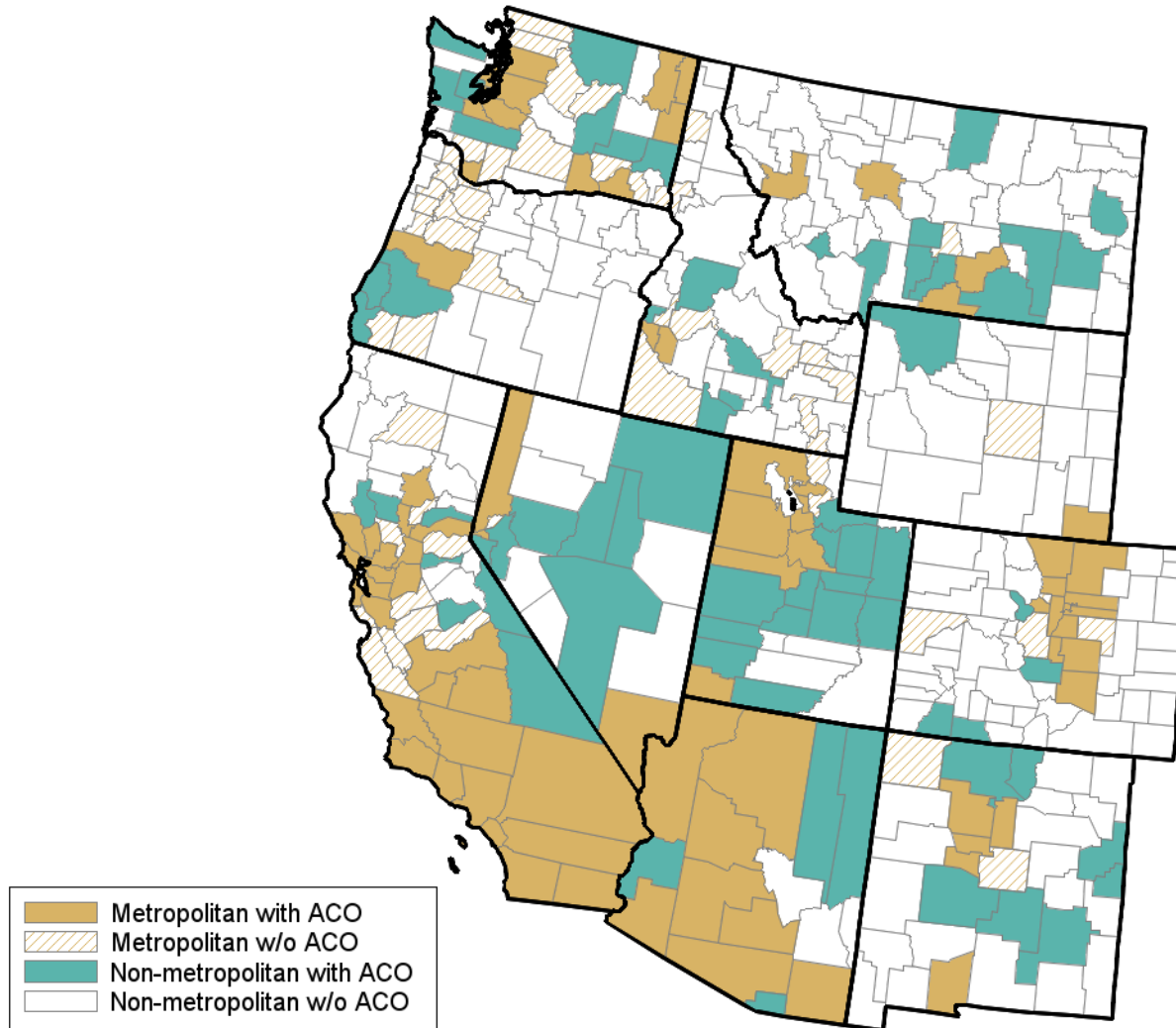
Northeast Census Region



Counties have an 'ACO presence' when they contain the practice site of at least one participating provider.
Includes all active CMS ACOs as of September, 2015.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2015.

County Medicare ACO Presence

West Census Region



Counties have an 'ACO presence' when they contain the practice site of at least one participating provider.
Includes all active CMS ACOs as of September, 2015.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2015.

Consortia ACOs

- National Rural Accountable Care Consortium
- 52 entities, including 28 rural and CAHs, 42 health clinics, 12 FQHCs and 9 private physician practices
- Aggregate beneficiaries from geographically dispersed entities
- Opens up aura of competition for ACO providers

Who Are They?

- Illinois Critical Access Hospital Network formed ACO with 19 CAHs as members and added 2 – 14,000 beneficiaries
- Trinity Pioneer ACO in Iowa: 9,342 beneficiaries
- SERPA-ACO in Nebraska: 11,175 beneficiaries
- Alegent Health Partners, LLC in Iowa and Nebraska: 25,954 beneficiaries



How Are They Performing?

- Well, it all depends
- Pioneer ACOs dropped from 32 to 19, 15 of whom generated savings in Performance Year 3 and 11 earned shared savings
- Total savings per Pioneer ACO in year 1 was \$2.7 million, \$4.2 million in year 2, \$6.0 million in year 3

How Are They Performing?

- In 2014 92 MSSP ACOs spend \$806 million less than targets, and received payments
- Question: do savings balance total cost?
- Question: what are the net savings to Medicare?



What About Rural and Mixed ACOs?

- One (of 4) rural received bonus payment: Jackson Purchase Medical Associates in Kentucky/Illinois
- Among 14 “mostly rural” ACOs none received bonus payment, 6 realized savings (4 had no performance data)
- Among 83 “mixed” ACOs, 14 received bonus payment

Performance on Quality Indicators

- Overall improvement:
Pioneer quality scores of 71.8% in Year 1, then 85.2% and 87.2%
- Pioneer improvements in 28 of 33 quality measures
- MSSP improvement on 27 of 33 measures 2013 to 2014
- Among highest quality scores in 2014: SERPA-ACO, 93.57%; Mercy ACO (Des Moines), 93.27%



Next Up for Rural: ACO Investment Model

- Pre-paid shared savings upfront and ongoing per beneficiary per month payments
- ACO accepted into MSSP
- ACO completely and accurately reported quality measures in most recent performance year if ACO started in 2012, 2013, or 2014
- ACO not owned or operated in whole or in part by a health plan
- ACO did not participate in the Advance Payment Model

Next Up for Rural: ACO Investment Model

- Targets rural areas and areas of low ACO penetration and ACOs committed to higher tracks
- Preference to ACOs that provide high quality of care and achieve financial benchmark



Next Up for Rural: ACO Investment Model

- Up front fixed payment
- Upfront variable payment based on number of beneficiaries
- Monthly payment depending on size of ACO



Medicaid

- ACO development being seen as an answer to cost of current and expanded program
- Reduced payments in systems based on pay for service
- Other innovations to reduce cost such as primary care case management, divert from emergency rooms



Early Results in Medicaid

- 8 states with active ACO programs, 10 states considering
- Colorado: \$44 million in gross savings or cost avoidance in FY 2013; reduced hospital readmissions 15-20%
- Oregon: in place 16 months, 90% of Medicaid beneficiaries
- Source: ACO Business News January, 2014

Should I Join an ACO?

- Perhaps, but not for lots of \$
- To obtain utilization and service location data
- To support transition through new techniques of
 - Population health management
 - Financial risk management
 - Preparing for population-based payment (capitation)

How Would I Be Successful?

- Commonwealth Fund study of projected ACO core components and 42 associated capabilities
 - People-centered care
 - Health homes
 - High value network
 - Payer partnership
 - Population health data management
 - ACO leadership

RUPRI Center Research

- Case studies of four ACOs active in rural counties
- One each of the four census regions
- Survey of 27 ACOs active in rural counties



Facilitating Rural ACO Formation

- Previous organizational integration among local healthcare organizations: multispecialty clinic in a PHO; 2 hospital systems and medical staff; physician IPA and hospital systems
- Risk-sharing experience: with Medicare Advantage, owning their own insurance plan

Facilitating Rural ACO Formation

- Information technology: in all four sites providers shared the same EHR; telehealth capabilities in three sites
- Strategic partnerships: with local employers and business leaders, with human service organizations, with healthcare providers not part of ACO structure (e.g., long term support services)

ACO as a Developmental Strategy

- Step toward value-driven rural delivery system, with or without ROI for this specific venture
- Strategies to increase value: care management, post-acute care redesign, medication management, end-of-life care planning



Findings from Survey of 27 ACOs

- Sixteen rural ACOs were formed by pre-existing integrated delivery networks.
- Physician groups played a more prominent role than other participant types (including solo-practice physicians) in the formation and management of these rural ACOs.

Findings from Survey of 27 ACOs

- Thirteen rural ACOs included hospitals with quality-based payment experience, and 11 rural ACOs included hospitals with risk-sharing experience.
- Twelve rural ACOs included physician groups with both quality-based payment and risk-sharing experience.
- Managing care across the continuum and meeting quality standards were most frequently considered by respondents to be “very important” to the success of rural ACOs.

For Further Information

Rural Health Value

<http://ruralhealthvalue.org>

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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