Accountable Care Organization Participation as a Platform for Transformation

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Overview of This Presentation

- Genesis of the ACO Model
- Growth of ACOs since 2012
- Early successes (financial and in quality metrics), related characteristics
- Rising tides
- Issues of policy and practice alignment
- Building from an ACO platform
Genesis of the ACO Model

- Began with a model relying on physician group practices to control utilization
- While maintaining quality
- Integrates quality metrics with expenditure targets
- Target is total cost of care for defined populations
- Works in principle if market adjustments occur simultaneously, with covered lives replacing service volume as revenue stream
Growth of the ACO Phenomenon

- 61 in 2011 to 923 in 2017
- Increase of 2.2 million covered lives in year ending with first quarter of 2017 to reach 32 million
- In all states; only 15 hospital referral regions not served by an ACO

World of Medicare ACOs

- 480 Shared Savings ACOs in 2017
- 9.0 million assigned beneficiaries (in MSSP) in 50 states, Washington D.C., and Puerto Rico
- 438 Track 1
- 42 Tracks 2 and 3
- 45 ACO Investment Model ACOs (subset of MSSPs)
- Plus 44 Next Generation ACOs
Providers Participating Include

- Networks of individual practices: 267
- Federally Qualified Health Centers: 65
- Rural Health Clinics: 71
- Critical Access Hospitals: 55
Rural Presence

- Where the providers are located
- Where the assigned beneficiaries live
County Medicare ACO Presence
Continental United States

Metropolitan/Non-metropolitan ACOs
- Metropolitan with ACOs
- Non-metropolitan with ACOs
- Metro. ACO, unknown area
- No ACOs
- 'Known' ACO city location

CMS-designated sites as of January, 2013.
Produced by: RUPRI Center for Rural Health Policy Analysis, 2013.
County Medicare ACO Presence
Continental United States

- Metropolitan with ACO
- Metropolitan w/o ACO
- Non-metropolitan with ACO
- Non-metropolitan w/o ACO

Counties have an 'ACO presence' when they contain the practice site of at least one participating provider. Includes all active CMS ACOs as of August, 2015. Produced by: RUPRI Center for Rural Health Policy Analysis, 2016.
Medicare Shared Savings Program ACO Assigned Beneficiary Population by ACO by County
(counties with more than 1 percent of an ACO’s assigned beneficiaries)
Medicaid ACOs

- 10 states with active Medicaid ACO programs
- Colorado: $77 million savings from Regional Care Collaborative Organizations in 2014 report
- Minnesota: $76.3 million savings in Integrated Health Partnerships program in first two years
- Oregon: ED visits reduced 23%, reductions in ambulatory-sensitive conditions admissions; all Coordinated Care Organizations earned bonuses in FY 2015

Factors Contributing to Early Development of ACOs

- Commitment to person-centered health care
- Health home providing primary and preventive care
- Population health and data management capabilities
- Provider network that delivers top outcomes at reduced cost
- Established ACO governance structure
- Payer partnership arrangements

Characteristics of Early Rural ACOs

- Formed by pre-existing integrated delivery networks
- Physician groups played prominent role in formation and management
- 13 of 27 included hospitals with quality-based payment experience, and 11 included hospitals with risk-sharing experience; 12 included physician groups with both
- Managing care across continuum considered very important

Early Performance of ACOs

- First year spending reductions greater in independent primary care groups
- 31% received bonuses for 2015 performance (27% in 2014)
- Quality scores improved year 1 to 2, but no direct relationship to savings
- Physician-led and smaller ACOs seem to perform better (national data)


Success (savings) associated with physician-based

Advanced Payment Program ACOs more likely to generate savings (8 of 11 did so)

No association with ACO size or experience

ACOs in rural counties perform better than urban on Care Coordination/Patient Safety, Preventive Health, and At-Risk Population Domain scores (2014)

Urban outperform others on Patient/Caregiver Experience score (2014)

All improved 2014 to 2015

Findings from Current RUPRI Research

- Rural ACOs’ quality performance is lower than urban ACOs’ with larger variation.
- ACOs that are sponsored by hospital system, participate in the program for more than one year, receive advance payment, and have larger beneficiary panels perform better than their counterparts.
- Percentages of primary care provided by advanced practice providers or health centers are positively associated with quality performance.
Physician engagement and leadership, including prior activity

Collaboration across key providers, especially physicians and hospitals

Sophisticated information systems

Scale needed for investment or an initial outside source of capital

Effective feedback loops to care providers

Rising Tides: Disruptive Change Agents

- Next Generation ACO Program
- Provider affiliations to form ACOs
- Systems spreading ACOs
- Aggregators
High risk arrangement model – up to 80% or 100%
Prospective assignment of beneficiaries
Can move to capitated payment
Waivers: SNF 3-Day Rule; Telehealth originating site expansion
Post-discharge home visits
Provider Affiliations to Form ACOs

- Community Partnership of Maine: 11 organizations across the state; 3 hospitals, 8 FQHCs
- Chautauqua Integrated Delivery System: 4 rural hospitals, 11 primary care practices, 3 SNF facilities
- Illinois Rural Community Care Organization: 21 CAHs with 14,000 beneficiaries
Systems Spreading ACOs to Rural Locations

- In this room ...
- Billings Clinic in Montana
- Belin Health System in Wisconsin
Aggregators

- Collaborative Health Systems (wholly-owned subsidiary of Universal American Corporation): 24 ACOs
- Caravan Health: 22 ACOs
- Imperium Health: 12 ACOs
- Mission Point Health Partners: 5 ACOs
- Citra Health Solutions: 4 ACOs
- AmpliPHY Physician Services: 3 ACOs
Next Generation Program waivers an indication of what is needed

In rural settings aligning payment designed to assure access to services by creating a reliable and sufficient source of revenue, with incentives to lower current expenditures (pressuring current price over long term total cost)

Skilled nursing care and use of swing beds as an example

Payment for preventive services vs all inclusive rate another example

Worth emphasizing **total cost of care** as the goal
Practice alignment should be a rural advantage – primary care, person-centered health home a driver

Infrastructure that includes use of telehealth to support personal care, care across continuum (including access to off-site specialists)

Extensive of protocols in care management, especially for high-cot patients
A clinical care-based approach

Care redesign: PCMH/PCHH – incorporate behavioral health, long term supports and services

Care management: patients with complex needs

Patient engagement/activation (including family members)

Integrated data analytics

Starting with the population attributed to the ACO and needs related to chronic illness including behavioral health

Engaging safety net providers in managing care of vulnerable populations

The Accountable Health Communities model and engaging social service agencies in the care continuum

Addressing Non Medical Needs (Social Determinants of Health)

- Transportation
- Housing
- Food insecurity

Platform for Change: Social ACO Model

- Commonwealth Care Alliance (CCA)
- Includes dual-eligible population
- Fully integrates social and clinical services
- Person-centered approach
Particular Needs: Medicaid ACOs and Social Services

- Requiring relationships with public health entities and/or community-based organizations
- Demonstrating partnerships with social service agencies
- Require community advisory council and community health needs assessment
- Collaboration within the parameters of global budget
- Quality metrics for education, employment, and housing

Returning to Basics

- Total cost of care
- Care management affecting utilization
- Revenue streams as function of enrolled lives and shared risk
- Thinking beyond medical care
- End game is better care, better health, lower cost
For further information

The RUPRI Center for Rural Health Policy Analysis
http://cph.uiowa.edu/rupri

The RUPRI Health Panel
http://www.rupri.org

Rural Telehealth Research Center
http://ruraltelehealth.org/

The Rural Health Value Program
http://www.ruralhealthvalue.org
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