Accountable Care Organizations and Critical Access Hospitals

Keith J. Mueller, Ph.D.
Director, RUPRI Center for Rural Health Policy Analysis
Head, Department of Health Management and Policy
College of Public Health
University of Iowa

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The Patient Protection and Affordable Care Act Changes the Landscape

- Value Based Purchasing is here to stay, for CAHs a demonstration program followed by implementation by 2018 (Section 3001)
- Bundled payment across providers; Secretary to consult with CAHs in pilot program by 2013 (section 3023)

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Continued

- Quality reporting continues to evolve
- Now part of a national plan, released March 21
- Activities of the new Center of Medicare and Medicaid Innovation; without constraint of budget neutrality

Section 3022: Medicare Shared Savings Program

- Emphasis of the title is intentional
- Coordinate care in the FFS program through Accountable Care Organizations (ACOs)
- Must meet quality standards
- Accountable for patients for at least three years

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ACOs: Eligibility

- Could start with physicians
- Could start with hospitals
- Need formal legal structure to receive and distribute funds
- Need 5,000 beneficiaries

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- Leadership and management structure
- Process to promote evidence-based medicine, report data on quality measures, coordinate care
- Meet patient-centeredness criteria

Savings

- As compared to benchmark amount (benchmark to be determined by CMS)
- Meeting clinical standards in process, outcomes, patient experience, utilization (latitude for CMS)
- Sustaining the savings a challenge

Some Troublesome Assumptions Being Modified

- Requires large multi-disciplinary practices: one study published in May 2010 Health Affairs found 3.6% lower annual costs from group practices
- Minimum population requirements – meet for one carrier at a time or for multiple carriers?

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Flexibility: The three tiers approach (Shortell, Casalino and Fisher in July 2010 Health Affairs)

- **Tier 1**: minimal financial risk but eligible to receive shared savings and bonuses for meeting quality benchmarks and reduces per beneficiary spending
- **Tier 2**: eligible to receive greater proportion of savings if achieve spending rates below target, but also at risk for spending above target; partial capitation; report more comprehensive data
- **Tier 3**: full capitation or extensive partial capitation and bundled payments; highest potential reward but with greatest risk

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Measuring Performance of ACOs (from Health Affairs May 2010 article by McClellan et al)

- Care Coordination: hospital readmissions, depression follow-up and management to reconciled medication list and discharge plan
- Care effectiveness/population health: cancer care screenings to quality of life and functional outcomes

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Continued

- Safety: testing for patients using high-risk medications to outpatient medication errors
- Patient engagement: physician instructions understood
- Overuse/efficiency: imaging for low back pain during first 30 days to episode-based resource-use metrics linked to quality of life, functional, and patient engagement measures

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Lessons From Large Organizations: Scott & White attributes of Ideal Systems

- Information continuity
- Care coordination and transitions
- System accountability
- Peer review and teamwork for high-value care
- Continuous innovation
- Easy access to appropriate care

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Competencies Found by AHA Review of Brookings/Dartmouth, Baylor Med School, Premier

- Leadership
- Organizational culture of teamwork
- Relationships with other providers
- IT infrastructure of population management and care coordination

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Continued

- Infrastructure for monitoring, managing, and reporting quality
- Ability to manage financial risk
- Ability to receive and distribute payments or savings
- Resource for patient education and support

Other points made by AHA

- Spread of best practices
- Reach – linkages between ACOs and public health/community resources
- Regional health information exchange

Key findings from Vermont ACO Pilot

- ACO cannot exist in a vacuum
- Working design for pilot built on three major principles
  - ✓Local accountability for defined population
  - ✓Payment reform based on shared savings
  - ✓Performance measurement, including patient experience data, clinical process and outcome measures

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Continued

- Pilots need capabilities in five areas to get started
  1. Manage full continuum of care settings and services, beginning with PCMH
  2. Be financially integrated with both commercial and public payers
  3. HIT platform that connects providers in the ACO and allows for proactive patient management
  4. Physician leadership, as well as commitment of hospital CEO
  5. Have process improvement capabilities to change clinical and administrative processes

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Policy Advice

- Set realistic expectations
- Consider pairing new starts with existing ACOs
- Provide technical assistance to develop legal and other structures to support new relationships
- Provide practice redesign technical assistance

Continued

- Structure shared savings to consider historic cost-efficiency
- Offer various levels to financial risk
- Encourage other payers to develop healthcare delivery and payment models to parallel Medicare ACO program

Eight Rural Constraints

- From *Journal of Rural Health*. Winter, 2011 article by MacKinney, Mueller and McBride
- Rural provider autonomy
- Rural practice design
- Low rural volumes
- Historic rural efficiency

Continued

- Urban motivations
- Urban provider cost structure
- Legal and regulatory barriers
- Rural leadership inexperience

Strengthening Rural Provider Roles

- Developing rural provider networks in better negotiation postures
- Understand large health system motivations
- Adopting best practices in clinical management
- Help develop rural-relevant ACO performance measures

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Rural Providers in the Proposed Final Rule

- CAH: Method 1 Payment may participate, not form
- CAH: Method 2 Payment may form
- FQHC and RHC may not form, can participate in multiple ACOs
- Physician Group Practices can form, or participate in, only 1 ACO

Quality Measures in Proposed Rule

- 65 measures in 5 domains: must report all
- Meet benchmarks, either improvement or threshold
- 50% of physicians must meet meaningful use

Savings ??

- CMS keeps 2% of savings off the top
- Must achieve minimum savings, 3.9% in ACO with 5,000 beneficiaries
- Share 50% in one-sided model, 60% in two-sided

Savings ??

- Additional savings shared if RHC and/or FQHC participate; 2.5% in one-sided; 5% in two-sided
- Small ACOs share on first dollar basis

Anti-Trust in the Proposed Rule

- A 30% threshold for any review
- For each service line
- Can include rural hospital on non-exclusive basis

Resources

- Learning Network: https://xteam.brookings.edu/bdacoln/Pages/home.aspx
- Access Learning Network through: http://www.brookings.edu/health.aspx
- Presentations from RUPRI on our sites (following slide)

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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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Dr. Keith J. Mueller

Department of Health Management and Policy
College of Public Health

105 River Street, N200 CPHB

Iowa City, IA 52242

319-384-3830

keith-mueller@uiowa.edu

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