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

Source: David Mulestein, Robert Saunders, and Mark McClellan (2017) "Growth of ACOs and Alternative Payment Models in 2017," *Health Affairs Blog* June 28. accessed June 29: http://healthaffairs.org/blog/2017/06/28/growth-of-acos-and-alternative-payment-models-in-2017.

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World of Medicare ACOs

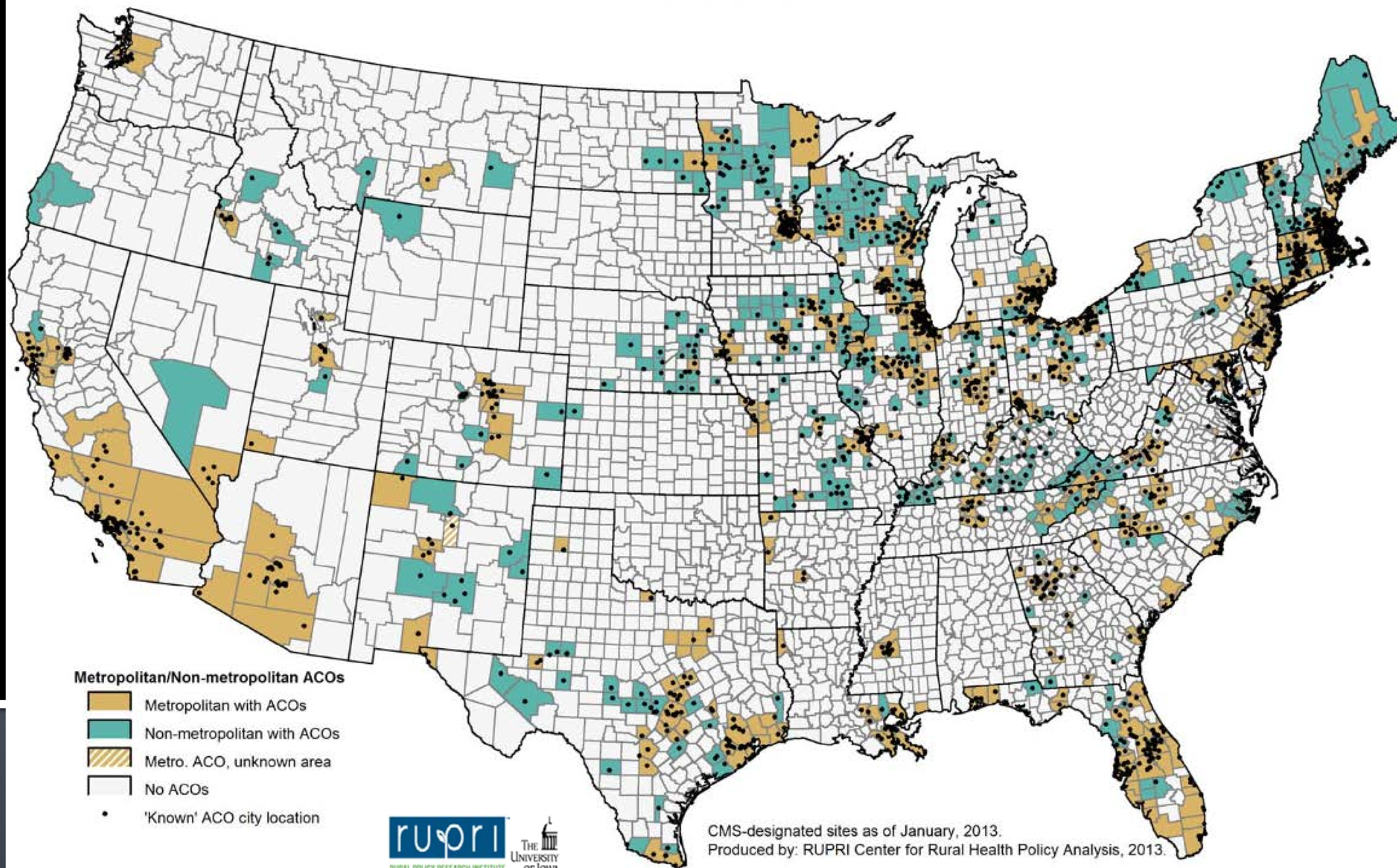
- 480 Shared Savings ACOs in 2017
- 9.0 million assigned beneficiaries (in MSSP) in 50 states, Washington D.C., and Puerto Rico
- 438 Track 1
- 42 Tracks 2 and 3
- 45 ACO Investment Model ACOs (subset of MSSPs)
- Plus 44 Next Generation ACOs

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
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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.

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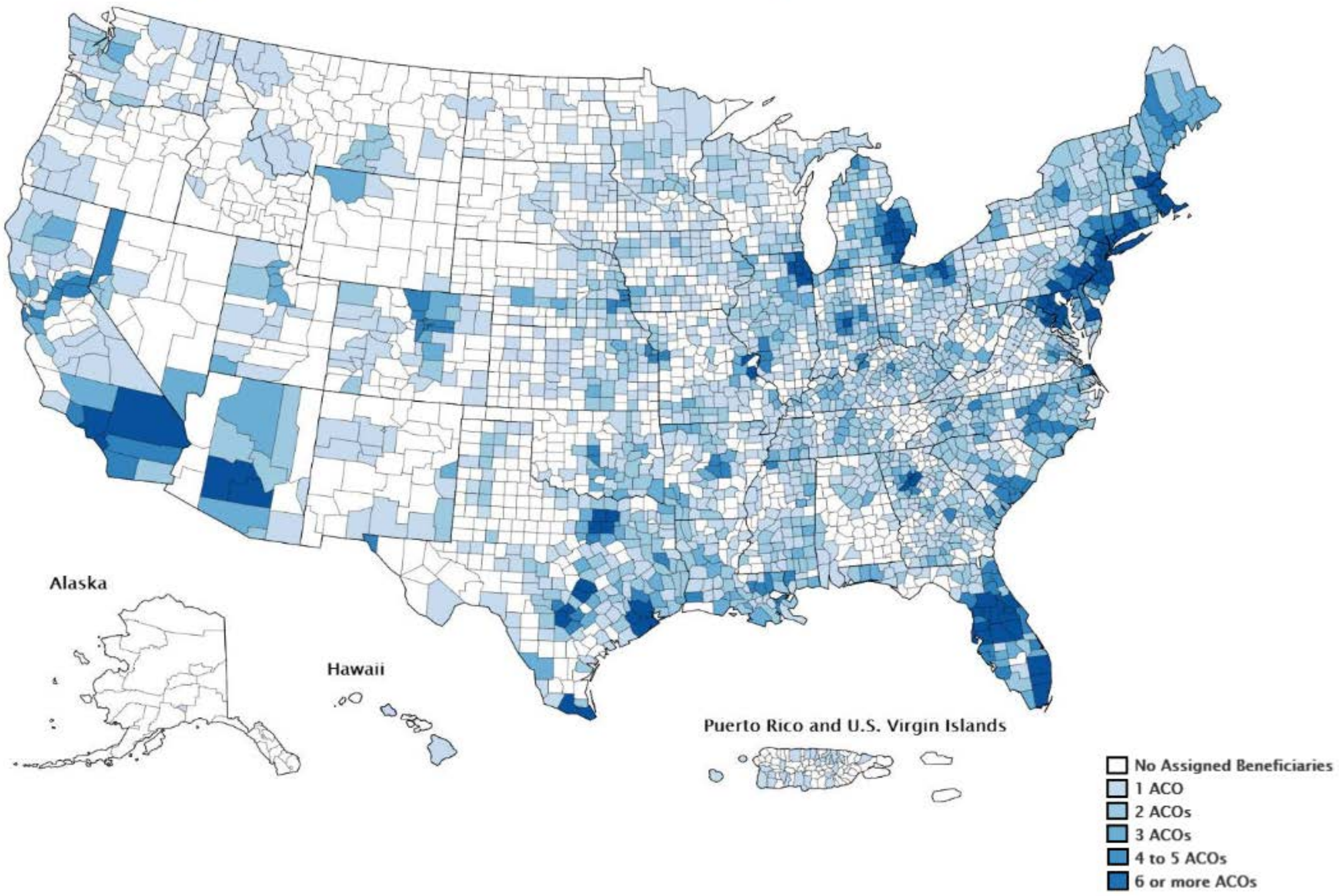
Medicare Shared Savings Program ACO Assigned Beneficiary Population by ACO by County

(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

Source: Center for Health Care Strategies (2017) Medicaid Accountable Care Organizations: State Update. *Fact Sheet* June. www.chcs.org.

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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

Source: Amanda J Forster et al (2012) "Accountable Care Strategies: Lessons from the Premier Health Care Alliance's Accountable Care Collaborative." The Commonwealth Fund.
http://www.commonwealthfund.org/publications/fund-reports/2012/aug/accountable-care-strategies

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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

Source: Abiodun Salako et al (2015) "Characteristics of Rural Accountable Care Organizations (ACOs) – A Survey of Medicare ACOs with Rural Presence" *Rural Policy Brief* RUPRI Center for Rural Health Policy Analysis, University of Iowa. www.ruprihealth.org

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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)

Sources: S. Lawrence Kocot and Ross White (2016) "Medicare ACOs: Incremental Progress, But Performance Varies." *Health Affairs Blog* September 21. www.healthaffairs/blog

J Michael McWilliams et al (2016) Early Performance of Accountable Care Organizations in Medicare. *New England Journal of Medicine* April 13.

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Rural-specific Findings: Financial Performance

- 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

Source: Matthew C Nattinger et al (2016) Financial Performance of Rural Medicare ACOs *The Journal of Rural Health*

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Rural-Specific Findings: Quality Metrics

- 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

Source: Xi Zhu et al (20016) Medicare Accountable Care Organizations: Quality Performance by Geographic Categories. *Rural Policy Brief* RUPRI Center for Rural Health Policy Analysis at the University of Iowa. November. www.ruprihealth.org.

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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.

Summary of Key Variables

- 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

Source: D'Aunno, T., Broffman, L., Sparer, M. and Kumar, S. R. (2016), Factors That Distinguish High-Performing Accountable Care Organizations in the Medicare Shared Savings Program. Health Serv Res. doi:10.1111/1475-6773.12642

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Rising Tides: Disruptive Change Agents

- Next Generation ACO Program
- Provider affiliations to form ACOs
- Systems spreading ACOs
- Aggregators

Next Generation ACOs

- 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

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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

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Systems Spreading ACOs to Rural Locations

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

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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

Policy and Practice Alignment

- 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

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Policy and Practice Alignment

- 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

Platform for Next Wave of Change: Population Health Management

- 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

Source: Douglas McCarthy, Sarah Klein, and Alexander Cohen (2014) The Road to Accountable Care: Building Systems for Population Health Management. Caste Studies of Accountable Care Systems. The Commonwealth Fund pub 1768 vol. 21.

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Platform for Change: Community Health and Vulnerable Populations

- Starting with the population attributed to the ACO and needs related ton 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

Sources: Iyah Romm and Toyin Ajayi (2017) Weaving Whole-Person Health Throughout an Accountable Care Framework: The Social ACO. *Health Affairs Blog* January 25.
Jim Maxwell et al (2016) The First Social ACO: Lessons from Commonwealth Care Alliance. Robert Johnson Foundation and JSI Research & Training Institute, Inc. February. http://www.jsi.com/JSIInternet/Inc/Common/_download_pub.cfm?id=16450&lid=3

Addressing Non Medical Needs (Social Determinants of Health)

- Transportation
- Housing
- Food insecurity

Source: Taressa Fraze et al (2016) Housing Transportation, and Food: How ACOs Seek to Improve Population Health By Addressing Nonmedical Needs of Patients. *Health Affairs.* 35:11 pp 2109-2115

Platform for Change: Social ACO Model

- Commonwealth Care Alliance (CCA)
- Includes dual-eligible population
- Fully integrates social and clinical services
- Person-centered approach

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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

Source: Roopa Mahadevan and Rob Houston (2015) Supporting Social Service Delivery through Medicaid Accountable Care Organizations: Early State Efforts. *Brief* February. Center for Health Care Strategies, Inc.

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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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  https://www.ruralhealthinfo.org/

- ✓ The National Rural Health Association

  https://www.ruralhealthweb.org/

- ✓ The National Organization of State Offices of Rural Health

  https://nosorh.org/

- ✓ The American Hospital Association

  http://www.aha.org/