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Rural Policy Brief

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Accountable Care Organizations in Rural America

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Key Findings

- Medicare Accountable Care Organizations (ACOs) operate in non-metropolitan counties in every U.S. Census Region.
- 79 Medicare ACOs operate in both metropolitan and non-metropolitan counties.
- Medicare ACOs operate in 16.7% of non-metropolitan counties.
- 9 ACOs operate exclusively in non-metropolitan counties, including at least 1 in every U.S. Census Region.

Medicare Accountable Care Organizations[1]

The Medicare Shared Savings Program (MSSP), more commonly referred to as the Medicare ACO Program, was created by the Patient Protection and Affordable Care Act of 2010 (ACA). The first Medicare ACOs were announced in April 2012. Private sector demonstrations of the ACO model began as early as 2009 with 5 sites.[2] Currently, 220 Medicare MSSP ACOs operate across the United States, and 32 ACOs operate under Centers for Medicare & Medicaid Services demonstration authority as Pioneer ACOs. Other ACOs have formed through commercial insurer and provider agreements, bringing the total as of April 2013 to more than 400.[3] This policy brief presents data collected from Medicare ACOs regarding their presence in metropolitan and non-metropolitan counties.

An ACO is a health care provider group (generally hospitals and/or physicians) that contracts with a payer (Medicare for the purposes of this policy brief) to provide high clinical quality and positive patient experience at reduced cost. During the 3-year initial ACO contract period, Medicare pays the allowed charges for submitted claims while collecting ACO performance data, measuring clinical quality and patient experience with 33 indicators across 6 domains.[4] Reduced cost is calculated as the difference between the total paid for all Medicare claims and the predicted Medicare costs for beneficiaries assigned to the ACO. If an ACO's clinical quality and patient experience are acceptable, and if total payments are at least 2% less than predicted costs, Medicare will pay the ACO 50% of the cost savings if the ACO is not risk sharing for excessive costs, or 60% of the cost savings if the ACO is sharing risk (also 60%) for excessive costs. Starting in the second year of the ACO contracts, a pay-for-performance system will be implemented using the 33 quality indicators.[5]

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Subsequent to ACA implementation, the Center for Medicare and Medicaid Innovation implemented 2 Medicare ACO demonstrations—the Advanced Payment ACO demonstration (which operates within the MSSP) and the Pioneer ACO demonstration. The Pioneer ACO demonstration provides experienced ACOs an opportunity to earn a greater share of the savings in exchange for accepting greater financial risk if actual ACO costs are higher than predicted. The Advanced Payment demonstration provides smaller ACOs (either not including any inpatient facilities, or including only inpatient facilities that are critical access hospitals or small low-volume rural hospitals) capital necessary for infrastructure development. The demonstration offers no-interest and forgivable loans at start-up and periodically over 18 months if the ACO remains in the program for at least 3 years.[6]

Medicare requires a minimum of 5,000 beneficiaries per ACO (15,000 minimum for urban Pioneer ACOs, 5,000 for rural Pioneer ACOs). The Medicare beneficiary assignment process is complex and will be the subject of a subsequent RUPRI Center policy brief. Briefly, Medicare assigns a beneficiary to an ACO if that beneficiary receives the plurality of his/her primary care from a primary care physician participating in that ACO.

ACO Geographic Presence

Medicare launched 3 ACO contracting cycles during the past 18 months. As a result, Medicare has awarded 252 contracts, including 2 in Puerto Rico. We excluded the 2 Puerto Rican ACOs from consideration in this research, yielding 250 Medicare ACOs. Considering the minimum requirement of 5,000 beneficiaries per Medicare ACO, most ACOs operate in metropolitan counties. However, provider affiliations and smaller, even rural, organizations are forming ACOs. Several have secured Medicare ACO contracts.

We contacted each of the 250 Medicare ACOs to obtain information about their coverage area; 232 provided either city- or county-specific information, which we used to say there is ACO presence. We placed the remaining 18 ACOs in a county/city based on their central office address. Our data show that 162 Medicare ACOs (64.8%) operate exclusively in metropolitan areas, 79 (31.6% operate in a mix of metropolitan and non-metropolitan areas, and 9 (3.6%) operate exclusively in non-metropolitan areas. Non-metropolitan Medicare ACOs operate in every U.S. Census Region (Table 1).

Table 1. Number of Medicare ACOs by Census Region and Metropolitan / Non-Metropolitan County Presence

Census Region	Metropolitan	Metropolitan / Non-Metropolitan Mix	Non-Metropolitan
Northeast	44	14	3
South	66	26	4
Midwest	18	32	1
West	34	7	1
TOTAL	162	79	9

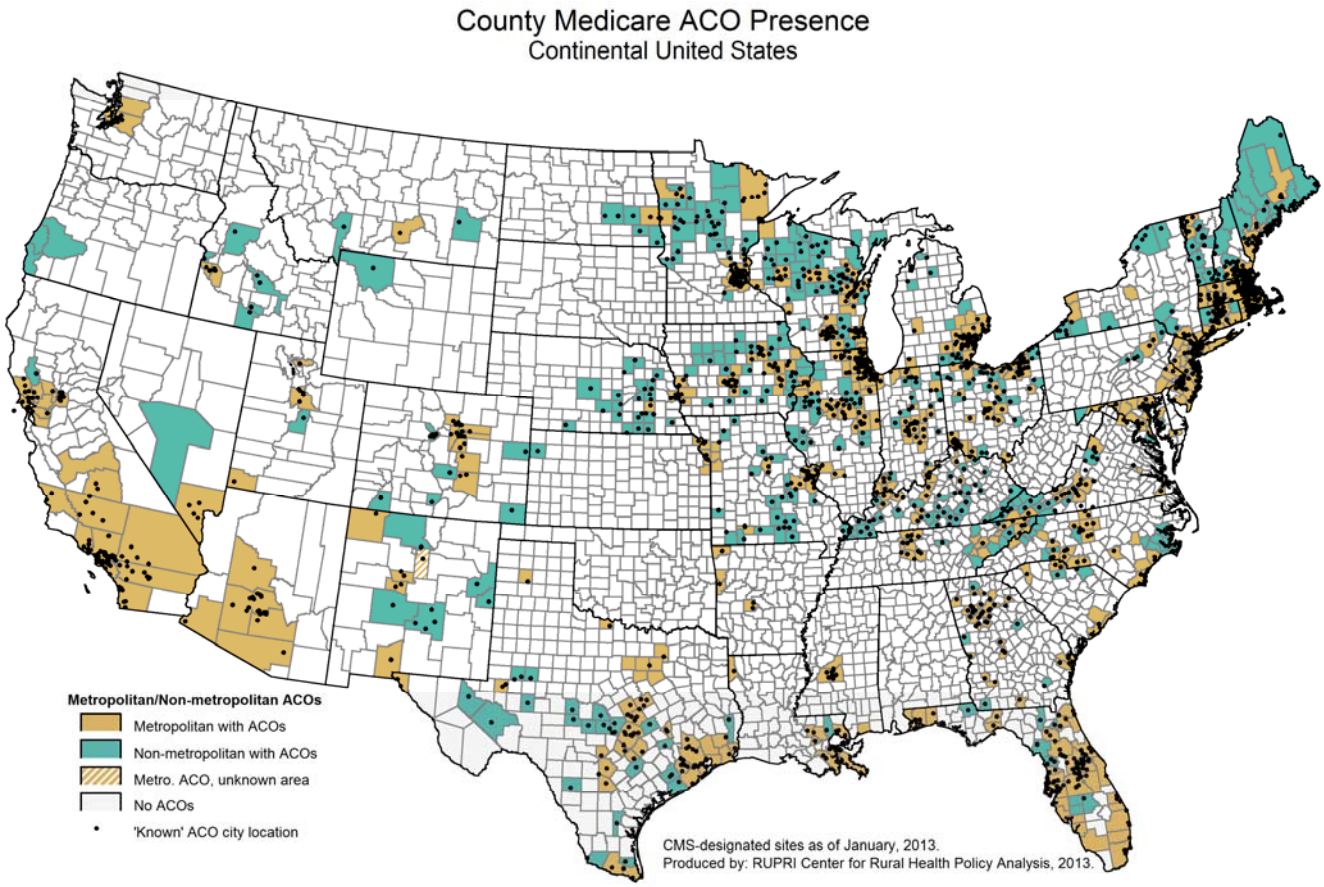
There are 218 MSSP ACOs, 35 of which are Advanced Payment ACOs, and there are 32 Pioneer ACOs. All three Medicare ACO types operate in metropolitan, metropolitan/non-metropolitan mixed, and non-metropolitan areas (Table 2).

Across the United States, Medicare ACOs operate in 42.9% of metropolitan counties and 16.7% of non-metropolitan counties. Our data indicate that beneficiaries in 343 rural counties (in 38 states) are assigned to 88 Medicare ACOs (Figure 1).

Table 2. Number of Medicare ACOs by Type and Metropolitan / Non-Metropolitan County Presence

Medicare ACO Type	Metropolitan	Metropolitan / Non-Metropolitan Mix	Non-Metropolitan	TOTAL
MSSP	120	59	4	183
Advanced Payment	21	10	4	35
Pioneer	21	10	1	32
TOTAL	162	79	9	250

Figure 1. Medicare ACO Presence – Continental United States[1]



Rural beneficiaries are assigned to Medicare ACOs in each Census Region (regional maps can be downloaded from the RUPRI Center web site http://cph.uiowa.edu/rupri/publications/policybriefs/2013/ACO_maps.html). The percentage of metropolitan and non-metropolitan counties within each Census Region in which ACOs operate is shown in Table 3.

[1]One national ACO has a site in Kahului, HI; there are no ACO sites in AK.

Table 3. Percentages of Metropolitan and Non-Metropolitan Counties in which ACOs Operate by Census Regions.

Census Region	Percentage of Metropolitan Counties with Medicare ACOs	Percentage of Non-Metropolitan Counties with Medicare ACOs
Northeast	55.3%	39.4%
South	35.9%	13.3%
Midwest	54.0%	21.3%
West	37.8%	8.7%

Conclusion and Implications

The MSSP and associated demonstrations represent a new health care delivery and payment model intended to support clinical quality, patient satisfaction, and controlled costs. If health care providers organized as an ACO deliver high quality care, positive patient experience, and lower costs than predicted, Medicare shares the cost savings (above a threshold value) with the ACO. As with other programs and demonstrations (e.g., the Value-based Payment Program and the Bundled Payment Program), Medicare is increasingly rewarding health care providers for delivering health care value, not simply service volumes.

The number of Medicare ACOs has increased steadily since 2011. The most recent announcement of new Medicare ACO contracts (January 2013) added 106 new ACOs, nearly doubling the total, and among them 33.3% (excluding the ACO in Puerto Rico) included rural areas. Medicare ACOs now operate in 16.7% of non-metropolitan counties, including 9 that operate exclusively in rural areas. These data show that, despite some requirements based on scale (e.g., minimum of 5,000 attributed beneficiaries) and the resources needed to implement strategies that lower costs, ACOs can be developed in rural places.

The implications of ACOs for rural providers are significant. ACO participants (principally hospitals and physicians) can no longer rely exclusively on a business model that prioritizes service volume as an operational priority. Instead, they must direct attention and resources to increasing clinical quality, improving patient experience, and lowering the cost of care. We anticipate that ACOs will compete aggressively for patient loyalty to capture savings realized through care management and other value-driving strategies, placing non-participating providers at a competitive disadvantage. Rural hospitals and physicians that embrace strategies to improve value, not simply increase volume, will be best positioned for future success.

Endnotes

[1] More information about Medicare ACOs is available from the Centers for Medicare & Medicaid Services: http://innovation.cms.gov/initiatives/ACO/

[2] Van Citters AD, Larson BK, Carluzzo KL, Gbemudu JN, Kreindler SA, Wu FM, et al. "Toward Account able Care: Four Health Care Organizations' Efforts to Improve Patient Care and Reduce Costs." *Case Study Series*. January, 2012. New York: The Commonwealth Fund. Accessed July 11, 2013: www.commonwealthfund.org/~/media/Files/Publications/Case Study/2012/Jan/1571_Van Citters_dartmouth_ACO_synthesis_01_12_2012.pdf

[3] Glass D, Stensland J. Presentation to the Medicare Payment Advisory Commission. April 4, 2013. Accessed July 11, 2013: http://medpac.gov/transcripts/ACO%20April%202013%20Presentation%20public.pdf

[4] For a complete description of all indicators see: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-NarrativeMeasures-Specs.pdf

[5] Centers for Medicare & Medicaid Services (2012). "Improving Quality of Care for Medicare Patients: Accountable Care Organizations." *Fact Sheet* November. Accessed June 10, 2013: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Quality_Factsheet_ICN907407.pdf

[6] Centers for Medicare & Medicaid Services (2011). "Advance Payment Solicitation." Accessed June 10, 2013: http://innovation.cms.gov/Files/x/Advance-Payment-Model-ACO-solicitation-doc.pdf