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Facilitating the Formation of Accountable Care Organizations in Rural Areas

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Purpose

This *Policy Brief* presents characteristics contributing to the formation of four accountable care organizations (ACOs) that serve rural Medicare beneficiaries. Doing so provides considerations for provider organizations contemplating creating rural-based ACOs.

Key Findings

- Previous organizational integration and risk-sharing experience facilitated ACO formation.
- Use of an electronic health record system fostered core ACO capabilities, including care coordination and population health management.
- Partnerships across the care continuum supported utilization of local health care resources.

Introduction

Accountable care organizations (ACOs) are charged to reduce costs and improve quality by holding groups of providers (typically physicians and/or hospitals) accountable for the care provided to a population of patients. The Medicare Shared Savings Program (MSSP), established under the Patient Protection and Affordable Care Act of 2010, now includes 343 ACOs. An additional 23 participate in the Medicare Pioneer ACO program, and there are an estimated 240 private ACOs.[1] Of the 366 Medicare ACOs, 119 have a presence—at least 1 primary care physician to whom Medicare beneficiaries are assigned—in rural (nonmetropolitan) counties, with 7 operating exclusively in rural counties.[2]

Little is known about what facilitates the inclusion of rural sites in ACOs, and what might precipitate more rural provider engagement. Studies performed at the levels of hospital referral region[3] and hospital service area[4] generally share two findings—previous organizational integration and risk-sharing experience facilitate ACO formation. One study also found that ACOs are less likely to form in high-poverty and rural areas.[2] The purpose of this policy brief is to examine four ACOs with a rural presence selected from the four census regions, describe common formation factors, and discuss implications for policies intended to facilitate rural ACO formation.

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Methods

A convenience sample was drawn from the universe of ACOs with providers in rural counties to whom beneficiaries were attributed. For purposes of geographic distribution, one ACO was selected in each census region (West, Midwest, Northeast, and South). Semi-structured interviews were conducted with ACO leaders and representatives of key stakeholder groups (e.g., board members, physicians, information technology managers). Interviews were recorded and transcribed; two coders independently extracted key information regarding the following:

- History (formation, precursor organizations, growth)
- Governance (membership structure and committees)
- Management structure and operations (dedicated vs. shared executives, quality committees, data management, clinical management)
- Financing (initial, shared savings)
- Emerging health care delivery models (hospital/system-based model, primary care physician group model)
- Lessons learned
- Legislation/regulation
- General ACO characteristics (organizations involved, physician mix, geographic coverage, attributed patients, participation in other integration efforts)

Additional information was obtained from telephone interviews and/or publicly available sources, including Centers for Medicare and Medicaid Services (CMS) announcements and individual ACO websites.

Findings

Although the four ACOs studied vary (see text box), they share many characteristics important for ACO formation and operation: all four ACOs include providers with previous organizational integration experience, three ACOs include providers with experience in risk-sharing arrangements, providers in each of the four ACOs share the same electronic health record (EHR) system, and all four ACOs established partnerships in their local and regional communities.

Organizational Integration: One ACO was established by a multispecialty clinic, which had previously participated in a physician-hospital organization (PHO), and had several years of experience with ACO-like care delivery models. Furthermore, since the 1990s, this clinic has built affiliations with critical access hospitals and other rural providers. Another ACO grew out of a 10-year partnership between 2 hospital systems and their medical staffs, each with integration strategies beginning in the 1990s (e.g., physician practice acquisitions, PHO). The third ACO was started by an independent practice association

Characteristics of the Four ACOs and Their Markets

- One ACO was selected from each census region.
- Three ACOs participate in the MSSP (one as an Advance Payment ACO), and one participates as a Pioneer ACO.
- The number of Medicare beneficiaries assigned to the ACOs ranges from 7,000 to 24,000.
- Parent organizations range in size from a 40-physician multispecialty group practice to a network of 2 health systems and about 700 physicians.
- Three ACOs operate in both metropolitan and rural areas, and one ACO operates in an exclusively rural area.

and now includes a hospital network, both with more than 15 years of integration experience. The fourth ACO was founded by a multispecialty group practice established over 15 years ago by merging independent practices.

Despite their history of integration, all four ACOs reported that providers in their area had "cultures of independence"; both hospitals and physicians traditionally viewed integration with skepticism. However, as one executive observed, such a culture can in fact facilitate ACO formation because ACOs allow provider collaboration without necessarily imposing limitations on provider autonomy.

Risk-Sharing Experience: Two of the four ACOs include providers who have participated in the Medicare Advantage program. One created their own health plan (full risk) and the other entered a partnership with an established health plan (shared risk). The former also participated in the Program of All-Inclusive Care for the Elderly (PACE), a joint Medicare and Medicaid program with capitated payments. A third ACO includes a provider who owned an insurance plan for more than 15 years, and the ACO reported that insurance plan experience prepared the organization for population health management and care coordination.

Information Technologies: In all four ACOs, the providers who formed the ACO shared the same EHR. A shared EHR enabled several critical ACO capabilities, including care coordination, population health management, quality improvement efforts, and quality reporting. Three of the four ACOs are also developing telehealth capabilities designed to improve access and increase care delivery value, especially in rural areas. For example, one ACO has established a diabetes prevention program using telehealth to offer diet and exercise advice to pre-diabetic patients in rural communities. In partnership with an Alzheimer's community coalition, this ACO has also established a telehealth program to offer psychiatry visits with providers from another state.

Strategic Partnerships: All four ACOs have developed partnerships with health and human services organizations in their local and regional communities. While broader regional partnerships (e.g., Quality Improvement Organizations and Health Information Networks) help providers target areas such as quality improvement and reporting, local community partnerships offer more community-specific benefits. For example, one ACO developed partnerships with local employers and business leaders to help the ACO target specific health issues and consider innovative approaches to dealing with them. Furthermore, some ACOs reported that rural providers tend to have a shared interest in keeping care local, providing common ground for partnership conversations.

Practice and Policy Implications

Rural providers interested in forming or participating in an ACO should consider several issues. First, they should develop core structures and capabilities including analytic and communication tools that support population health management, quality improvement and reporting, and care coordination.

Second, rural providers interested in forming or participating in an ACO should identify strategic partners, most of whom will contribute to the core structures and capabilities mentioned above. Sharing the same EHR within the ACO and with other providers in the area can facilitate care coordination and other core ACO capabilities. Engaging partners previously involved with integration and risk sharing can provide necessary financial management expertise. Local partnerships across the care continuum may be essential for keeping care in the local communities. Partnering with organizations outside health care, such as human services organizations or local businesses, can provide additional opportunities for identifying critical needs and addressing population health in innovative ways.

Rural provider participation in ACO formation and early growth is facilitated by supporting infrastructure investments in EHRs and analytical capacity. In the sites studied for this *Brief* the investments occurred prior to ACO formation. In other scenarios the investments may be part of the early activities of the ACO; for example, organizations in two sites were growing from an urban base into rural communities in part by supporting and enhancing infrastructure used by rural providers. Those investments improved access to timely data and provide technical assistance and tools to translate data into insight that improves care and lowers cost.

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