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High-Functioning Rural Medicare ACOs – A Qualitative Review

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Introduction and Purpose

An accountable care organization (ACO) is typically a group of physicians and/or hospitals that agree to form an independent entity for the purpose of providing high-quality health care to a group of attributed patients. If in doing so the ACO reduces the cost of care for the attributed patients to less than what was predicted, the payer shares a portion of those cost savings with the ACO. The Patient Protection and Affordable Care Act of 2010 (PPACA) established the Medicare Shared Savings Program (SSP), also known as the Medicare ACO program. In 2019, there were 559 Medicare ACOs serving more than 12.3 million attributed beneficiaries¹, and a total of 1,588 public and private ACO contracts, covering almost 44 million lives.² Furthermore, multiple demonstrations supported by the Center for Medicare & Medicaid Innovation have tested various ACO innovation configurations, including the Advance Payment Model, the ACO Investment Model (AIM), the Pioneer ACO Model, and the Next Generation ACO Model.³ The Advance Payment Model and the AIM built on the existing SSP structure while the Pioneer and Next Generation ACO Models represented different configurations.

This policy brief provides a qualitative review of success factor commonalities among four high-performing rural Medicare SSP ACOs. ACO success factors can inform ACO stakeholders and policy makers, and can facilitate additional ACO success strategy development—in both health care quality and cost reduction. Achieving success may be especially important because as of July 1, 2019, the SSP changed from Track 1, Track 2, Track 3, and Track 1+ options to only two tracks—Basic (five levels) and Enhanced. In this new SSP “[Pathways to Success](#),” Levels A and B of the Basic Track allow time-limited one-sided risk (financial reward potential only). However, all Medicare SSP options will soon require two-sided risk (potential for reward and risk for penalty).⁴

High-performing ACOs

Discovering success factors is a common interest among forward-thinking health care organizations, particularly within programs that are relatively new or in which participants have limited experience. Although ACOs have significantly expanded since their legislated inception in the PPACA of 2010, ACO quality scores improved from 83.08 percent (2014) to 94.65 Percent (2016), and ACOs outperformed fee-for-service providers on most (81 percent) of the quality measures.⁵ However, only 37 percent of SSP ACOs received shared savings in 2018.⁶ Infrequent ACO shared savings is due in part to the minimum savings ratio (MSR), calculated as a percent of total cost. To share in savings, the Centers for Medicare & Medicaid Services (CMS) mandates that ACOs achieve an MSR



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that varies based on the number of beneficiaries attributed to the ACO. The MSR is designed to avoid rewarding ACOs (by not sharing savings) for random cost reductions not due to ACO activity. If the ACO savings rate does not meet the MSR threshold, no savings are shared.

Through urban ACO leadership interviews, researchers have identified five urban ACO characteristics that appear to be associated with ACO success, i.e., high clinical quality coupled to significant shared savings.

- *High-value and innovative organizational culture*⁷ – A culture that prioritizes health care value (high quality at low cost) and is embraced by senior leadership is associated with ACO success. An additional cultural factor associated with ACO success is active physician engagement in strategic planning and operations. Some ACO leaders see high value delivered by innovation and reenergized primary care.
- *Financial risk-bearing experience*⁸ – Participation as an ACO for at least two years and prior financial risk-based contracting experience are both associated with ACO success. With financial risk management experience comes the capacity to develop alternate revenue (e.g., shared savings and capitation) pro formas and negotiate contracts likely to be financially favorable.
- *Proactive population health management*⁹ – Successful ACOs proactively improve population health through attributed patient engagement, high-need/high-cost patient identification, disease management strategies, and comprehensive care coordination. Population health management also employs best clinical practices and reduces unnecessary or duplicative care.
- *Continuous improvement infrastructure*¹⁰ – Advanced performance improvement resources and processes support a continuous improvement culture. Successful ACOs invest in quality improvement professionals, system engineers, feedback loops to clinical practitioners, and shared learning opportunities. To speed adoption of best practices, provider compensation is often tied to performance.
- *Knowledge management capacity*¹¹ – Successful ACOs employ sophisticated data measurement, analytics, and reporting to achieve broad information sharing and organizational learning that supports continuous improvement.

In contrast to the interview-based urban ACO research noted above, rural researchers have found that rural ACO financial success was correlated with physician sponsorship, but there was no correlation between ACO financial success and ACO size or experience.¹² Additional research found that quality performance was positively correlated with hospital-system sponsorship and beneficiary panel size. There was no significant difference in quality performance between rural and urban ACOs.¹³

Rural ACO Selection for Qualitative Review

The RUPRI Center selected four high-performing rural Medicare ACOs for qualitative study via semi-structured interviews. Sixteen rural Medicare ACOs were placed in financial performance quartiles and quality performance quartiles, based on performance Year 2014 data compiled by the RUPRI Center. Four rural Medicare ACOs that performed in the third or fourth quartiles (higher performance) of both financial and quality performance were selected for interviews. Descriptions of each, with data as of early 2018:

- *The Chautauqua Region ACO* was created in 2012 and operates in western New York state. The ACO evolved from an independent practice association. ACO members include 11 physician practices (48 physicians) and 4 hospitals. Approximately 5,600 beneficiaries are attributed to the Chautauqua Region ACO.
- *The Maine Community ACO* was created in 2012 and operates in northeastern Maine. The ACO includes 8 Federally Qualified Health Centers (FQHCs) that collectively operate at 22 sites (85 providers). The ACO is managed by Collaborative Health Systems (a subsidiary of WellCare) that manages 17 other ACOs across the country. Approximately 7,000 beneficiaries are attributed to the Maine Community ACO.

- *The Mercy Health ACO* was created in 2013 and operates in southwest Missouri and Arkansas. The ACO evolved from a [Physician Group Practice Demonstration](#) program and is now part of a multistate health care system. ACO members include 7 clinics (1,000 providers) and hospitals. Approximately 40,000 beneficiaries are attributed to the Mercy Health ACO.
- *The North Country ACO* was created in 2012 and operated in northern New Hampshire. The ACO was a subsidiary of the North Country Health Consortium, an association of 4 FQHCs, and had approximately 7,500 attributed beneficiaries. The North Country ACO was dissolved in 2015. In 2016, the North Country Health Consortium created a new ACO with 3 FQHCs and 9 Critical Access Hospitals.

Interview Process

RUPRI Center faculty conducted the qualitative research via onsite interviews at 3 Maine Community ACO sites and telephone interviews with leadership at the remaining 3 ACOs. Semi-structured interviews were based on an interview instrument¹ that inquired about six ACO characteristics.

- Governance, leadership, and membership
- History – founding, experience, and formation rationale
- Operational issues (e.g., care coordination, quality improvement, and data analytics)
- Financial issues (e.g., cost savings and quality incentives and financial loss protection)
- Population health
- Lessons learned that might benefit other rural ACOs

Interviews were completed in 2018. The research, including interview protocols, was approved by the University of Iowa Institutional Review Board.

Common Rural ACO Success Factors

The interviews were transcribed and compared to contemporaneous notes made during the interviews. The interviews were then summarized for this policy brief. Based on the interview results, researchers identified six common ACO success factors among high-performing rural Medicare ACOs.

1. *Prior collaboration experience* – All ACOs noted the importance of collaborative experiences with current partners and newly developed collaborations, such as with community-based organizations. Important experience also included managerial expertise developed in precursor or partner organizations, including an independent practice association, a national ACO management firm, and a Physician Group Practice Demonstration project. Prior collaborations helped build trusting relationships and common strategic priorities.
2. *Volume-to-value transformation strategic focus* – The ACOs believed that ACO participation allowed an opportunity to gain value-based care experience in a relatively low risk (but not riskless due to ACO implementation and operation costs) environment. Participating providers appreciated the opportunity to improve care quality through care coordination with other ACO participants and partners.
3. *Clinician championship* – The ACOs noted the importance of physician and advanced practice providers in both leadership (i.e., board membership) and operations roles. Clinicians redesign care processes to optimize quality and efficiency.
4. *Shared governance* – The ACOs shared governance equitably among member clinics and organizations. Additional ACO governing members included Medicare beneficiaries, a state

¹ Interview instrument available upon request.

primary care network representative, and local citizen advisors. Shared governance was important to engage stakeholders, add expertise, and collect user input.

5. *Care coordination services* – The ACOs recognized that care coordination (and primary care) is fundamental to population health improvement. Care coordination has the potential to improve clinical care and reduce duplicative or unnecessary services, both necessary for ACO success. Thus, each ACO developed care coordination service lines. Some ACOs used data analytics platforms to risk adjust patients and identify those in need of care coordination. Others developed algorithms in-house to identify high-need/high-cost patients. In some cases, distance between patients, providers, and care managers challenged care coordination. In response, Chautauqua Region ACO was investigating a tele-psychiatry program and Mercy ACO had already developing telehealth care management, virtual neurology, and telepsychiatry.
6. *Data access and analysis* – The ACOs recognized the importance of timely data access and sophisticated analysis. In the three non-system ACOs, multiple electronic health records in use was challenging. Data availability time lags of six to eight weeks was also problematic. But the most important and challenging factor was data analysis. Some ACOs engaged outside data analytic vendors and others developed in-house data analysis capacity.

Rural and Urban ACO Success Factor Alignment

In general, key ACO success factors identified by urban-based ACO leadership aligned with the RUPRI Center qualitative findings from four high-performing rural Medicare ACOs. A high-value and innovative organizational culture was identified by urban ACOs as a success factor. Although not stated as such, interviews with rural ACO leaders suggested a desire to proactively prepare for the developing volume-to-value transition. Relationships and skills developed through prior experience in multiorganizational collaborations and with ACO members was an important success factor in both rural and urban ACOs. The rural ACOs had less financial risk-bearing experience, but this likely would have been a success factor for them as well. Although the rural ACOs did not specifically list proactive population health management as a success strategy, all four ACOs worked with community-based organizations to promote the health of their representative communities. Additionally, care coordination, a rural ACO success factor, is essential to effective population health management. Data analytics capacity is a key component of knowledge management infrastructure. The rural ACOs noted its importance and also noted limitations in their capacity to receive and analyze performance data. Thus, the rural ACOs recognized that sophisticated data analytics (or more broadly, knowledge management) would be essential to their long-term success.

Policy Implications

By incorporation of an ACO model in the PPACA, and by its iterations tested through the Center for Medicare & Medicaid Innovation, Federal policymakers see potential for ACOs to improve health care quality and reduce cost growth.¹⁴ Similarly, commercial health insurers see value in ACOs as manifest by approximately 1,000 private ACOs in existence today. Therefore, policies that increase the likelihood of ACO development and success should be of interest to potential ACO participants, public policymakers, and commercial insurers. Optimizing ACO success will be particularly important to an organization considering ACO incorporation because the cost of developing an ACO is not inconsequential. Although ACO start-up cost estimates vary widely, ACOs on average require \$4 million of startup capital until there is an opportunity for shared savings.¹⁵

Public and private policies should develop and reinforce ACO success strategies previously identified in urban ACOs and identified in this sample of high-performing rural Medicare ACOs. The following policies should be considered.

1. The AIM demonstration tested the use of prepaid shared savings (i.e., interest-free loans) to encourage new ACOs to form in rural and underserved areas. The AIM demonstration resulted in a net Medicare savings of \$261.8 million in its first two years.¹⁶ The AIM demonstration could be renewed and expanded to additional sites.

2. Organizations with prior multiorganizational collaboration experience could be encouraged and supported (through planning grants and technical assistance) to develop ACOs and enter shared-savings contracts.
3. New accounting and financing models that blend fee-for-service, shared savings, and capitated (or global payment) revenue streams, and thus more accurately assess financial risk, could be developed and disseminated.
4. Care coordination and other population health management strategies could continue to be promoted with planning grants, technical assistance, and program design dissemination.
5. Sophisticated data access and analytics are fundamental to population health improvement and financial risk management. All payers could improve timely and accurate data transfers to providers that identify high-need/high-cost patients, highlight preventive health and disease management opportunities, and address social determinants of health. Such data analytic capacity should not be limited to high-volume or well-resourced health care providers. Payers should compete on data access, analytic, and interpretive services offered to health care providers.

Conclusion

The Medicare SSP changed as of July 1, 2019, from Track 1, Track 2, Track 3, and Track 1+ options to only two tracks—Basic (five levels) and Enhanced. Although Levels A and B of the Basic Track allow time-limited one-sided risk (financial reward potential only), all Medicare SSP options will soon require two-sided risk (potential for reward and risk for penalty).¹⁷ The CMS Director notes that SSP ACOs are “the first and most widespread efforts to make value-based care a reality.”¹⁸ CMS’s decision to move SSP ACOs into greater down-side risk via its “Pathways to Success” suggests an expanded CMS focus on ACO financial performance. Thus, it becomes more important than ever that aspiring ACOs and health care policymakers understand ACO success factors.

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