

Navigating the ACO Landscape - A Rural Perspective

The State of Value-Based Care

In 2012, an article in *Forbes Magazine*, titled “Value-Based Care: Fad or Future?” asked more than 200 C-Suite healthcare leaders if they thought value-based care was going to last, and nearly 40-percent were undecided about the future. Even though they weren’t sure, nearly 75-percent at least, “somewhat agreed” that providers needed to immediately begin shifting their focus from volume to value.ⁱ

The Centers for Medicare & Medicaid Services has brought this to fruition with its timeline of when Medicare will apply the Value-Based Payment Modifier to various groups.ⁱⁱ Based on this list, half of all providers will be in value-based payment programs by 2018, which means now is the time to make the change.

For rural healthcare providers, making the transition to value-based care is trickier than their urban counterparts. Smaller population bases and tighter operating budgets make it difficult to justify the money needed to transition from fee-for-service to value-based care.

This white paper will discuss Accountable Care Organizations (ACOs) and where they currently sit in the healthcare landscape, then drill down into rural healthcare organizations and the unique position they are in, as well as the challenges and advantages associated with rural providers. We will also lay out several of the considerations providers need to contemplate while making a successful transition to value-based care.

ACOs: The Current Situation

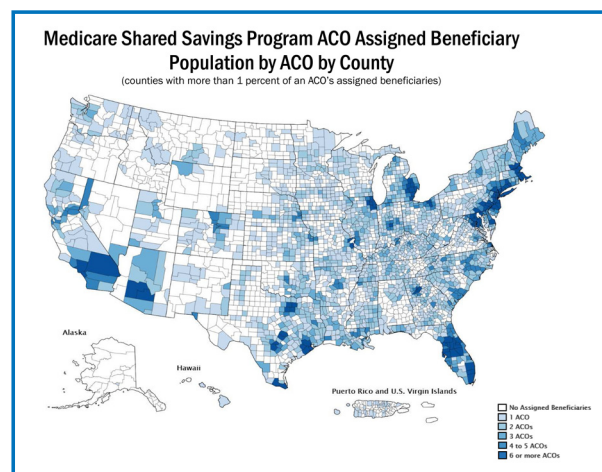
What is an ACO?

In 2011, The U.S. Department of Health and Human Services (HHS) released new rules under the ACA that were designed to help doctors, hospitals and other providers to work in tandem through Accountable Care Organizations. The term “ACO” was coined in part by Dr. Elliot Fisher, the Director of the Center for Health Policy Research at Dartmouth Medical School, who worked with colleagues to carry out the research that led to their inclusion in the ACA.ⁱⁱⁱ To qualify, the ACO would need to agree to manage all of the health care needs of a minimum of 5,000 Medicare beneficiaries for at least three years.^{iv} Since the introduction of the first ACOs, that number has grown quickly. Leavitt Partners has been tracking ACOs since 2010; 744 groups have formed since 2011, covering all 50 states. The number of lives covered by ACOs has also taken a staggering jump from 2.6 million in 2011 to 23.5 million in 2015. Of these, 7.8 million are part of the Medicare ACO programs with the rest coming from the commercial and Medicaid areas.^v

Current ACO Statistics

According to CMS data, in 2016, there were 480 active Medicare Shared Savings Programs ACOs with over 9 million assigned beneficiaries across the 50 states, Washington D.C. and Puerto Rico, an increase of 1.2 million covered lives.

The population density breakdown shows that 62% of all ACOs (296) exist in areas of high populations while just 12% (59) serve low density populations.^{vi} With over 700,000 counties in the United States with less than one-percent of the population an ACO assigned beneficiary, the need for increased rural participation has been recognized.



Rural Healthcare & ACOs: Challenges and Advantages

With rural healthcare providers underrepresented in ACO participation, they are in a unique position, one that has been recognized by CMS. In March of 2016, CMS released a document that discussed rural providers and ACOs. It recognized the unique needs and challenges faced by rural communities, but offered limited recourse for these challenges.^{vii}

However, this is not the last word for rural providers. While there are several challenges, there are advantages also. For rural hospitals, financial considerations, size and remote locations are universal challenges, but they do have advantages in their agility and the opportunity to receive assistance from groups created to assist rural providers.

In a 2016 article in the Rural Health Information Hub, rural leaders recounted challenges such as limitations of health information technology (HIT) compatibility across ACO partners, solid commitments and alignment, stable beneficiary attribution with a constant patient churn, and conversely, already high performing networks not achieving savings year-over-year due to high benchmarks.

Though these leaders discussed many of the issues they faced, they also saw advantages to their situations. Thanks to their size, they were able to quickly move towards the ACO model and put the infrastructure into care management. Strong relationships were formed because entire groups of hospitals were moving towards the same goal, creating additional opportunities. Additionally, there was the prospect of taking value-based success to commercial payers and work alongside the Center for Medicare and Medicaid Innovation to further industry knowledge.^{viii}

Caravan Health CEO and Founder, Lynn Barr, has been at the epicenter of value-based payments in the rural healthcare setting. Her work with both Caravan Health and the National Rural Accountable Care Consortium has given her a unique view of the landscape.

“Currently we treat the sick. We don’t prevent or manage disease,” said Barr. “We need to show the country the importance and impact of the rural healthcare system.”

Forming or Joining an ACO: What you need to know

Of the all decisions a facility may be required to make, the one to form or join an ACO could be one of the most important. It’s a decision that should not be made lightly as a lack of proper deliberation could turn out to be more costly than expected.

There are several aspects providers need to consider before making a final decision. Below are several points to deliberate while preparing to make a choice.

Understand your situation

Every facility will have its own set of positives and negatives that will dictate how they make their decision. In an interview with *Healthcare Finance*, Bob Williams, MD, director with New York-based Deloitte Consulting, said the most important thing for facilities exploring ACOs is to know their own market, and to look for an appropriate population to assume the risk for.^{ix} Obviously, this is an area of strength for rural providers.

Caravan Health CEO Lynn Barr said that as recently as 2015, rural providers were having trouble qualifying for the CMS payment models and were having to think outside the box to receive the same benefits as their urban counterparts.

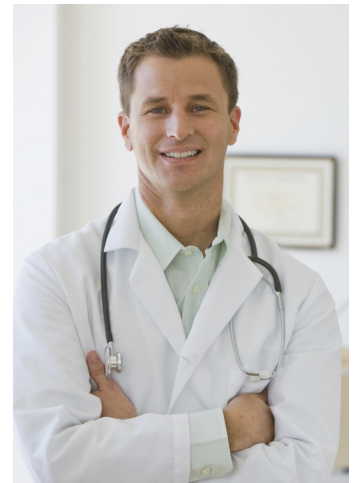
“We can define our destiny,” Barr said. “And if we don’t, others will. And they don’t understand us well enough to do that.”

Do your due diligence

It may be tempting to make a change as fast as possible, but that path can lead to more trouble down the road. Taking the time to review all options, along with the pros and cons of each step of the decision-making process is an important task.

While there are several steps to consider, three you'll want to be sure to review are included below.

- Engaging physicians – A critical step is to ensure your main partners are on board and you are able to create a solid physician leadership to champion the change.
- Select your ACO vehicle – For the most part, rural providers are not able to meet the covered lives requirement, which means you will need to review the various structures you have to choose from.
- Assess your population health capabilities – Assessing the current state of your population health management capabilities and identifying potential gaps will help you prioritize your activities and resource allocation.^x



If you don't know, ask. With the number of existing and starting ACOs, someone is bound to have asked the same question. There are groups designed to not only help answer your questions, but to also help you understand the pros and cons of following the ACO path.

Know your costs

While the potential rewards associated with participating in an ACO can be quite high, there also related costs. A 2014 survey by the National Association of ACOs found that the average startup costs for an ACO in the first 12 months of operation hit \$2 million, according to Becker's Hospital Review.^{xi}

There are other costs associated with forming/joining an ACO that may or may not be included in the \$2 million total. Network development and management, clinical information systems, data analytics, care coordination, quality improvement and utilization are just a few of the things to take into consideration.^{xii} Be sure to search out other potential hidden costs that could be associated with this endeavor.

Another path to consider are companies and groups that exist with the goal of assisting facilities and providers to reach their ACO goals. The National Rural Health Resource Center and the National Rural Accountable Care Consortium work to educate on options. Others exist to help minimize the financial impact hospitals experience when joining or starting an ACO.

Identify Additional Opportunities

In rural settings, there are opportunities that their urban counterparts are unable to take advantage of. ACO members must be able to take a broader view at their attributed lives to uncover what additional areas they are able to affect.

In a 2015 paper published by RUPRI Center for Rural Health Policy Analysis, based at the University of Iowa, a study found that all four of the ACOs identified found additional opportunities to enhance healthcare value. The three main areas of opportunity included: post-acute care, medication management, and end-of-life care.^{xiii}

Closing

Making the decision to move to the ACO model for the MSSP can be difficult, but value based care is becoming the healthcare standard. There are a wide variety of factors that must be considered, but there are organizations like the National Rural Health Resource Center and Caravan Health that are designed to assist rural providers find their way through the ACO landscape.

CPSI is leading the charge by assisting rural providers through an innovative strategy with the CPSI Rural ACO Program, powered by Caravan Health. Through this platform providers are able to work with CPSI to reduce the initial ACO startup costs through a shared income plan.

The most important thing to remember is that your facility is not on an island. There are similar hospitals that are making the same considerations you are and may be the partner you are looking for.



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- ⁱ <https://www.forbes.com/sites/forbesinsights/2012/06/11/value-based-health-care-fad-or-future/#1a0a74465a2e>
 - ⁱⁱ <https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeedbackprogram/valuebasedpaymentmodifier.html>
 - ⁱⁱⁱ <http://tdi.dartmouth.edu/faculty/elliott-fisher-md-mp/>
 - ^{iv} <http://www.npr.org/2011/04/01/132937232/accountable-care-organizations-explained>
 - ^v <http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/>
 - ^{vi} <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf>
 - ^{vii} <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Rural-Factsheet-ICN907408TextOnly.pdf>
 - ^{viii} <https://www.ruralhealthinfo.org/rural-monitor/rural-aco-leaders-speak/>
 - ^{ix} <http://www.healthcarefinancenews.com/news/what-you-need-know-starting-joining-aco>
 - ^x <http://www.healthcarefinancenews.com/blog/key-steps-becoming-medicare-aco-2015>
 - ^{xi} <http://www.beckershospitalreview.com/accountable-care-organizations/acos-need-4m-of-startup-capital-survey-finds.html>
 - ^{xii} <http://www.aha.org/presscenter/pressrel/2011/110513-pr-aco.shtml>
 - ^{xiii} <https://www.public-health.uiowa.edu/rupri/publications/policybriefs/2015/Rural%20ACO%20Development.pdf>

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