Accountable Care Organizations: A Viable Model for CAH Participation?

Keith J. Mueller, Ph.D.
Director, RUPRI Center for Rural Health Policy Analysis
Head, Department of Health Management and Policy
College of Public Health
University of Iowa
The Changing Landscape

- $$ must be squeezed out of current health care expenditures: 20+% of GDP by 2020 is not acceptable
- Both price and quantity of services must be reduced
- Changes will happen in the delivery system, fundamental not cosmetic
- For health systems, PRESSURE TO GROW AND SUSTAIN PATIENT VOLUME
Coincidental Presence of Models for Change (old and new)

- Prevention and population health
- Community well-being
- Bundled payment
- Value based purchasing
- Managed care organizations
- Accountable care organizations
Demand for services will shift

- Expansion of Medicaid enrollment with some federal help in paying providers, but limited
- Expansion of enrollment in the individual and small group markets
- CAN’T EXPECT CURRENT/HISTORIC APPROACHES TO DELIVERING AND FINANCING CARE TO RESPOND TO THIS SHIFT
Points of Emphasis

- Payment will change
- Numbers of patients will drive success
- Care management will be required
- Capturing share of shrinking dollar
ACOs are One Means to the End

- Medicare Shared Savings Program
- Pioneer ACOs
- Advanced Payment Model
- Private Sector
The future is NOW in many places

- Private action: Brookings-Dartmouth learning sites, Premier, CIGNA, Others
- Public Sector: Beacon communities, Practice Group Demonstrations, Medicaid, Medicare
- Urban based, FOR NOW
- But reaching beyond: Carilion System in Virginia
The National Map: Constructed by the ACO Learning Network

Looking back: the obvious progress
Many moving forward with ACOs

Private Sector
★ = Brookings-Dartmouth
★ = Premier
★ = CIGNA
★ = AQC (9 organizations in MA)
★ = Other private-sector ACOs

Public Sector
○ = Beacon Communities
○ = PGP, MHCQ

www.acolearningnetwork.org
164 ACOs nationally

“A clear movement is evolving within the health care industry towards the accountable care model of providing health services.”

“Poorer and rural regions in particular have little ACO growth

LeavittPartners.com
ACO Activity in the Northwest

- Washington:
  - 3 ACOs headquartered in hospital systems
  - 3 ACOs headquartered in Independent Practice Associations
- Oregon:
  - 2 ACOs in hospital systems
  - 1 ACO in an IPA
  - Coordinated Care Organizations
Changes in the MSSP Final Rule

- In Track 1 no transition to risk in third year
- Preliminary prospective assignment of beneficiaries
- 65 quality measures across 5 domains reduced to 33 in 4 domains; 70% threshold in one domain, one measure in each of the others
- Pay for reporting continued for 3 years instead of just 1, in combination with reporting in years 2 and 3
Changes in the Final Rule

- Share on first dollar of ACOs in both models after minimum savings achieved
- FQHCs and RHC eligible to both form and participate in an ACO
- Dropped requirement that 50% of primary care physicians be meaningful users of EHR, but is a quality measure with higher weighting
Rural Options

- Shared Savings Program, most likely Track 1
- Pioneer ACOs unlikely to be rural-based, but could be rural-inclusive
- Advanced Payment ACO Model
- Other innovative models
Pioneer ACOs Include

- Central Illinois (including RHCs)
- North Central Iowa
- Eastern and Central Maine
- Northeast Wisconsin
“Designed to provide support to organizations whose ability to achieve the three-part aim would be improved with additional access to capital, including rural and physician-owned organizations.”

- CMMI has budgeted $170 million to the Advanced Payment ACO program.
Only two types of organizations are eligible

- ACOs without any inpatient facilities and less than $50 million annual revenue
- ACOs in which only inpatient facilities are CAHs and/or Medicare low volume hospitals and less than $80 million annual revenue

- Co-ownership with health plan not allowed
Advanced Payment ACO Selection

- April 2012 and July 2012 entries for 3-year contract
- Selection will favor ACOs:
  - With least access to capital;
  - That serve rural populations;
  - That serve a significant number of Medicaid beneficiaries
- Application, Section 6:
  - “Explain how the ACO intends to use the funds awarded as advanced payments from CMS.” (Limit of 20,000 characters)
Advanced Payments

- Upfront fixed payment
  - $250,000 for ACO start-up
- Upfront variable payment
  - $36 per prospectively assigned beneficiary
- Variable monthly payment
  - $8/month per prospectively assigned beneficiary
- ACO can request less
Advanced payments to be recouped from the ACO’s shared savings

- If savings not enough to recoup advanced payment after 18 months, CMS will recoup in last 18 months of contract
- CMS will not pursue recoup of savings after 3-year agreement period, unless ACO does not complete the 3-year contract
Primary care role central

Savings mostly from care management and cost avoidance

So effects on hospital may be pronounced, especially for inpatient care

Therefore important for hospitals to be engaged
Forming even for Track 1 MSSP or Advance Payment Model should be based on combination of patient care and business considerations.

Joining for similar reasons, but also assessing future for integrated services with local base being sustained.

Sit might work for market that has limited appeal to other providers.

Highest risk is “go it alone.”
For Further Information

The RUPRI Center for Rural Health Policy Analysis
http://cph.uiowa.edu/rupri

The RUPRI Health Panel
http://www.rupri.org
Dr. Keith J. Mueller

Department of Health Management and Policy
College of Public Health
105 River Street, N232A, CPHB
Iowa City, IA  52242
319-384-3832
keith-mueller@uiowa.edu