RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

Brief No. 2015- 8 **MAY 2015** http://www.public-health.uiowa.edu/rupri/

Characteristics of Rural Accountable Care Organizations (ACOs) – A Survey of Medicare ACOs with Rural Presence

Abiodun Salako, MPH; Xi Zhu, PhD; A. Clinton MacKinney, MD, MS; Fred Ullrich, BA; and Keith Mueller, PhD

Background and Purpose

Accountable Care Organizations (ACOs) are groups of health care providers, principally physicians and hospitals, who develop a new entity that contracts to provide coordinated care to assigned patients with the goal of improving quality of care while controlling costs.[1,2] Section 3022 of the Patient Protection and Affordable Care Act of 2010 created the Medicare Shared Savings Program (SSP).[3] The Centers for Medicare & Medicaid Services (CMS) implements this program and has approved SSP contracts in five cycles since 2011,[4,5] including some that participated in a special demonstration project that provided advance payment (as a forgivable loan).[6] A new ACO Investment Model (AIM) program starts in 2015 that provides initial investment capital and variable monthly payments to ACO participants in rural and underserved areas who may not have access to the capital needed for successful ACO formation and operation. CMS also contracted with 32 organizations under a special demonstration project,[7] "Pioneer ACOs" (as of November 16, 2014, there were 19 remaining).[8] At the time of the research reported in this brief, there were 455 Medicare ACOs (Pioneer and SSP). While there is growing literature about ACOs, much remains to be learned about ACO development in rural areas. A previous RUPRI Center policy brief [2] examined the formation of four rural ACOs. The authors found that prior experience with risk sharing and provider integration facilitated ACO formation. This brief expands on the earlier brief by describing the findings of a survey of 27 rural ACOs, focusing on characteristics important to their formation and operation. Prospective rural ACO participants can draw from the experiences of predecessors, and the survey findings can inform policy discussions about ACO formation and operation.

Key Findings from 27 Respondents

- Sixteen rural ACOs were formed by pre-existing integrated delivery networks.
- Physician groups played a more prominent role than other participant types (including solo-practice physicians) in the formation and management of these rural ACOs.
- Thirteen rural ACOs included hospitals with quality-based payment experience, and 11 rural ACOs included hospitals with risk-sharing experience. Twelve rural ACOs included physician groups with both quality-based payment and risk-sharing experience.
- Managing care across the continuum and meeting quality standards were most frequently considered by respondents to be "very important" to the success of rural ACOs.

Methods

We conducted a web-based survey of Medicare ACOs that had a rural presence (i.e., at least one ACO participant in a nonmetropolitan county). For the purpose of this survey, an ACO participant was identified

This project was supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant # U1C RH20419, RUPRI Center for Rural Health Policy Analysis. The information or content and conclusions in this brief are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by, HRSA, HHS, or the U.S. Government.

RUPRI Center for Rural Health Policy Analysis,
University of Iowa College of Public Health,
Department of Health Management and Policy,
145 Riverside Dr., Iowa City, IA 52242-2007,
(319) 384-3830
http://www.public-health.uiowa.edu/rupri
E-mail: cph-rupri-inquiries@uiowa.edu

using the definition provided by CMS.[i] One hundred eighteen rural ACOs were identified, from those with start dates in 2012-2014, using a database of ACO geographic presence, described in a previous brief.[9]

The survey contained questions relating to ACO history, governance, management structure, operations, financial management, lessons learned, and perspectives on the future. The survey instrument (available upon request) was piloted and revised, and invitations to participate in the survey were distributed to executives of all 118 rural ACOs in June 2014, with a single follow-up email invitation sent two weeks later. As shown in the results section, we obtained a sample of 27 respondents. Therefore, this is a summary of findings from 27 ACOs that is not generalizable to the entire population of rural ACOs. Some respondents did not provide answers to some questions. For context, we report both the total number responding to a question and the number of respondents who selected each response option.

Results

There were wide variations in the rural portion of the geographical areas and populations served by the 27 responding ACOs (Table 1). However, there were no statistically significant differences between respondents and nonrespondents in terms of their rural service areas and populations.

Table 1. Characteristics of Surveyed ACOs (N = 118)

	Respondents (n = 27)	Nonrespondents (n = 91)
	Mean	Mean
No. of rural counties served by the ACO	6.2	6.1
% of all counties served that is rural	50%	44%
% of total population served that resides in a rural county	24%	21%
Total assigned beneficiaries*	17,358	23,991

*Data from CMS Shared Savings Program Accountable Care Organizations (ACO) PUF (http://cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/SSPACO/Overview.html) and "Accountable Care Directory 2014, version 2," HealthQuest Publishers from MCOL.

ACO Composition: Among the 12 ACOs reporting specifics about their composition, the majority contained hospital and/or physician group participants, and the majority of those participants provided services to rural populations (Table 2).

Table 2. Composition of ACOs (N = 12)

Participant type	Rural participants	Nonrural participants
Hospital/health system	7	1
Physician group	10	1
Solo-practice physician	4	1
Nursing facility	1	0
Residential living facility	0	1
Home care agency	2	0

Forming the ACO: The majority of responding ACOs reported significant prior experience with integrated delivery systems or quality-based payments. Sixteen (of 25) ACOs indicated that they were formed from pre-existing integrated delivery systems, while 17 (of 17) ACOs reported that at least one organization involved with the ACO had experience with quality-based payments and/or risk-sharing arrangements. Thirteen (of 16) ACOs included hospitals with prior quality-based payment experience, while 12 (of 16) ACOs included physician groups with prior quality-based payment experience. Twelve (of 17) ACOs included physician groups with prior risk-sharing experience, and 11 (of 17) ACOs included hospitals with prior risk-sharing experience. Financial considerations such as preparation for value-based purchasing (14 of 25) and getting paid for quality (10 of 25) were the most frequently cited "very important" reasons for the formation of the responding ACOs. In addition, shared savings (19 of 25) and gaining leverage with payers (12 of 20) were also frequently cited by respondents as being "important" or "very important" reasons for forming the ACO. However, nonfinancial considerations also played a role in ACO formation, with a majority of respondents citing joining like-minded organizations (15 of 25), and minimizing future risk (18 of 25) as being "important" or "very important" reasons for forming the ACO.

Few respondents indicated that specific activities in place or in process prior to ACO formation facilitated its creation. Activities such as hospital mergers, merger/acquisition of physician groups or other types of

[i] "An individual or group of ACO provider(s)/supplier(s), that is identified by a Medicare-enrolled TIN (tax identification number), that alone or together with one or more other ACO participants comprise(s) an ACO, and that is included on the list of ACO participants (provided to CMS)". See 42 C.F.R. § 425.20

providers, or contractual relationships were each indicated by only one, two, or three respondents as facilitating the formation of their ACO. A similarly small number of ACOs indicated that they engaged in such activities specifically to support the creation or expansion of their ACO. The importance of organizations and other factors to ACO formation are summarized Table 3.

Table 3. Important Organizations and Factors in ACO Formation

	Not important	Somewhat important	Moderately important	Important	Very Important
How important were the following organizations in initiating your ACO?					
Hospitals/health systems (n = 20)	6	0	0	1	13
Physician groups (n = 20)	1	0	0	2	17
Solo-practice physicians (n = 20)	12	1	0	2	5
Health plans (n = 19)	10	5	0	3	1
When your Medicare ACO was created, how important were the following factors in determining ACO participant selection?					
Market share (n = 18)	9	2	1	3	3
Reputation (n = 18)	2	3	3	4	6
Informal relationships (n = 19)	3	1	5	6	4
Existing formal affiliations (n = 19)	2	2	1	4	10
Need for services across care continuum (n = 19)	4	0	3	5	7
Need for human services (n = 19)	9	2	3	3	2
Expressed interest prior to ACO develop. (n = 19)	3	2	4	7	3
Need to reach a beneficiary threshold (n = 20)	4	3	4	5	4
Level of EHR* capability (n = 15)	2	2	5	2	4

*EHR – Electronic Health Records

Organization and governance: Organizational representation on ACO governing boards mirrors the participant organizations. The average governing board among responding ACOs contained 11 members. All 17 of the ACOs responding to the question had physician group representation on their governing board, 10 indicated hospital representation, and 14 indicated consumer representation.[ii] Solo practice physicians, nursing facilities, home care agencies, and others had much lower representation on governing boards (Table 4).

The same three organization types most frequently represented on ACO governing boards were also most frequently cited as having formal affiliations with the ACO. Responding ACOs indicated that they had formal affiliations with hospitals (12 of 18), physician groups (15 of 18), and solo practice physicians (7 of 18). The same pattern was present in organizational involvement with ACO committees (e.g., quality committee, compensation committee), with responding ACOs indicating that hospitals (8 of 18), physician groups (11 of 18), and solo practice physicians (5 of 18) were members of their committees. However, other organizations, including public health agencies (4 of 18), and home care agencies (5 of 18), were also cited as members of ACO committees.

Table 4. Organization and Governance of ACOs

Organization type	ACO governing board (N = 17)	Formal affiliation (N = 18)	Committee membership (N = 18)
Hospital/health system	10	12	8
Physician group	17	15	11
Solo-practice physician	4	7	5
Health plan	1	1	1
Public health agency	0	1	4
Nursing facility	1	2	3
Residential living facility	N/A*	1	3
Home care agency	2	4	5
Pharmacy	N/A	2	2
Human service agency	N/A	2	3
Consumer	14	N/A	N/A
Other	5	0	0

*N/A – survey question did not have this response option.

[ii] ACOs are required to have consumer representation (i.e., a Medicare beneficiary) on their governing board, but that requirement may be met by someone who is both a beneficiary and a professional (e.g., a physician or hospital administrator).

Fourteen (of 19) ACOs indicated that their Medicare ACO participants also engaged in commercial ACOs or similar shared-savings or risk-sharing contracts, with a little over half of those (8 of 14) indicating that all their Medicare ACO participants engaged in the same commercial arrangement.

Operational Considerations: Coordination among providers, including those within and outside the ACO, will be critical to meeting ACO goals of improving quality of care while controlling costs. The majority of responding ACOs identified clear team member responsibilities across multiple facilities (11 of 13) and standardized clinical care protocols (10 of 13) as being either "important" or "very important" to improving care management. While public health and human service agency involvement (6 of 13) was also seen as being "important" to improving care management, only one of the respondents indicated that this was "very important." All of the responding ACOs (18 of 18) indicated that meeting quality metrics was "important" or "very important" to the success of the ACO. Other factors, including managing care across the continuum (17 of 18), shared culture (16 of 18), cooperation among all providers in care management (16 of 18), consistent employment of care protocols (15 of 18), maintaining good working relationships among partners (15 of 18), and capital availability (14 of 17), were cited as "important" or "very important" to the success of ACOs.

Conclusion and Implications

While only 27 ACOs responded to the survey, we can draw lessons from their responses about factors contributing to ACO formation and about early ACO experience. The predominance of pre-existing integrated delivery systems as precursors to the ACOs in our survey may indicate an ability of providers with prior integration experience to be early adopters of the ACO model. This, however, is not surprising, as care coordination—a bedrock of the ACO model—requires substantial care delivery integration. Prospective ACO participants should consider partnering with one or more integrated delivery systems to benefit from the latter's experience with service integration.

ACOs are relatively new organizational types. Consequently, participants face uncertainty regarding structures, governance, and management. In our survey, 10 (of 19) respondents indicated that informal relationships were "important" or "very important" and 14 (of 19) indicated that existing formal relationships were "important" or "very important" in participant selection, suggesting that familiarity and trust mitigate uncertainty in ACO formation. As ACOs become more common, more standardized organizational and contractual relationships may substitute for these factors. Selecting one or more participants who have prior experience with risk-sharing and quality-based payments is similarly important. Prior experience with these payment systems provides better preparation for the ACO reimbursement system of risk-sharing and payment-for-quality. Prospective ACO participants lacking previous experience and sufficient scale to support rapid develpoment of new capacities in patient management under alternative payment may wish to consider partnerships with larger systems with risk-sharing experience. System partnerships may also provide financial resources to develop rural provider capabilities necessary for successful ACO participation.

References

1. Accountable Care Organizations (ACO). Centers for Medicare & Medicaid Services. (Accessed October 2, 2014, at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ACO/index.html?redirect=/ACO.)
2. Baloh J, Zhu X, Vaughn T, et al. *Facilitating the Formation of Accountable Care Organizations in Rural Areas.* Iowa City, IA: RUPRI Center for Rural Health Policy Analysis; 2014. Brief No. 2014-9.
3. The Patient Protection and Affordable Care Act. The U.S. Government Publishing Office (Accessed December 27, 2014, at http://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.)
4. Shared Savings Program: Program News and Announcements. Centers for Medicare & Medicaid Services. (Accessed November 16, 2014, at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/News.html.)
5. Shared Savings Program. Centers for Medicare & Medicaid Services. (Accessed November 16, 2014, at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/index.html?redirect=/sharedsavingsprogram/.)
6. Advance Payment Accountable Care Organization (ACO) Model. Centers for Medicare & Medicaid Services. (Accessed November 16, 2014, at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO_Advance_Payment_Factsheet_ICN907403.pdf.)
7. Pioneer Accountable Care Organization Model: General Fact Sheet. Centers for Medicare & Medicaid Services. (Accessed November 16, 2014, at http://innovation.cms.gov/Files/fact-sheet/Pioneer-ACO-General-Fact-Sheet.pdf.)
8. Pioneer ACO Model. Centers for Medicare & Medicaid Services. (Accessed November 16, 2014, at http://innovation.cms.gov/initiatives/Pioneer-ACO-Model/.)
9. MacKinney A, Vaughn T, Zhu X, Mueller K, Ullrich F. *Accountable Care Organizations in Rural America.* Iowa City, IA: RUPRI Center for Rural Health Policy Analysis; 2013. Brief No. 2013-7.