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Rural Policy Brief

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Spread of Medicare Accountable Care Organizations in Rural America

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Purpose

This RUPRI Center data report describes Medicare accountable care organization (ACO) growth in non-metropolitan U.S. counties from 2016 to 2017. This data report, which includes data through December 2017, follows a similar analysis released in October 2016 that described ACO trends from 2013 to 2015.

Key Findings

The following findings are based on activity through 2017:

- Medicare ACOs operate (an ACO provider is present) in 60.3 percent of all nonmetropolitan counties, up from 41.8 percent in 2016
- As of December 2017, no nonmetropolitan ACOs were participating in ACO models that included downside risk (meaning they are liable for expenditures exceeding a benchmark).

Background

The ACO models are the most widely adopted value-based payment initiatives from Centers for Medicare & Medicaid Services (CMS) (1). The Shared Savings Program (SSP), started in 2011, is the most commonly adopted Medicare ACO model (1). In 2016 and 2017, SSP ACOs could choose between three different financial risk arrangements. Track 1 allowed ACOs to assume only upside (one-sided) risk where they can receive a share of savings in Medicare expenditures, but are not required to repay Medicare for losses. Tracks 2 and 3 allowed ACOs to assume different levels of two-sided risk – receiving a share of savings in Medicare expenditures, but also assuming risk for repaying Medicare for growth in Medicare expenditures (1). Initially, SSP ACOs remained in a specific track for a three-year contract period and could then renew participation in the same track or change from Track 1 to Track 2 or 3 (3). Beginning in performance year 2017, CMS added an option for Track 1 ACOs completing a contract period to extend Track 1 contracts for up to one year before beginning a new three-year contract in Track 2 or 3 (3). CMS has attempted to facilitate ACO development among rural health care providers with the ACO Investment Model (AIM) initiative, a one-time program which provides pre-paid shared savings to support infrastructure development for SSPs established in or before performance year 2016 in rural or underserved areas (2). AIM provides monthly payments to participating ACOs for up to 24 months or until they cease participation in the Shared Savings Program or AIM, whichever is sooner (12).

As a follow-up to the Pioneer ACO demonstration project, a two-sided risk model that ended in 2016, and as an alternative to the SSP, CMS developed the Next Generation ACO Model in 2016 (4). This model allows ACOs with more experience in coordinating care to share a greater percentage of savings, in return for

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assuming greater downside risk than other ACO models (6). For the 2017 performance year, CMS reported that there were 480 ACOs participating in the SSP (7) and 45 ACOs participating in the Next Generation program (8).*

* Starting in 2018, ACOs have the opportunity to join the new Track 1+ model which incorporates more limited downside risk than is currently present in Tracks 2 or 3.

Data and Methods

Information on the city and county locations of ACO participating providers was obtained from a variety of sources: CMS websites, web-based ACO public reports (when available), and telephone contact with many ACOs. Additional ACO information was obtained from the 2017 Accountable Care Directory published by HealthQuest Publishers (9).

The compiled data was analyzed to identify the county locations of all ACO participating providers, including non-primary care providers. Counties included parishes, organized boroughs, census areas, independent cities, and the District of Columbia. Counties were classified as metropolitan or nonmetropolitan based on their Urban Influence Code (UIC) (10). Counties classified as a UIC code of 1 or 2 were considered metropolitan, and remaining counties were classified as nonmetropolitan.

One ACO is located in Puerto Rico and is excluded from the remainder of this report. We found no evidence of participating ACO providers in Hawaii or Alaska. We were unable to obtain location data for four ACOs.

Results

The number of "Nonmetro" ACOs in existence has only increased by one since the 2016 report (table 1). However, the number of "Mostly nonmetro" ACOs doubled and the proportion of metro ACOs decreased (from 50.3% in 2016, to 40.6%) in the same time period. Some of this growth in the rural presence of ACOs might be attributed to participation in AIM among nonmetropolitan ACOs (36 of the 45 ACOs participating in AIM were 2016 SSP starters). Table 2 shows the distribution of AIM participation by metropolitan/nonmetropolitan ACO status.

Table 1: Medicare ACOs by Metropolitan/Nonmetropolitan County Presence of Participating Providers, as of January 2017

Metro/Nonmetro	Description	2016 Count	2016 Pct	2017 Count	2017 Pct
Nonmetro	100% nonmetro counties	7	1.7%	8	1.5%
Mostly nonmetro	70%-99% nonmetro counties	23	5.4%	45	8.7%
Mixed	30%-69% nonmetro counties	104	24.6%	144	27.7%
Mostly metro	1%-29% nonmetro counties	76	18.0%	112	21.5%
Metro	0% nonmetro counties	213	50.3%	211	40.6%

Source: RUPRI Center ACO database.

Table 2: Medicare ACO Participation in AIM, by Metropolitan/Nonmetropolitan County Presence, as of January 2017

Metro/Nonmetro	Description	AIM Participation Count	AIM Participation Pct
Nonmetro	100% nonmetro counties	6	75.0%
Mostly nonmetro	70%-99% nonmetro counties	16	35.6%
Mixed	30%-69% nonmetro counties	16	11.1%
Mostly metro	1%-29% nonmetro counties	2	1.8%
Metro	0% nonmetro counties	5	2.4%

Source: RUPRI Center ACO database.

Table 3 shows the distribution of ACO model participation by metropolitan/nonmetropolitan ACO status. All of the nonmetro ACOs participate in the SSP Track 1 model, which includes only upside risk. ACOs participating in models with downside risk tend to be more metropolitan.

Table 3: Medicare ACO Model Participation, by Metropolitan / Nonmetropolitan County Presence, as of January 2017

Metro / Nonmetro	Description	Track 1		Track 2		Track 3		Next Gen	
		Ct	Pct	Ct	Pct	Ct	Pct	Ct	Pct
Nonmetro	100% nonmetro counties	8	100%	0	0%	0	0%	0	0%
Mostly nonmetro	70%-99% nonmetro counties	42	93.3%	0	0%	1	2.2%	2	4.4%
Mixed	30%-69% nonmetro counties	124	86.1%	0	0%	9	6.3%	11	7.6%
Mostly metro	1%-29% nonmetro counties	95	84.8%	2	1.8%	5	4.5%	10	8.9%
Metro	0% nonmetro counties	172	81.5%	3	1.4%	14	6.6%	22	10.4%

Source: RUPRI Center ACO database.

Conclusion

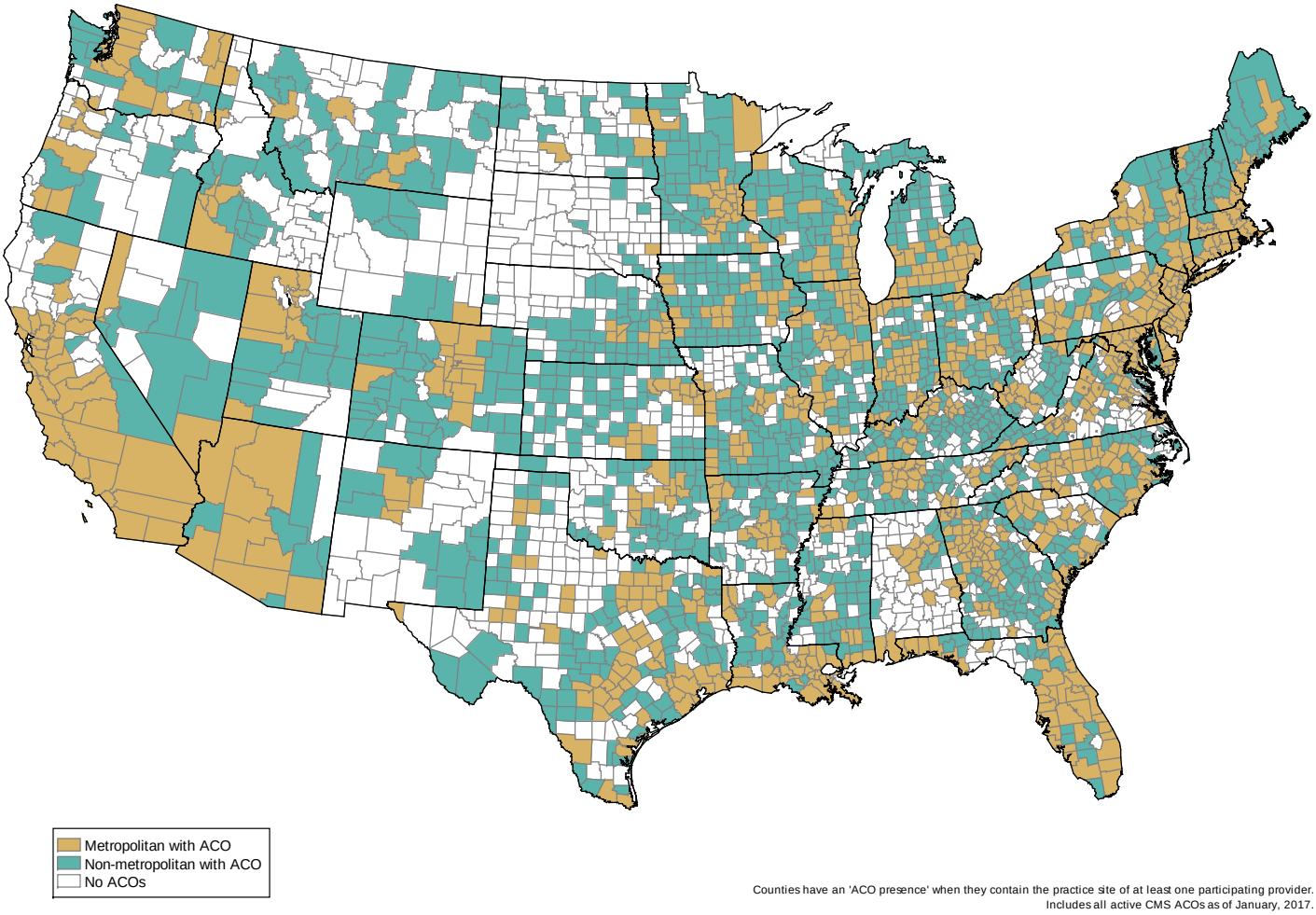
The number of Medicare ACOs present in nonmetropolitan America has grown since the RUPRI Center's October 2016 data report. As of January 2018, 1,210 Rural Health Centers (sic) and 421 critical access hospitals participated in SSP ACOs (11). Some (unspecified) percentage of the 2,560 Federally Qualified Health Centers participating in the program are in rural places (11). The observed increase in the proportion of nonmetropolitan ACOs since performance year 2015 likely reflects the impact of the AIM program's support for infrastructure development in rural ACOs. The map at the end of this document shows all counties with presence of an ACO provider.

Following a trend present in previous years, nonmetropolitan ACO participation in two-sided risk models remains low. No nonmetropolitan ACO in performance year 2017 participated in a model that included downside risk, and ACOs who did participate in these models tended to be more metropolitan. Preference for one-sided risk models may be attributable in part to the 2016 final rule allowing ACOs to extend their time in Track 1 (3).

The findings described in this data report reflect what are still the early years of ACO operations. As more years of data become available, future research should attempt to generate statistical observations about ACO outcomes related to cost and quality. The growth in ACOs in nonmetropolitan America evidenced in this data report underscores the need in the meantime for continued monitoring of ACO impacts on health care service delivery.

County Medicare ACO Presence

As of January 2017



Note: We found no evidence of participating ACO providers in Hawaii or Alaska

Sources

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