

Accountable Care Organizations and Rural Hospitals: Approaches and Recommendations for Success

A HEALTHLAND WHITE PAPER

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Introduction: The Drive to Value-Based Care

As part of the Affordable Care Act (ACA), primary care became the focal point in the mission to improve health and lower overall healthcare costs in America. The Centers for Medicare & Medicaid (CMS) announced earlier this year that at least 50% of Medicare payments will be linked to value-based models by 2018.ⁱ This push to shift the payment model from fee-for-service to value-based reimbursement has raised concerns for some hospitals and providers about the financial management of their organizations. The new models are all based on a shared risk/shared savings concept, including Accountable Care Organizations (ACO).ⁱⁱ

At its core, an ACO is a group of doctors, hospitals and other healthcare providers who voluntarily form a coordinated organization to give high quality care to their patients. Their overall goal is to ensure that all patients – especially the chronically ill – get the right care at the right time, without duplication of services and with an eye to proactive, preventive medicine versus treating the sick reactively.

For the majority of urban and suburban providers, reaching the 5,000-patient ACO requirement is not difficult. For rural providers, ACO options can be limited based on a variety of factors, including location and proximity to other providers. This white paper will discuss Accountable Care Organizations and how they play into the rural market, as well as options and suggestions for rural providers to consider when making the decision about joining or creating an ACO.

ACOs: A Brief History

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

Rural Healthcare, ACOs and Changes in Healthcare Delivery

While Accountable Care Organizations started in highly-populated areas, expansion to rural communities has been gaining momentum across the country. Many of these rural healthcare providers had neither the funding to make the needed investments nor the Medicare patient count needed to apply, but did have innovative leaders that found ways to find ways to change that.

A 2013 study showed that nearly half of their respondents reported having little knowledge of ACOs, with only one percent responding as being very knowledgeable of ACOs. Over half of the respondents cited financing (53%) and legal/regulatory (51%) as the reasons they were not seeking ACO participation, and 41% claimed that their

population base was not large enough to qualify.^{vi}

In 2014, HHS and CMS recognized that rural communities face unique challenges and have different needs than their urban counterparts. HHS released a [Fact Sheet](#) created specifically for rural providers, discussing how Critical Access Hospitals (CAHs), Federally Qualified Health Centers (FQHCs) and Rural Health Clinics (RHCs) could choose between interacting with existing ACOs, joining a new ACO or forming their own.^{vii}

Finding the capital needed to move towards value-based care is a constant issue for rural providers, so in 2014 CMS announced a new program where up to \$114 million in additional funding would be made available for rural participants of the Medicare Shared Savings Program (MSSP). Under the ACO Investment Model (AIM) Program, rural ACOs were able to apply to be one of the 75 programs selected to receive funds to make the capital investments needed to improve the health of their patients.^{viii}

And most recently, a comparative look at the list of CAHs in the country and the list of hospitals currently in ACOs shows that in a relatively short time the rural knowledge of ACOs has changed. Over 150 CAHs^{ix} are now in ACOs, and that number is on the rise.

Ultimately, ACOs continue to make significant progress in achieving their underlying goal: changing the healthcare delivery system. With a variety of quality metrics being used to measure both facility and patient performance in light of this industry shift, quality of care has never been more important.

The current view of rural providers under value-based payments is mixed. Recent studies performed by the Agency for Healthcare Research and Quality show that ambulatory quality scores tend to be lower in rural areas than their urban counterparts. A study published by iVantage contains encouraging data on rural beneficiary costs, where as recently as 2012, rural patients accounted for 3.7% less in total per beneficiary spending. But unit costs for critical access hospital inpatient and swing beds, outpatient procedures, and provider-based RHC visits can be up to three times higher than urban providers.^x

How can rural hospitals address these discrepancies? According to Lynn Barr, Chief Transformation Officer for the National Rural Accountable Care Organization (NRACO), the key to success for rural hospitals is to keep the primary care visit in-house – to not lose control of that key care interaction. Lynn also recommends implementing preventative care programs and a chronic care management (CCM) program to better position your healthcare delivery model for managing the health of your population. Additionally, Lynn insists rural providers must get better at measuring their quality scores and outcomes, and carefully evaluating their referral network to direct their patients to the highest value providers.

Rural Value-Based Care Options

Rural healthcare providers are no longer finding themselves alone in the transition towards value-based care. Organizations like the National Rural Health Association, the National Rural Health Resource Center (NRHRC) and the American Hospital Association Section for Small or Rural Hospitals are working to help meet the needs of small and rural hospitals with this effort. One view put forth by Terry Hill, the Senior Advisor for Rural Health Leadership and Policy for the NRHRC, is that rural hospitals often do not offer the same available services that

urban locations do, making partnerships even more important. Not only do you need partnerships with your primary care physicians, but also with other key providers in the service area, like mental health, long term care, home care and even local businesses. He also believes that community engagement activities will help to drive better population health outcomes as well as result in improved market share and less outmigration for health care.

Rural healthcare providers are also finding a variety of options when moving towards value-based care, including several ways to get engaged with an ACO. The NRACO is one option that works to assist small, rural healthcare systems in coming together to form and manage successful organizations.

National Rural Accountable Care Organization: An Overview

The National Rural Accountable Care Organization (NRACO) was formed in 2013 by nine CEOs from rural hospitals in California, Michigan and Indiana in an effort to combat the challenges rural providers face in the transition from fee-for-service toward value-based care. This initial group has grown to include six ACOs comprised of thirty health systems in nine states.

Size, location and funding are major challenges for rural providers who want to transition to an ACO, and the NRACO has developed a program that allows rural health clinics, federally qualified health centers and hospitals to join an ACO, regardless of size, and with no downside risk. All reimbursement stays the same. This is a bonus program only.

Requirements to participate include forming a local steering committee, hiring a nurse to function as the Community Care Coordinator, assigning an ACO Champion to lead the program, and working with NRACO staff to redesign workflows to improve care and lower costs. In return, these participants receive all claims data on their Medicare Patients regardless of point of care, patient satisfaction surveys, 24-hour advice nurse hotlines, and step-by-step instructions on how to transform their delivery systems to be successful under the new payments models.

On the following pages, we've profiled three distinct approaches that rural hospitals have taken to embrace value-based care by interviewing an executive from a participating Healthland client hospital. These three hospitals are at different levels of progress in their ACO journey; they each discuss the model they are using, as well as several other topics that pertain to ACOs in the rural setting.



Pioneers Medical Center: Ken Harman, CEO

ACO: Rocky Mountain ACO

ACO Member Hospital Locations: Aspen, CO; Glenwood Springs, CO; Rifle, CO; Craig, CO; Meeker, CO; Rangely, CO; Shelton, WA; Elma, WA; Port Townsend, WA; Forks, WA; Goldendale, WA; Norwood, WA.

Background: PMC made the decision with other regional hospitals to form their own ACO from the ground up

Why make the decision to move to an ACO?

“Over the last few years, we have started coming together in northwest Colorado to have discussions about how we can work together as hospitals. Like the rest of the country, we are seeing tremendous pressure to consolidate and come together as the healthcare payment mechanisms are moving from traditional fee-for-service to a value-based payment methodology. As I visited with our medical staff, the executive team and our board, it was our belief that we needed to be able to develop or enhance some skill sets and position ourselves as an organization to move down that path.”

How did you decide on the model selected?

“We wanted to create not only a legal structure to satisfy the requirements, but to really begin to create a clinically integrated network that allowed the smaller hospitals to maintain their independence while bringing us all together. We have two regions within our ACO, one in northwest Colorado, one in western Washington. By creating these two networks we have the ability to not only garner the lives required to meet the Medicare Shared Savings Program requirements, but to be able to create regional commonality to get us to the next step of that clinical integrated network.”

What investments have you made towards the ACO?

“At this point (October 2015), we’re waiting to hear back on our applications for both the MSSP and the AIM programs. We think we have a very exciting and compelling case for approval. If we’re successful in getting the AIM funding it will cover much of our start-up costs. During the three years of the AIM funding, we estimate that each hospital will incur an additional \$45,000 per year. This funding will require that each hospital places one Community Care Coordinator per 900 Medicare beneficiaries.”

What do you think will be the biggest roadblock?

“There are two things that always come to mind for me. The first is we chose to form our own entity. While we’ve hired some phenomenal consultants, we don’t have a turnkey program. We do run the risk of going in and not doing the Care Coordinator function properly, and of not being able to extract the information we need from our data. The second concern is that we could be too successful. That sounds strange, but in the short term, that success could financially harm us if we see a reduction in patient admissions. Right now, we can get money

from MSSP to support this initiative, but volume is still the driver for us. We will develop new services lines to provide more proactive care in better managing community health, but these potential financial outcomes can be scary.”

What are your thoughts on the future of ACOs – how this will develop 5 years from now?

“I personally believe that the movement to being accountable for healthcare and getting paid based on value isn’t going back. I also don’t believe it is being driven by the ACA and the federal government. I think the bigger movement is coming from larger employers. You see it happening in California. You see a number of these larger companies saying that they can’t continue to do what they’ve been doing. That there has to be a different mechanism. I think that as an industry we’re going to be compelled to go down this path and I would rather be able to help create what gets imposed upon me as opposed to have it forced on me.”

What insight would you give to someone thinking about joining or creating an ACO?

“The most difficult thing is you have to really look at the market you are in. There’s no such thing as a standard rural hospital because each one has a different market. Your ability or need to react to change and move into an ACO is somewhat dependent on the market you’re in. Part of it is who is your competition? What is happening around you? Are there tertiary facilities, other facilities getting into and creating ACOs?”

“... We could be too successful. That sounds strange, but in the short term, that success could financially harm us if we see a reduction in patient admissions.”

Ken Harman, CEO

Pioneers Medical Center



Coryell Memorial Healthcare System: David Byrom, CEO

ACO: American Rural ACO (NRACO)

ACO Member Hospital Locations: Hospital, Clinic, Specialty Clinic, Residential Care Facilities, EMS, Home Health – Gatesville, TX; Clinic – Goldthwaite, TX; Mid Coast Medical Clinic; Matagorda Regional Medical Center; Matagorda Medical Group; Matagorda Episcopal Health Outreach Program; Nephrology Leaders & Associates, PLLC; Medical Leaders & Associates, PLLC; Brazosport Regional Health System; Brazosport Regional Physician Services; Chambers Health; Coryell Memorial Healthcare System; Connally Memorial Medical Center; Truckee Tahoe Medical Group Inc.; Missouri Delta Medical Center

Background: After researching their options, Coryell decided to join an ACO through the National Rural ACO (NRACO).

Why make the decision to move to an ACO?

“I think every community has its own market indicators and unique characteristics. We had some changes in our community, and as we looked at what was happening and at ACOs, we saw an opportunity to do a number of positive activities for our patients. We wanted to make sure we’re doing everything we can to secure future market share and prepare for the reimbursement model changes that are coming in the future.”

How did you decide on the model selected?

“When we talk about the NRACO, this isn’t really a national model. It’s more of a regional concept within the framework of the NRACO. Part of the driving factor for us is you have to have 5,000 covered lives to be in an ACO, which is a challenge in rural markets. Sometimes to be able to do that, you have to band together to be sure you have the number of covered lives to accomplish the goal. The NRACO has helped us achieve that goal.”

What investments have you made towards the ACO?

“As part of our membership with the NRACO, we have a monthly fee that funds the help we receive. We also applied for the AIM Grant for 2016, which we believe would help offset some of the costs of being an NRACO member. We’ve also hired a Care Coordinator, but we haven’t limited them to just Medicare beneficiaries. Because of the Medicaid 1115 Waiver in Texas, which is focused on Medicaid beneficiaries and the uninsured, we’ve opened up to that broad spectrum as well.”

What do you think will be the biggest roadblock?

“We have to track a lot of details that go into each visit and it’s quite challenging. It’s something that we’re facing, not only in the ACO, but for everything else we’re trying to do through our quality improvement projects. Also, some people look at joining the NRACO as a risk since we have dollars going out without any guarantee of a return today. We’re trying to make the investments needed to make sure we’re ready for the future of this model. You learn a lot about your facility when you participate in an ACO. You’re forced to look at your data and your patterns of patient outcomes. It’s been a very enlightening experience.”

What are your thoughts on the future of ACOs – how this will develop 5 years from now?

“I think the push at the national level is always that bigger is better. I don’t necessarily believe that concept. I think that we have seen this in the financial sector in the U. S.; we don’t have as many small banks today compared to several years ago. These same concepts are being applied to healthcare. I think we see that nation-wide the perception is that the cost and quality is going to be better if we push people all to one place, and I don’t believe in that principal. That doesn’t leave the infrastructure in place for the rural facilities, which is vital to local communities. As rural hospitals, we have to be better at competing with our urban marketplace to be sure that we’re demonstrating quality and cost effectiveness as we go forward. That’s part of what this is about.”

What insight would you give to someone thinking about joining or creating an ACO?

“We’re all moving in different directions, maybe under different programs with different names, but when I start looking at it, everybody’s goal is the same – how can we work to keep and expand quality services so that we’re sustainable going forward, and thus helping the patient in keeping that market share at home? So how are we going to coordinate all of that? The market focused data and unique care coordination activities will work together to help accomplish that goal.”

“You’re forced to look at your data and your patterns of patient outcomes. It’s been a very enlightening experience.”

David Byrom, CEO

Coryell Memorial Healthcare
System



Manning Regional Healthcare Center: John O'Brien, CEO

ACO: Member of Catholic Health Initiatives, Mercy Health Network ACO

ACO Member Hospital Locations: Manning, IA; 59 total locations in ACO

Background: This Iowa hospital found that through their current situation, a tertiary ACO was already within their grasp.

Why make the decision to move to an ACO?

“Having been in healthcare networks for almost 20 years, we think this is going to give us a number of advantages within healthcare right now. The biggest advantage being that an ACO is going to help us adapt to the speed of change in healthcare with the move to value-based purchasing.”

How did you decide on the model selected?

“We’re a private, not-for-profit hospital that has been part of Mercy Health Network (MHN) for quite a while. Catholic Health Initiatives (CHI) in southern Iowa, and Trinity Health in the north jointly own MHN, which is our ACO. Dave Vellinga, the Mercy Health CEO has been looking at the ACO concept and what we can do as a network from both a competitive and patient care nature so we can move forward. They’ve been talking about this for a couple years and we signed up in the fall of 2014.”

What investments have you made towards the ACO?

“The funding we’re receiving is through the Medicare grant. It’s helping to pay for our Care Coordinator. I believe year one is 90-percent, year two is 75-percent and year three is 50-percent of her salary. After that we’re on our own. One investment we’ve made is we’re sending information in. I haven’t seen a lot back yet, but I know that should be happening shortly, especially information from Medicare. They told us up front that we’re probably not going to make a lot of money from this, and I haven’t seen any. But they feel that the data that we will get from Medicare as part of an ACO is invaluable. The claims data we will get will be absolutely valuable.”

What do you think will be the biggest roadblock?

“We haven’t experienced any major barriers yet. I think we’re going to have data requirements, but I don’t know what they are yet. What would have made our lives easier for this is if we were all on the same platform. The different facilities in the ACO are all on a variety of different programs. I think part of the issue over time is going to be our systems being able to talk to each other. Right now they don’t, but the ACO is gathering data about this. That’s going to be the bigger issue, the interoperability issue between the different platforms that are out there. More and more data is going to be required from the ACOs.”

What are your thoughts on the future of ACOs – how this will develop 5 years from now?

“I don’t know if the ACO is the final answer yet. They don’t know. The ACO may be step one between a two or three-step process to where we end up. Nobody’s crystal ball is clear on that one. Healthcare is going to change dramatically in the next 5-10 years. I think it’s going to be very difficult – not impossible – but very difficult to

be an independent critical access hospital and meet all the obligations that are coming down the pike. I think you're going to need some help."

What insight would you give to someone thinking about joining or creating an ACO?

"I think you're going to need to join an ACO sooner rather than later. I don't know if this is an interim step or not, but I think it's how it fits within your area, how it fits within the healthcare environment that you have. I think being part of an ACO is going to be better than not being part of one, but make sure you get the right one. I am absolutely convinced we have the right one here. It fits with our culture, it fits with the arrangements we have in our network. Most of the stuff I'm reading right now is saying that the ACOs have been successful in some areas, but not always. As we're making this change from fee-for-service to value-based, we may find that what we think is going to work does or doesn't. I know there are some that think that ACOs are still the answer and some that think they are not. I frankly don't know. I don't think anybody knows right now. This is something that we have to do and it's part of the progression."

"I think you're going to need to join an ACO sooner rather than later."

John O'Brien, CEO

Manning Regional Healthcare Center

Healthland Assessment of ACOs for Rural Healthcare

Having discussed the impact of ACOs on rural hospitals and organizations with a variety of clients and industry leaders, we have compiled the following list of suggestions and recommendations for rural hospitals thinking about pursuing an ACO arrangement. While there is no magic bullet when answering the ACO question for rural providers, we hope that the observations and recommendations below will be beneficial in your journey towards considering to create or join an ACO.

- **The shift in rural healthcare delivery is well underway**

The shift to using ACOs to change healthcare delivery in the rural setting is real and happening now. Groups such as the National Rural Health Resource Center are creating momentum through federally funded programs and resources designed to assist rural providers as they transition to value payments and population health management. Leading industry publications, including Healthcare Business & Technology, Healthcare Finance News and Modern Healthcare, are bringing this change in healthcare to light in a variety of ways, including information about available grants and programs from HHS for rural value-based care. The NRACO is also making an impact in rural healthcare. Currently the NRACO has 30 member healthcare systems across six ACOs, and they are looking to continue expanding. Now is the time to determine how you will address this market shift if you haven't already.

- **Control your destiny and develop key partnerships**

When it comes to guiding your facility through the changes in the healthcare industry, a common concern is the ability to maintain your independence. An important aspect is making the decision yourself instead of waiting to be forced to make a move. Joining an ACO is just one way of guiding your change in healthcare delivery, providing opportunities for earning and partnering with providers like you. Partnerships will be key in your decision-making process. You will need to form partnerships with other health systems to gather enough Medicare patient lives to qualify for the program. Additionally, you will need support with your IT infrastructure, obtaining claims data to stratify your population health data, and developing the clinical programs to support changes in the way you deliver care. Taking the "wait and see" approach is good for some events; this is not one of them.

- **Know your situation**

Market conditions, competition and other factors make each and every situation unique; each of the executives we spoke to were clear on this point. The best way to ensure your success is to understand your market conditions and determine how to organize your ACO partners to best service your population, while maintain control of your destiny.

- **Go in with a long term goal, but recognize the outcomes are uncertain**

While programs like AIM, the Medicare Shared Savings Program and others that guarantee funds are a great way to start, they are not the end game. Eventually those funds will go away, which means you need to be

Observations

1. The Shift is On
2. Control Your Destiny
3. Know Your Situation
4. Long Term Goal
5. Don't Wait
6. Make a Fundamental Shift

prepared to replace them with a viable income that fits within your ACO model. When admissions go down, what changes will you bring to your hospital to replace a loss in volume? Changing your delivery system will also require some fundamental shifts in care coordination, preventive health programs and Chronic Care Management. These programs can be new sources of revenue for your health system while helping to strengthen your population health management efforts.

- **Make more than changes: make a fundamental shift**

Nobody can say that the ACO model is the final answer—or even your answer—to address the market shift towards value-based care, however this shift is undeniably well underway. No matter which direction your facility chooses to go, in the end, a core shift in how you deliver care needs to take place. As Terry Hill shared, in the end, the goal for every provider – urban or rural – is a health system that links health care with community stakeholders, creating a network of organizations working together to improve population health. For rural providers to begin the journey, the five recommendations above are a great place to start.

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