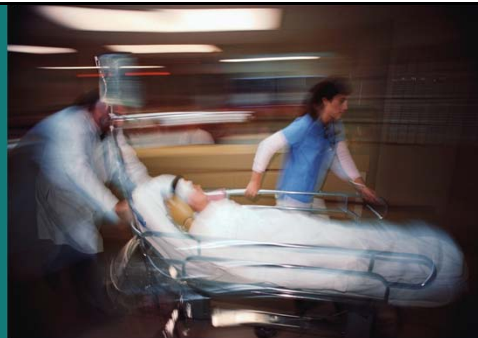
How Rural Hospitals Can Prepare for Accountable Care Organizations



NOSORH Webinar

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Implementation challenges in rural communities

- Achieving capacity and variety of services
- Aggregate patient volume a/k/a critical mass
- Risk adjustment and predictive modeling accuracy
- Start-up costs
- HIT and data demands
- Managing expectations of cost savings
- Anti-trust, Stark, civil monetary penalty restrictions

ACO opportunities for rural hospitals

- ACA calls for CMS to create ACO demonstrations for critical access hospitals
- New Center for Innovation at CMS has latitude to create ACO or similar payment models focused on rural communities
- Private insurers, large employers looking for new models

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Models for thinking about ACOs in a rural community

- Participate with or respond to larger ACO
  - Vendor or contractor or referral relationship
    - Geographic-sensitive services
    - Organizational strengths (high quality, low cost)
  - Affiliate, join, integrate
  - Compete
    - Geographic-sensitive services
    - Organizational strengths (high quality, low cost)
    - Local provider relationships critical

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Models for thinking about ACOs in a rural community

- Regional co-ops
  - Aggregate multiple hospital(s), clinics, individual providers across region
  - Aggregate patients across region to get critical mass (e.g., 5,000 Medicare beneficiaries)
  - Identify potentially unnecessary duplication, gaps of service
  - Beware of existing anti-trust, Stark, civil monetary penalty restrictions

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Models for thinking about ACOs in a rural community

- Micro-ACOs
  - Specify smaller geographic region, fewer patients, fewer services and less financial risk
  - Focus on total cost of care coordination, not necessarily total cost of care delivery
  - Develop referral and other agreements with other providers to provide quality improvements and cost containment

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Models for thinking about ACOs in a rural community

- Nano-ACOs
  - Identify sub-population from community to coordinate care under total-cost-of-care payment incentives
  - E.g., dual eligible population in CAH with attached nursing home; diabetics in CAH with clinic
  - Focus on total cost of care coordination, not necessarily total cost of care delivery
  - Negotiate global payment or shared savings with stakeholders (Medicare, Medicaid, local employer)

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Models for thinking about ACOs in a rural community

- Uncoupled-ACOs
  - Develop ACO (cost/quality accountability) for RVU or FFS providers within community/region
  - Carve out CAH and other cost-based providers from direct ACO/risk participation, but provide incentives for quality and cost performance
  - Create financial rewards for ACO providers based on total cost and quality (excluding CAH incentives)

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Initial issues for rural hospitals to consider

- Primary care provider relationships
  - Other provider relationships important but secondary
- Focus aggressively on quality improvement and patient safety
  - Readmissions and rehab
  - CHF, other chronic conditions with local needs
- Define “total cost of care” or “continuum of care” (parts A and B, long-term care, Rx drugs, mental health)

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