RUPRI Center for Rural Health Policy Analysis
Rural Policy Brief

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Spread of Accountable Care Organizations in Rural America

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Purpose

The RUPRI Center for Rural Health Policy Analysis continues to monitor the spread of Medicare accountable care organizations (ACOs) into rural U.S. counties to determine whether this model appeals to rural providers and health systems. The RUPRI Center's periodic reports reveal trends in rural ACO activity; this brief follows one released in July 2013, with data through December 2015.

Key Findings

The following findings are based on activity through 2015:

- Medicare ACOs operate in 41.8 percent of all nonmetropolitan counties.
- Non-metropolitan provider participation in ACOs has increased considerably since 2013, especially in the South, West, and Northeast census regions.
- The 101 new ACO entrants in 2016 included at least 43 ACOs with providers in non-metropolitan areas.

Background

The Centers for Medicare & Medicaid Services (CMS) Medicare Shared Savings Program (MSSP) for ACOs began in 2012, as did the Pioneer ACO demonstration. Through January 2016, there have been six cycles of MSSP ACOs and one round of Pioneer ACOs. This brief presents analysis of the first five cycles and the Pioneer ACOs, and provides information about the sixth cycle (January 2016). As of December 2015, there were 424 ACOs (19 of which were Pioneer ACOs) in the Medicare program; after exits and new entrants in early 2016, CMS reports a total of 433 ACOs,[1] including 45 ACOs participating in the new ACO Investment Model demonstration.[2] Medicare ACOs are held accountable for achieving quality benchmarks as measured by 33 indicators across four domains. An ACO's ability to share in savings (determined by comparison to a benchmark using the three previous years of Medicare expenditures for attributed beneficiaries) is influenced by its scores on quality measures and by exceeding a threshold percentage savings that is in part a function of the number of attributed beneficiaries.

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Methods

Information on ACOs was obtained from a variety of sources: (1) Web-based public reports, where available, were used to identify the city location of providers; (2) information was extracted from the 2015 *Accountable Care Directory* published by HealthQuest Publishers; (3) a database with information on provider locations developed by Levitt Partners, LLC, was obtained; and (4) many ACOs were contacted via telephone to obtain either city- or county-specific information on their providers' locations. The compiled data was analyzed to obtain the county locations of all ACO participant providers. (It should be noted that the providers identified included ALL providers, not only primary care providers). Counties were classified as metropolitan/nonmetropolitan based on their Urban Influence Code (UIC).[2] Counties classified as a UIC code of 1 or 2 were considered metropolitan; remaining counties were classified as nonmetropolitan. One of the 424 ACOs is located in Puerto Rico and is excluded from the remainder of this report. We were able to confirm the presence of an ACO provider participant in 48 states and the District of Columbia (we found no evidence of providers in Hawaii or Alaska, although CMS indicates that one ACO is operating in Alaska).

Results

We estimate that at least one Medicare ACO was operating (i.e. at least one ACO participant provider was practicing) in 53.5 percent of all 3,143 counties (including parishes, organized boroughs, census areas, independent cities, and the District of Columbia) in the United States in April 2016. These ACOs operated in 73.2 percent of all metropolitan counties, and 41.8 percent of all nonmetropolitan counties.

We grouped ACOs into five categories based on the percentage of counties in which they operated designated as metropolitan/nonmetropolitan: completely nonmetropolitan (100 percent nonmetropolitan counties), mostly nonmetropolitan (70-99 percent nonmetropolitan counties), mixed (30-69 percent nonmetropolitan counties), mostly metropolitan (1-29 percent nonmetropolitan counties), completely metropolitan (0 percent nonmetropolitan counties).

Over half of the ACOs (50.3 percent, n = 213) operated exclusively in metropolitan counties. Less than 2 percent (1.7 percent, n = 7) operated exclusively in nonmetropolitan counties. Table 1 shows the distribution of metropolitan/nonmetropolitan ACOs.

Table 1: Medicare ACOs by Metropolitan/Nonmetropolitan County Presence, as of April 2016

Metro/Nonmetro	Description	Count	Percentage
Nonmetro	100% nonmetro counties	7	1.7%
Mostly nonmetro	70%-99% nonmetro counties	23	5.4%
Mixed	30%-69% nonmetro counties	104	24.6%
Mostly metro	1%-29% nonmetro counties	76	18.0%
Metro	0% nonmetro counties	213	50.3%

Source: RUPRI Center ACO database.

Nonmetropolitan Medicare ACOs have been present since the beginning of Medicare ACOs (Trinity Pioneer ACO in Iowa). The uptake in nonmetropolitan and mostly nonmetropolitan areas was initially slow, but the total number has remained steady in recent years (there has been shifting among categories such as Pioneer ACOs moving to Track 1 or Next Generation, and some turnover in Track 1). Table 2 shows the distribution of metropolitan/nonmetropolitan ACOs over the six generations of Medicare ACO cycles.

Table 2: Metropolitan/Nonmetropolitan County Presence of Medicare ACOs by Announcement Generation

Metro/ Nonmetro	Jan. 2012 (Pioneer)	April 2012	July 2012	Jan. 2013	Jan. 2014	Jan. 2015
Nonmetro	1 (5.3%)	2 (8.7%)	0	0	1 (0.9%)	3 (3.4%)
Mostly nonmetro	1 (5.3%)	0	2 (2.4%)	8 (8.4%)	7 (6.1%)	5 (5.6%)
Mixed	4 (21.1%)	6 (26.1%)	29 (35.4%)	20 (21.1%)	24 (20.9%)	21 (23.6%)
Mostly metro	2 (10.5%)	2 (8.7%)	14 (17.1%)	16 (16.8%)	26 (22.6%)	16 (18.0%)
Metro	11 (57.9%)	13 (56.5%)	37 (45.1%)	51 (53.7%)	57 (49.6%)	44 (49.4%)
Total	19	23	82	95	115	89

Source: RUPRI Center ACO database.

The CMS announcement of participants in the AIM demonstration program[3] contained 45 ACOs (9 from pre-2016 entrants) which, given the requirements of the program, are presumably rural-based ACOs. Our preliminary estimate is that at least 43 of the 101 new ACOs announced by CMS in January 2016 operate in non-metropolitan areas. Given the number of consortia-based ACOs now in operation, we believe this is a conservative estimate.

Conclusion

The number of Medicare ACOs present in non-metropolitan America, and the number of participating non-metropolitan providers, is growing (see Figures 1 and 2). An April 2016 CMS fact sheet reported that 65 (15 percent) of Medicare ACOs included at least one participating Rural Health Clinic, and 55 (13 percent) included at least one participating Critical Access Hospital.[4] By contrast, the same fact sheet from 2015 showed that 35 (9 percent) of Medicare ACOs included a Rural Health Clinic and 31 (8 percent) of Medicare ACOs included a Critical Access Hospital.[5]

Although the total number of providers remains small, the increased participation indicates rural interest in this program. However, ACOs in MSSP (rural and urban) have been interested predominantly in the one-sided performance-based risk model (Track 1). The MSSP is designed to encourage sharing in the risk of exceeding expenditure targets, but CMS extended the time ACOs could remain in Track 1 before having to opt into two-sided risk sharing. The spurt of interest in ACOs in 2016 was bolstered by the AIM demonstration, which provided initial capital for some existing and new rural-based ACOs.

In short, rural experience with ACOs remains limited, and most early findings, including those published by this research team, reflect what is *possible* based on the operations of early ACO innovators. Future research will need to focus on what can be *known* about the rural ACO experience based on statistical conclusions from a larger number ACOs operating for multiple years. Continued health care organization interest in the program is reason to continue to study how rural-based ACOs operate, including their actions to meet or exceed quality targets and reduce total Medicare expenditures.

[1] https://data.cms.gov/ACO/2016-Medicare-Shared-Savings-Program-Organizations/5kdu-cnmy, accessed 8/9/2016.

[2] https://data.cms.gov/dataset/ACO-Investment-Model/dyd8-sjvc, accessed 8/9/2016.

[3] https://innovation.cms.gov/initiatives/ACO-Investment-Model/, accessed 8/9/2016.

[4] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/All-Starts-MSSP-ACO.pdf, accessed 8/9/2016.

[5] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/PioneersMSSPCombinedFastFacts.pdf, accessed 8/9/2016.

Figure 1. 2013 Map of ACO County Presence

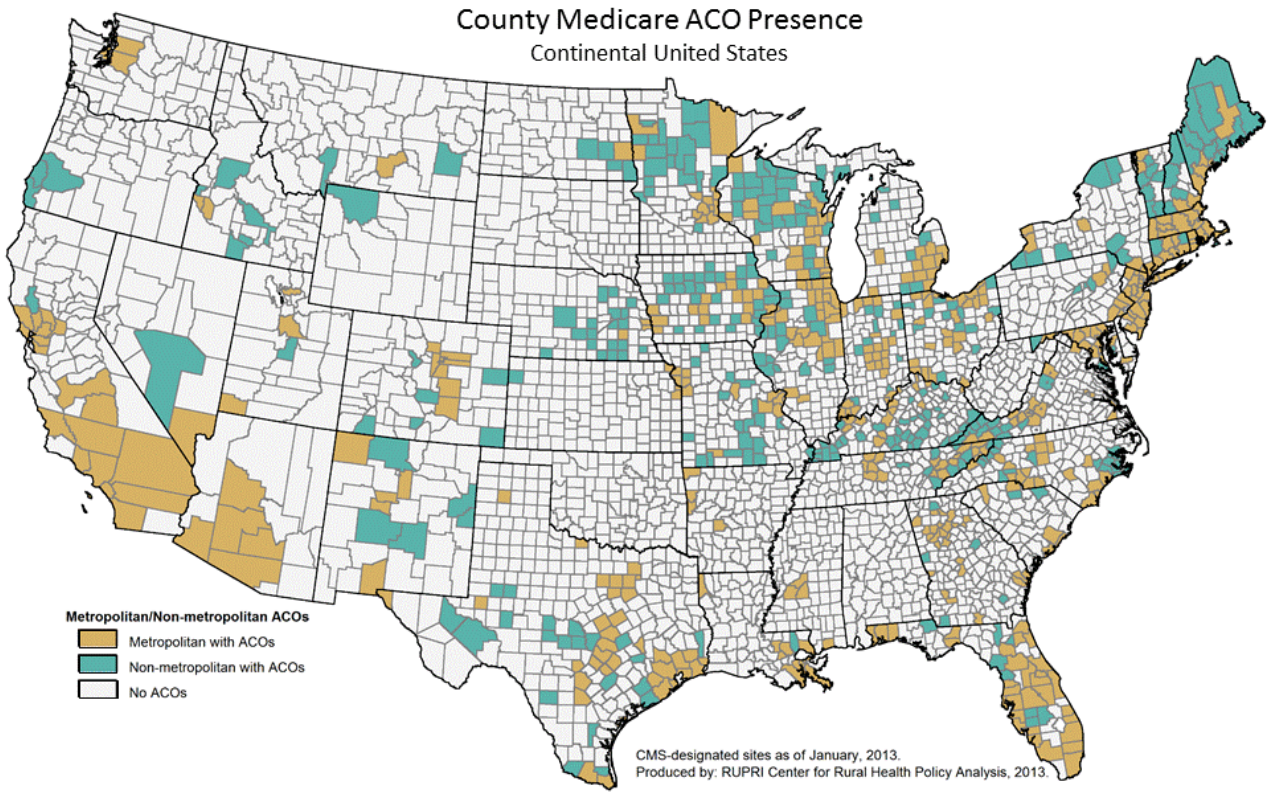

Figure 2. 2015 Map of ACO County Presence