

# Challenges and Pitfalls of Operating a Rural Accountable Care Organization

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The development of Medicare Shared Savings Program (MSSP) accountable care organizations (ACOs) by the Centers for Medicare & Medicaid Services (CMS) offers challenges and opportunities for rural physicians. These providers can participate in a model that improves quality of care for patients, provides care coordination services that were not previously available, and offers educational experiences that are lacking in most rural settings. In exchange for lowering the cost of medical care by eliminating waste and low-quality care, a potential financial reward might come to our rural practices. With this background in mind, the Accountable Care Coalition of Eastern North Carolina embarked upon the ACO journey. We partnered with an experienced insurance company that had invested heavily in analytics and had the investment capital for staff and startup costs, with the understanding that these costs would be paid back out of shared savings.

The Accountable Care Coalition of Eastern North Carolina completed 2 years as one of the original 13 MSSP ACOs. During that time, we met quality goals and provided care coordination services to our patients. We also dramatically lowered our rates of preventable admissions and readmissions according to our ACO-specific CMS-supplied data reports. This led to improved quality of care for patients. Despite obvious savings to the Medicare system, design flaws in the program (risk management, benchmark calculations, and shared savings design) made it impossible for us to qualify for shared savings. After a first-year loss of over \$5 million, leadership redesigned care coordination programs to shift our focus from man-

agement of all chronically ill patients to intense management of very sick patients. By focusing on the sickest and costliest patients in real time during the occurrence of their problems, we were able to lower costs and prevent readmissions and complications of previous hospitalizations while providing better care for patients. Our efforts to improve care by altering workflows offered an opportunity to change outcomes for patients. These efforts led to the ACO lowering readmission rates and preventable admissions, resulting in a second-year loss approaching zero. However, given the slim possibility of achieving shared savings, our financial partner chose to withdraw their participation, and a notice of termination was provided to CMS.

## Understanding the MSSP Program

The MSSP program establishes financial and quality benchmarks and measures the performance of practices against those benchmarks. Each benchmark is a blend of historic expenses for a patient population that is risk-adjusted for an attributed population of patients. The goal of the ACO should be to raise quality and lower expenses.

## ACO Challenges in Rural Areas

### *Technological*

ACOs need to be able to collect and manage data and analyze patients with active medical problems who need transitional services and care coordination. However, large health systems sometimes refuse access to information on admissions and discharges. Another challenge is that Internet bandwidth and electronic medical record

adoption status vary widely in rural areas, which can make data collection efforts difficult.

### **Leadership**

Active participation by physicians in administrative processes that guide clinical interventions is integral to ensuring that focus and interventions serve patients.

### **Regulatory**

Compliance with rules and regulations are such that failure to complete all aspects of the program could nullify any achieved savings.

### **Communication**

Space to operate and communicate the information necessary to meet program demands was difficult to establish. It was also difficult to fill staff positions given the lack of experienced personnel in rural areas.

### **Financial**

The costs and overhead to support the operations and reporting functions of ACOs are considerable. Rural locations, with their heavy concentrations of primary care physicians and few specialists, do not often possess excess capital to invest in ACO development. Operational costs of ACOs range from \$350,000 to millions of dollars, depending on infrastructure and the number of staff required to meet ACO requirements.

### **Workflow**

Another challenge is that workflow was disrupted to support data collection, quality measures, and transition of care efforts. These disruptions had significant impacts on practice administrative efforts and close working relationships with disparate staff across a broad geographic area.

### **Geographical**

A rural ACO is spread across hundreds of square miles in order to obtain adequate numbers of patients to qualify for MSSP ACO participation. Gathering all physicians and staff together for discussions was problematic and required multiple individual briefings on current topics of discussion.

There are many compelling reasons for developing ACOs in rural areas. Care coordination, teaching patients about their medications, and management of disease states can lead to significant increases in the quality of care and quality of life for patients served by the ACO. Unfortunately, structural flaws in the MSSP in risk management, benchmark calculations, and shared savings design are prohibitive obstacles for long-term operation. This lack of an adequate financial model to support the ACO program and other value-based programs may ultimately preclude their operation in rural areas. NCMJ

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