IMPACT OF ACOS ON RURAL COMMUNITIES AND PROVIDERS IN CALIFORNIA

505 Fourteenth Street, Fifth Floor | Oakland, CA 94612-1912 | T 510.768.0066 | F 510.768.0044 | hfsconsultants.com

Introduction

The Patient Protection and Affordable Care Act ("ACA") is an ambitious endeavor to improve health care in the United States. One of the ACA's key features is the Accountable Care Organization ("ACO"). ACOs will contract with the Centers for Medicare and Medicaid Services ("CMS") to provide comprehensive coordinated services for a defined population of Medicare beneficiaries. If they meet quality standards and reduce costs, ACOs will share in the savings.

California's rural areas constitute 85% of its land mass and are home to 5 million people, or 13.7% of its total population. This population faces many challenges that affect its health status and the delivery of health care services:

- A higher level of poverty
- Lower levels of educational achievement
- Travel distances and travel times
- Higher rates of chronic disease
- A shortage of health care providers
- Financial problems for many current rural health care providers[i]

The Accountable Care Act acknowledges these issues for rural areas nationwide and indicates intent to improve rural health conditions. The ACO provisions in the ACA specifically address rural communities.[ii]

At the same time that CMS is promoting ACOs ("federal ACOs"), the marketplace has accelerated the development of organizations and business relationships that perform in an ACO-like manner ("commercial ACOs"). Both federal and commercial ACO development has implications for California's rural communities. The purpose of this white paper is to address several questions:

- How relevant is the ACO legislation and concept to California rural communities?
    - What are the benefits and costs of participating?
    - What are the consequences of not participating?
- Do California rural communities have the resources and necessary conditions to develop or participate in an ACO?
- What are specific communities doing to develop or participate in ACOs? What lessons can rural communities and providers learn from these specific endeavors?

Definition of an Accountable Care Organization ("ACO")

An ACO is "a health care delivery system organized to improve health care quality and control costs through care coordination and provider collaboration, and … be held accountable for its performance."[iii] Two sectors of the economy are promoting and encouraging the development of ACOs: the federal government and the commercial marketplace.

Impact of ACOs on Rural Communities and Providers in California

There are three federal ACO programs: the Medicare Shared Savings Program (MSSP); the ACO Advance Payment Model; and the ACO Pioneer Model. The Medicare Shared Savings Program (MSSP) ACO is the most basic. Final rules for participation as a MSSP ACO were published on October 20, 2011 by the Centers for Medicare & Medicaid Services (CMS). The Advance Payment Model is designed to provide advance payments to physician-based ACOs and ACOs with rural hospitals in order to partially fund the costs associated with forming an ACO. The Pioneer Model is intended for mature organizations that are already experienced in coordinating care for patients across care settings and are willing to take on greater risk.

Competition and anticipation of the federal ACO program have stimulated development of Commercial ACOs. Many Commercial ACOs may ultimately meet MSSP participation requirements. California has several such organizations, including Kaiser Permanente, Sutter Health, John Muir Health, Monarch Health, and the Blue Shield ACO that was developed with Hill Physicians and Catholic Healthcare West for Sacramento CalPERS beneficiaries. They are integrated delivery systems that manage, or contract for, a wide spectrum of medical specialties (primary to specialty) and levels of care (outpatient, acute, post-acute). Many of these entities receive significant amounts of their revenue on a capitated (prepaid per member per month) basis, and many have evolved to what they are today in order to better manage the care provided to their beneficiaries. These Commercial ACOs may or may not choose to participate in the one of the federal ACO programs

The existence of commercial ACOs in California is due in large measure to the prevalence of managed care in the state. Although a significant percentage of health care in California is delivered under managed care contracts, managed care is not prevalent in rural California, e.g. statistics for the CalPERS Health Program for August 2011[iv] show that 67% of all beneficiaries, but only 38% of rural residents, are covered by HMO contracts. This lack of managed care in rural California is due to relatively low numbers of potential beneficiaries and low numbers of providers in rural communities.

Although there are few HMOs serving rural California, some rural providers have formed networks to recruit and retain physicians and to ensure that their communities have access to services that they do not provide locally – specialists, advanced diagnostics, and tertiary services. Such networks may also yield operational cost savings through economies of scale in the sharing of certain services such as specialist call coverage, IT support, telemedicine technology, and various technical and professional services. The lessons from these networks and the managed care history in California are important guides for assessing whether ACOs will benefit rural communities.

Conditions for participation in the Medicare Shared Savings Program

The following are the general conditions for participation in the MSSP and therefore being an ACO as defined by federal law.

Table A: General Conditions for Participation in Medicare Shared Savings Program (MSSP)[v]

Category	Detail
Eligible participants	• ACO professionals (physicians, physician assistants, nurse practitioners, clinical nurse specialists) in group practice arrangements • Networks of individual practices of ACO professionals • Partnerships or joint venture arrangements between hospitals and ACO professionals • Hospitals employing ACO professionals • Critical Access Hospitals (CAHs) that bill under "Method II" – billing for both facility and professional services • Federally Qualified Health Centers (FQHCs) • Rural Health Clinics (RHCs)
Contract duration	3 years beginning 4/1/2012, 7/1/2012, or January 1 of each succeeding year
Legal structure	• Able to conduct business in the State • Able to ensure provider compliance with quality criteria • Able to receive and distribute payments for shared savings • Governing body composed of at least 75% of participants (see above)
Leadership	Demonstrated ability to "improve efficiency, processes, and outcomes"
Medicare fee-for-service beneficiary population	Assigned by CMS and must be greater than 5,000
Assignment of beneficiaries	CMS will assign beneficiaries to an ACO based on data showing historical utilization of primary care physicians. An ACO cannot select its beneficiaries.
Processes	Documented plans to promote: • Evidence-based medicine • Beneficiary engagement • Internal reporting of quality and cost measures • Coordination of care

Impact of ACOs on Rural Communities and Providers in California

Category	Detail
Health Information Technology	"Meaningful use" was dropped as a requirement, but is included as a heavily weighted quality performance measure.
Performance reporting	33 quality measures organized in four "domains": • Patient satisfaction with caregiver services • Care coordination • Preventive health • At-risk/frail elderly
Benchmarking	CMS will establish cost benchmarks using the most recent 3 years of per-beneficiary expenditures for beneficiaries assigned to the ACO.
Shared savings	When an ACO meets the savings benchmarks, a portion of the savings will be distributed to the ACO.
Risk	There are two cost-sharing options: • One-way, in which savings above the benchmark are shared, but there is no risk if savings are not realized in the first two years. • Two-way, in which losses and savings would be shared
Financial security	Demonstrate ability to absorb financial losses if participating in two-way incentive

The following shows the additional conditions for participation in the Advanced Payment ACO Program.

Table B: Additional Conditions for Participation in the Advanced Payment ACO Program

Category	Detail
Eligible participants	• ACOs that do not include any inpatient facilities & have less than $50 million in annual revenue • ACOs in which the only inpatient facilities are Critical Access Hospitals or Medicare low-volume rural hospitals AND have less than $80 million in annual revenue
Application deadline & contract duration	Only open to participants in MSSP entering in April or July 2012. Three years.
Advanced payments	Three types: up front fixed, up front variable (based on assigned beneficiaries), monthly (based on number of assigned beneficiaries). Purpose: to provide funds to cover ACO development costs.
Recoupment of advanced payments	Recouped from an ACO's earned shared savings • If savings are not sufficient by midpoint of second year, CMS will recoup remaining amounts in subsequent year. • If savings are not sufficient by end of first agreement period (3 years), CMS will not pursue recoupment of remaining balance
Legal agreement	Obligation to repay advance payments will be established with separate legal agreement with CMS

These general conditions raise two issues for rural communities. The first is that the minimum number of beneficiaries is 5,000. In California, only 12 out of 65 rural hospital service areas had more than 5,000 Medicare beneficiaries[vi]. Assuming that 15% of the population is of Medicare age, a rural community or provider group would need to have a total population base of at least 33,000 patients in order to have the minimum number of required Medicare beneficiaries. This suggests that, in order to meet minimum beneficiary requirements, many rural providers wanting to participate in an ACO would need to do so as part of collaboration with other neighboring rural providers or with suburban and urban providers.

The second issue for rural communities is the limitation that only Critical Access Hospitals (CAHs) billing under "Method II" for outpatient services can develop an ACO. Under Method II, a CAH bills for both the hospital and professional services.

Functional requirements to succeed as an ACO

The following is a summary of the critical functions that must be adequately performed to ensure "success" as an ACO.

Table C: Critical Functions of an ACO

Network development and management	
	ACO management
	Provider management
	Legal, actuarial, other professional functions
	Financial and management information systems
	Recruiting/acquiring Primary Care Providers (PCPs)
	Relationship management with specialists
	Post-acute care services
	Contracting capabilities
	Agreed-upon rules for distributing savings
Care coordination, Quality Improvement, Utilization Management	
	Disease registries
	Care coordination and discharge follow up
	Specialty-specific disease management
	Integration of inpatient and ambulatory services
	Patient education and support
	Medication management
	Designation as a patient-centered medical home
Clinical information systems	
	Electronic Health Records
	Intra-system EHR interoperability
	Link to a health information exchange (HIE)
	Clinical data warehouse
Data Analytics	
	Analysis of care patterns
	Quality reporting

Benefits for rural communities and providers participating in an ACO

The general goals of ACA and ACOs address many of the frequently identified health needs of rural communities. The "triple aim" of ACA is to improve health status, improve quality of care, and manage and contain costs for the population as a whole. This is to be accomplished with collaborative provider networks. Accountability for performance is based upon targets and metrics that measure cost and quality.

Many rural communities are served by health care districts, and those districts were created and exist to protect the health of their residents[vii]. The mission statements of these districts often mirror the "triple aim". In order to survive and to provide services to their local residents, rural providers often collaborate and build "networks" between local physicians, local hospitals and regional specialists and health care systems. Also, in order to meet their obligation for public accountability and to mitigate a frequent perception that better quality service is available in

urban settings, many rural providers monitor and report data to their communities on quality of service and patient experience. In short, rural communities and providers frequently share the goals and strategies of ACOs.

The following table shows how an ACO might be able to provide benefits that are of particular importance to rural communities.

Table D: Potential ACO Benefits

Community Need	Potential ACO Benefit
Access to primary care	• PCP access and care coordination • Improved primary care recruitment & retention
Access to specialty care	Improved access by including a larger network of physicians
Access to acute services	Access to tertiary care coordinated with local providers
Access to post acute services	Coordination of services with rehabilitation, long-term care, and home health
Coordination of care across levels of service	Required core competence of an ACO
High need for chronic disease management & prevention	• Required core competence of an ACO. • Incentives to reduce incidence, provide coordination, engage patients
High poverty levels – affordable care	FQHCs and RHCs can form ACOs
Quality	Required monitoring and incentives for performance
Electronic Health Records & Health Information Exchanges	• Highly incentivized within MSSP • Key part of infrastructure of existing market defined ACOs • Essential for care coordination within a geographically distributed network

In summary, access to an effective ACO has the potential to increase access to services, improve chronic disease management, and improve the quality of care.

The preceding list excludes the benefit of shared savings. According to the *Dartmouth Health Atlas* the cost of services for Medicare beneficiaries is 20% lower in rural areas than urban areas.[viii] Additional savings – as measured by payments to healthcare providers --- are unlikely for rural populations. However, rural communities incur higher economic costs due to higher levels of chronic disease and the costs associated with lack of access to critical services – e.g., lost economic productivity and earnings. An effective ACO may provide a community with the potential of “cost savings” that relate to these other economic measures.

Impact of ACOs on Rural Communities and Providers in California

Costs of participation in an ACO

Participation in an ACO may result in the following costs to a community and its providers:

- Investment in the ACO infrastructure: new policies, procedures, systems, related facilities, and recruitment of providers
- Investment of management time and focus
- Additional ongoing expenses for management and operation of the ACO
- Loss of hospital service volume and related revenue

The costs and time to develop an ACO from scratch are high. Using the experience from the Medicare Physician Group Practice Demonstrations (PGPD), the GAO estimated the cost of developing an "average" ACO at $1.7 million.[ix] This estimate has been challenged and replaced with higher estimates. For example, McManis Consulting[x] estimated the development costs for a 200-bed hospital with 80 PCPs and 150 specialists would be $5.3 million. Incremental annual ongoing expenses were estimated to be $6.3 million. McManis made it clear that its estimates are for the total costs to support all necessary functions. Some of these costs may already have been incurred by some organizations and might be attributable to purposes other than ACO development, such as serving managed care contracts. In addition to capital investment, a significant cost is the investment of management time and attention.

The Advance Payment ACO model offers to provide payments that can be used to cover an ACO's development costs. Key features of this model are:

- Three types of payments: an upfront fixed payment, an upfront variable payment based on number of assigned beneficiaries, and a monthly payment based on the number of assigned beneficiaries.
- CMS will recoup the advanced payments through an ACO's earned shared savings. If full recoupment is not realized by the end of the three year agreement period, CMS will not pursue recoupment of remaining balances.
- The Advance Payment model is open to organizations that:
    - Enter the MSSP in April or July 2012
    - Do not include inpatient facilities and have less than $50 million in annual revenue, or
    - The only inpatient facilities are critical access hospitals and/or Medicare low volume rural hospitals and have less than $80 million in annual revenue

A successful ACO may also cause a decrease in the revenue of its hospital participants. In order to reduce the per capita costs of health care, and, arguably, to improve the quality of healthcare, hospital admissions and utilization must decrease. Therefore, a successful ACO will likely reduce hospital revenue, and the loss of hospital revenue may not be entirely offset by either shared savings or reduced operating expenses. In addition, a rural hospital participating in a larger ACO may also lose service volume to larger, more economical, participants in the ACO. Concentration of service volumes may occur at the expense of lost revenue of the rural hospital participant. Hospital operating margins may decline significantly. This may cause the closure of some rural hospitals, reducing community access to diagnostic services as well as emergency and acute care.

Impact of ACOs on Rural Communities and Providers in California

Costs of not participating in an ACO

Not participating in an ACO may also generate other forms of cost for both providers and communities.

An ACO that can meet the triple AIM objectives of reduced cost, increased quality, and improved health status would be beneficial to the community and an attractive contractor for a health plan. A decision by the community hospital, or other local providers, not to participate in a regional ACO could result in fragmentation of already limited health care resources as some providers align with the new ACO and others do not. In addition, physician recruitment, hospital service volume, and reimbursement rates could all be impacted.

Although the Federal Trade Commission has provided guidelines indicating that an ACO would operate within a "safe harbor" from anti-trust laws if it has less than 30% of a service area's market and would likely be considered "safe" if it has less than 50%, there are "rural exceptions". This may result in a rural provider competing with a larger regional ACO whose market share in the rural community is much higher than 30%, or even 50% -- which could result in decreased, rather than increased, competition. Finally, developing EHRs may be more difficult for rural providers not participating in an ACO. Achieving "meaningful use" requires connecting with other local providers. If those other providers are participating in an ACO, they are likely to first focus on connecting within the ACO network rather than with unaffiliated providers.

Capacity and capability of California rural communities to develop or participate in an ACO

Tables A, B, and C show what is needed in terms of legal requirements and organizational functionality. Table E summarizes the capability and capacity of rural communities to achieve that functionality. This summary and the following discussion emphasize hospitals, which in most rural communities are the only health care organizations with the "scale, financial strength, and management depth to undertake an ACO".[xi]

Impact of ACOs on Rural Communities and Providers in California

Table E: Capability of Rural Communities and Providers

Requirement: resource or condition	Use in developing ACO	California Rural status/situation
Greater than 5,000 Medicare beneficiaries	Participation requirement	12 of 65 hospital service areas have more than 5,000 Medicare beneficiaries
Financial capacity of provider organizations to invest	Invest in ACO infrastructure	Low cash reserves – 39 days cash on hand for California CAHs in 2008[xii]
		Low operating margins -- -3.7%[xiii]
		Low debt capacity
		Conflicting capital requirements
		Occasional community support via GO bonds & donations
Financial capacity of hospitals to absorb changes in operating margin	Offset reductions in hospital revenues	• Low operating margins • Poor economies of scale
	Offset increases in ACO related expenses	
Ability to integrate rural physicians	Need for sufficient local primary care	• Prevalence of solo or very small group practices • Low-tech infrastructure
Adequate numbers of providers	Provide sufficient primary care and a full continuum of services	Most are in Medically Underserved Areas or Health Professional Shortage Areas
Leadership experience	Development and management	Inexperienced with managed care, integrated delivery systems, other ACO functional competencies

A significant requirement for development of an ACO is financial capacity. Very few rural providers have sufficient cash reserves and/or debt capacity to invest in the development of an ACO[xiv]. In 2008 the average cash balance in California CAHs was about $2 million, equivalent to 39 "days cash on hand" and the operating margins averaged -3.7%. Other demands for capital funding include the requirements to upgrade facilities to meet seismic safety standards, the need to upgrade core management information systems, and the need to recruit and retain physicians. In some cases, communities have shown the ability to raise significant philanthropic donations, but this is not common. More frequently, hospital districts have obtained community financial support for capital investment in the form of General Obligation Bonds, which are secured and funded by property taxes; however, this form of financing is not available to all rural providers.

Adequate operating margins could also enable a rural hospital to absorb two additional costs of ACO participation: an increase in operating expenses related to ACO expenses and a reduction in revenues due to lower utilization. Very few rural providers have such margins In any case, rural hospitals may need to increase operating efficiency to offset the impact of the ACO on their

operating margins—i.e., reduce overhead (non revenue-productive expenses) and cost per unit of service in revenue producing departments. However, many rural providers have faced financial stress for long periods and have reduced expenses to minimal levels – making it more difficult to get additional marginal savings.

Another limitation in the capability of rural communities participating in ACOs is that rural physicians outside of clinics are frequently in solo or very small group practices. Their infrastructures do not match the functional requirements of ACOs, and it may be challenging to integrate their practices with the more sophisticated requirements of an ACO. It may also be costly in terms of funds and time. Electronic Health Record systems are a key component of an ACO. Their installation in clinics has demonstrated that although the explicit costs paid to vendors is clear, the provider time and the short term impact on revenue and cash flow is almost always greater than expected. Solo and very small group practices in rural areas often do not have the resources to make such changes. D. Hatton of the American College of Physicians has noted that "the current requirements of ACO/MSSPs …sets too high of a bar for participation... by internal medicine physicians... who practice in smaller, independent, physician practices."[xv] This challenge can be mitigated through cooperative ventures, sharing arrangements, and participation in larger existing ACOs.

For rural providers, participating in an urban ACO may raise other issues. The first is the likelihood of conflicting incentives and motives. "Urban health care systems will use their financial strength, leadership experience, market dominance, and policy clout to leverage market share from rural providers. Urban predation will shift patients (and hence payment) out of rural areas to support extensive urban infrastructure investments. Rural shortages will worsen."[xvi] In addition, the relative financial burden of an ACO may be greater for a rural participant. Urban cost structures yield lower marginal costs and average costs, and rural providers have low volumes over which to spread the cost of investing in new infrastructure. Finally, rural leadership is relatively inexperienced in terms of the broad spectrum of ACO-required functional competencies.

Most rural providers are in Medically Underserved Areas (MUAs) or Health Professional Shortage Areas (HPSAs) and will have a difficult time providing a comprehensive continuum of care. They will need to finance and support the integration of new functions such as preventive medicine and health promotion. According to the National Rural Health Association "Outcome-oriented practice in workforce shortage areas is a challenge."[xvii] This further indicates that participating in an existing and/or larger ACO is the most feasible course of action.

Decision to Participate in an ACO

Despite the challenges and apparent restrictions, rural providers and communities cannot afford to ignore the ACO phenomenon. In general, their options are:

- Participation in a federal ACO/MSSP
- Participation in a commercial ACO
- Moving in the direction of being able to participate in an ACO. Lynn Barr, of Tahoe Forest Hospital District has suggested adopting the ACO framework "without becoming one". Tim Size of the Rural Wisconsin Health Cooperative has suggested that: "Rural providers need to focus on developing the core competencies related to care coordination

and not get distracted by trying to become an early adopter of an urban-centric set of federal incentives."[xviii]

Relevance of the ACO legislation and concept to California rural communities

The ACO legislation and concept are very relevant to California rural communities even if they choose not to develop an ACO or participate directly. Although the costs and challenges of developing or participating in an ACO are great, there are significant longer-term risks of not participating. Commercial ACOs already exist and have significant strength in California. The impact of the ACA on these commercial ACOs is likely to further strengthen their organizations even if they choose not to participate in the MSSP.

In California most urban and suburban areas will have competing commercial ACOs. Many rural providers will connect with those entities in order to attract or retain market share, recruit and retain local physicians and access specialists and tertiary services. These existing relationships could provide the basis for participation in an ACO.

ACO Rural Impact Case Studies

Discussions with rural providers that have taken actions consistent with the development of an ACO (if not full participation in the MSSP) indicated several recurring themes that form the basic elements of ACO strategy and tactics.

1. Alignment with the ACA triple aim goals --- improvement of health, quality of health service, and cost management --- directed toward the local community. All of the organizations interviewed for this report have business plans and mission statements that contain these goals.

2. Development of business relationships with similar provider organizations. Virtual peer organizations have formed networks and business partnerships– e.g., the Northern California Healthcare Authority -- to share services and costs, to contract with vendors and payers, and to provide access (e.g., via telemedicine technology) to services not available locally.

3. Development of business relationships between providers of different service levels: hospitals, physicians, community health centers, providers of specialty services, and long term care providers. Integration of these components of the health care continuum can take the form of collaborative partnerships, contracts, or direct ownership and control – e.g., the management contract agreement between Sonoma Valley Healthcare Distrtict and Marin General Hospital.

4. Investment in Information Technology to enable electronic health record systems (EHRs), connectivity and interoperability via Health Information Exchanges (HIEs), and telemedicine connections with other providers – e.g., the initiatives undertaken by the Tahoe Institute for rural Health Research and by the Northern California Healthcare Authority.

5. Quality management, measurement, and reporting. All of the organizations interviewed for this report had active programs for managing, measuring, and reporting quality performance. It should be noted that these programs focused primarily on patient satisfaction and service quality. Less frequently, community health status is addressed.

Several rural provider organizations have shared their experiences to illustrate these elements of ACO development in rural California. These provider organizations are differentiated by the size, location and dynamics of their communities, and can be organized into the following groups:

- True rural --- distinguished by consistently long transportation times to other communities with healthcare services. Examples: Mendocino Coast District Hospital and Open Door FQHC.
- Rural/suburban --- distinguished by being far enough from other healthcare providers to require local services but being close enough that local residents frequently travel outside of the local community to obtain healthcare services. Other characteristics of these communities are that
    - The transportation times vary significantly by time of day and season
    - The expansion of urban areas and highways has changed the situation dramatically over time
    - The local providers face significant competition from out-migration of local residents to larger and more urban organizations
    - Examples: Sonoma Valley Hospital, Healdsburg Hospital, and Tahoe Forest Hospital.

The Northern California Healthcare Authority

The Northern California Healthcare Authority (NCHA), a partnership of rural health care districts, demonstrates collaboration between rural hospitals to pursue the objectives expressed in the ACA and develop an ACO-like organization. At the same time, the development demonstrates the challenges faced by rural providers who want to form such collaborative organizations.

Five rural district hospitals in Sonoma, Mendocino, and Humboldt counties formed a partnership called the Northern California Healthcare Authority with the intention of gaining strength through collaboration: Sonoma Valley Healthcare District (Sonoma), Palm Drive Hospital District (Palm Drive), North Sonoma County Healthcare District (Healdsburg), Mendocino Coast Healthcare District (Mendocino), and Southern Humboldt Community Hospital – Garberville (Garberville).

Because hospital districts are governmental entities, the partnership takes the form of a “Joint Powers Authority” (JPA), which requires public meetings and compliance with State government procedural laws. The NCHA was initially funded by generous donations from a Sonoma County philanthropic organization, the Hillblom Foundation, and is now funded by its members and by new grants.

NCHA also created a not- for-profit corporation (501c3) – Northern California Integrated Health (NCIH) – in order to provide a vehicle for participation by the community health centers, the local FQHCs and RHCs. This is still work in progress and is a priority for most members.

Three of the NCHA members – Sonoma, Palm Drive, and Healdsburg – share very similar situations and histories. First, they face competition from Kaiser Permanente (which has a market share in excess of 25%), Sutter Health (with a hospital in Novato and in Santa Rosa), and the Sisters of Saint Joseph of Orange (with hospitals in Santa Rosa, Petaluma, and Napa). Second, they are hospital districts with significant local community support as expressed in terms of philanthropy, property taxes and support for General Obligation Bond measures. Third, they had participated in a provider-created non-profit health plan called the "Health Plan of the Redwoods" (HPR), which had been forced into bankruptcy in 2002. Upon its dissolution, HPR had 100,000 beneficiaries in Napa, Sonoma, and Marin counties. HPR had been of significant financial benefit to Sonoma County providers and had over 11,000 Medicare managed care lives in Sonoma County. The financial impact of HPR's bankruptcy on the district hospitals and on their related IPAs was negative and significant.

The other NCHA members – Mendocino Coast and Garberville – are more geographically remote but share many of the same challenges: significant patient out-migration for services that could have been provided locally, poor economies of scale (low volumes and revenues relative to high fixed costs), limited capital funds and sources, inadequate "legacy" information systems, aging medical staffs, difficulties in recruiting and retaining new physicians, relatively low reimbursement rates.

The goals of NCHA are to pursue funding of mutually beneficial projects, share costs, share administrative and clinical services, discuss best practices and matters of mutual concern, and develop an organization to realize the lost benefits of the HPR. Relative to the Sonoma County market, they want to create an integrated delivery system or ACO which could be a viable alternative to Kaiser Permanente. The challenges faced by the NCHA in building a successful collaborative organization are common for rural providers: the time demands of collaborating over relatively great distances, the difficulties of aligning the priorities of the members, and the difficulties of engaging local physicians with the concept of the NCHA. Due in large measure to their relatively wide geographic distribution and to the distinct nature of their local markets, the members of the NCHA are also pursuing independent paths toward participation in ACOs.

Sonoma Valley Hospital

The experience of Sonoma demonstrates collaboration with peers as well as integration with providers of other services within the health care continuum. The situation of Sonoma also demonstrates a common dilemma for rural communities: the demand for services within the community is not great enough to provide economies of scale but the demand is great enough that local services are needed.

Sonoma is a district hospital serving a population of 45,000 with approximately 9,000 Medicare beneficiaries and 9,000 Kaiser members. Sonoma is located 40 minutes from Santa Rosa and Marin General Hospital and 25 minutes from the Queen of the Valley Hospital in Napa. Sonoma has 83 licensed beds (not a CAH), a 27 bed distinct part SNF, and a home health agency. It is supported in part by parcel taxes and has issued $35 million in General Obligation Bonds to

upgrade its facilities to meet State seismic standards. It is in a Health Professional Shortage Area (HPSA), and there is a single FQHC in Sonoma's district, the Sonoma Valley Community Health Center, which serves over 7,000 community members.

Five years ago Sonoma's priorities were dominated by a need to meet the State's seismic upgrade requirements. Through significant community participation, resulting in the general obligation bond measure, Sonoma was able to develop and fund a plan to meet the requirements. Despite this success, Sonoma faced other problems: operating losses; difficulty in recruiting and retaining physicians; difficulty obtaining affordable call coverage for critical sub-specialties (OB-Gyn, Orthopedics, General Surgery); loss of market share in orthopedics and gastroenterology due to competition from physician-owned ambulatory centers in neighboring communities, each 25 – 30 minutes from Sonoma; significant out-migration of community members for other services; relatively unfavorable commercial insurance reimbursement compared with rates estimated for the larger systems in the area.

In response to these challenges, Sonoma took several initiatives. First, it led the development of the NCHA. Second, it collaborated with its physicians and executed a business plan with the follow results:

- Recruitment of new PCPs and specialists in collaboration with the Marin-Sonoma IPA and its Prima Medical Group. The Marin-Sonoma IPA is a successful independent practice association that has served both Marin and Sonoma physicians for several years. Most of the physicians in the Sonoma Health Care District participate in the IPA. The IPA developed a primary care medical group called Prima, and Prima opened a small group office in the District several years ago. The IPA and Prima have had an Electronic Health Record system operational for several years. Sonoma and the IPA and Prima reached an agreement whereby Prima would employ physicians recruited by Sonoma --- including both primary care physicians and specialists.
- Co-sponsorship, with Marin General Hospital District, of a new medical foundation called the Prima Medical Foundation. While this agreement was being developed, the Marin Healthcare District terminated its management contract with Sutter Health and employed its own management team. Prima, Sonoma and Marin worked together to develop a plan for a medical foundation which would serve both counties and provide integrated health services.
- Contracting with Marin General Hospital for management services. Sonoma's business planning led to the determination that the hospital did not have sufficient revenues to support an adequate administrative infrastructure. In response, Sonoma explored alternative affiliations and management arrangements. Sonoma and Marin are now managed by the Marin General Hospital management team.

These actions constitute clear steps in the direction of Sonoma participating in an ACO-like entity.

Healdsburg District Hospital

The experience of Healdsburg is similar to that of Sonoma and demonstrates collaboration between peers and the development of an integrated continuum of services --- supported by significant funding from the local community. Healdsburg also represents a district that is becoming decreasingly rural and whose local providers face clear competition from providers in the neighboring urban area of Santa Rosa.

Another of the NCHA district hospitals, Healdsburg serves a market of about 60,000 people with about 10,000 Medicare beneficiaries (an estimated 1,800 of whom are enrolled in Kaiser) and 15,000 Kaiser members. Healdsburg is located 21 minutes north of Santa Rosa on Highway 101. It is a CAH and operates 17 SNF beds. It is supported by property taxes and, as described below, has significant support from a local philanthropic foundation. Healdsburg owns a campus that includes both the Alliance Medical Center FQHC -- with nine primary care providers and four dentists-- and a hospital-operated clinic (Healdsburg Primary Care) with 7 primary care physicians.

The North Sonoma County Healthcare District, which owns and operates the hospital, was created in 2002 in response to a decision by a for-profit hospital management company to stop operating the hospital. In response to the threat of losing its local hospital, the community formed the philanthropic Healthcare Foundation Northern Sonoma County (the Foundation), which provided the funds and community support to create the District. The Foundation raised over $19 million dollars and has provided funds to both the hospital and the Alliance Medical Center FQHC. These funds have been used to provide business plans, upgrade facilities and equipment, upgrade information systems – including EHRs --, recruit and retain physicians, and invest in telemedicine technology. Both the hospital and the FQHC have actively participated in the development of a Health Information Exchange, called the Redwood Med Net. Several other NCHA members also participate in Redwood Med Net.

Healdsburg faces several critical challenges. First, Healdsburg is relatively near Santa Rosa -- with Kaiser, Sutter Health, and Santa Rosa Memorial which is operated by the Sisters of St. Joseph of Orange. Healdsburg’s market share of its local zip codes is about 24% of acute discharges. Second, Sutter is developing the Sutter Medical Group of the Redwoods in Santa Rosa, which is a part of the Sutter Medical Foundation. Third, Sutter is building a new facility located 13 miles south of the hospital with a 60 bed hospital, ambulatory care center, and medical office building. Finally, Healdsburg faces reductions in cost-based reimbursement and for SNF services.

In response to these challenges, Healdsburg has taken several actions in addition to what it has already done in implementing the business plan developed by the Foundation. It participates in NCHA. It participates in a two-county (Marin and Sonoma) planning group to pursue development of a successor to the Health Plan of the Redwoods. It is collaborating with the Alliance Medical Center and the Foundation to expand specialty physician services to Windsor, a town of 26,000 which is within the district but 8 miles south of the hospital. It has obtained an award for excellence from HealthGrades for its orthopedic joint replacement program. It has used telemedicine to connect to several specialists and more tertiary hospitals.

Impact of ACOs on Rural Communities and Providers in California

Tahoe Forest Hospital District

Tahoe Forest demonstrates the development of a broad service continuum and has a played a significant leadership role in organizing rural hospitals and communities in moving toward healthcare reform and the development of rural-based ACOs. Tahoe Forest serves a rural area that experiences large seasonal changes in its population and in transportation times to other communities and providers.

Tahoe Forest Hospital District operates two critical access hospitals, one in Truckee and the other in Incline Village, Nevada. The resident population of the district is about 30,000, with about 2,500 Medicare beneficiaries. The district has a very a large recreational visitor population which accounts for about 47% of the economic activity within the district. The district is 35 minutes to Reno in good weather, but in winter, the connecting highways and access roads are occasionally impassable. Its Truckee facilities are licensed for 72 beds: 25 general acute (12 swing), 37 SNF, 6 ICU and 4 perinatal. The Incline Village facility has four beds. TFHD also operates outpatient service facilities, specialized care centers and satellite locations that serve six counties in two states spread over approximately 3,500 square miles.

TFHD has achieved considerable financial success and has robust financial reserves. In addition, in 2007 the residents of TFHD approved a $98.5 million general obligation bond issue to meet State seismic regulations and to build a new central utility plant, cancer center, emergency department, and skilled nursing facility.

Despite its financial strength, TFHD faces several challenges. First, it is close enough to Reno during favorable weather conditions that it has significant patient outmigration. Second, the demand for its services has very large seasonal variability, peaking during the tourist seasons of summer and winter. This makes efficient staffing difficult. Third, the overall local demand for its services is too low to allow economies of scale and too high to not provide the services on a local basis. Fourth, the overall demand for medical services is too low to provide sufficient revenues to have enough physicians for call coverage, yet it is too far from medical centers for physicians to comfortably split their practices. Fifth, it does not have enough residents to meet the requirements of the Medicare Shared Savings Plan or to participate in managed care products. Finally, it does not have a contemporary HIS or EHR.

To deal with these challenges, THFD: implemented strategies for physician alignment, which include acquisition and operation by TFHD of a physician-owned surgery center and operation of a hospital-owned clinic and medical office building; operates the post-acute services of a SNF and a Home Health Agency; is implementing a new HIS and EHR; employs Press Ganey to monitor patient satisfaction throughout the organization; is evaluating the possibility of using its self-insured employee health plan, with about 2400 beneficiaries, to build experience and competence in managing healthcare costs.

THFD has also taken significant steps toward future development of ACO capability in rural California. TFHD created the Tahoe Institute for Rural Health Research (TIRHR), a 501c(3) non-profit corporation whose mission is “to create an environment in which practitioners, scientists, and industry leaders collaborate to address relevant healthcare questions through the application of rigorous research methodology to produce innovative solutions that can be integrated into rural healthcare delivery settings.” In September 2011 TIRHR was awarded a HRSA grant “to assist 15 unaffiliated CAHs adopt Health Information Technology.” They have

formed a network, the California Rural eHealth Information Network (CAReHIN), which is supporting the development of electronic health record systems and a health information exchange in California. TIRHR is now developing an application to the Center for Medicare and Medicaid Innovation (CMMI) to "to demonstrate and inform CMS of the impact of the Rural-Rural ACO model". In the application TIRHR points out that "none of California's CAH Referral Regions have the minimum 5,000 Medicare beneficiaries to become a standalone ACO" – a fact which means that, in order to participate in ACOs, California CAHS would need to affiliate with other organizations. TIRHR is concerned about the inherent conflicting incentives in the "urban-rural model". The application proposes to engage ten rural-based communities in the study --- five participants will implement reforms and five will serve as controls. All ten will be "meaningful users of electronic health records in the inpatient and outpatient settings", will participate in a health information exchange and a clinical data repository, and will get quality and beneficiary cost reports.

Cases in More Rural Areas

The following cases are both located in the more rural areas of the Northern California coast region. These case examples differ in several respects from the preceding cases. First, their communities have few local alternatives for healthcare. Second, these providers do not appear to be directly facing competition from regional ACOs. Nonetheless, their movement in the ACO direction is primarily demonstrated in the development of broad service networks – in both cases relying on telemedicine and innovative relationships with specialists and more tertiary facilities.

Mendocino Coast District Hospital

Mendocino is more geographically remote than the previous hospital case studies --- with greater transportation times to other communities and providers. Mendocino's experience demonstrates significant peer collaboration, building of a continuum of services across a broad spectrum, and the use of telemedicine technology to add to this continuum.

Also a member of the NCHA, Mendocino's district has a population of about 15,000, with less than 5,000 Medicare beneficiaries. Its residents have long transportation times to alternative facilities: 1 hour 23 minutes to Ukiah, 58 minutes to Willits, and 2 hours 22 minutes to Santa Rosa. It operates a 43-bed hospital with 26 acute care beds and 17 swing beds, a home health agency, and a hospice. It is a CAH. Mendocino also operates a Rural Health Center (RHC) with ten primary care providers. The clinic is located on the hospital campus.

Mendocino faces these challenges: operating losses; outmigration of patients for ambulatory procedures; a medical staff with an average age of over 60; the need to replace most or all of its facilities to comply with the State's seismic upgrade deadline of 2030; the need to implement an EHR for both the hospital and clinic; reimbursement reductions.

In response to these challenges, Mendocino has taken the following initiatives: developed a Strategic Plan to address the issues; constructed a diagnostic imaging center; operates the "Healing Hospital" wellness program; obtained an award for excellence from HealthGrades for its joint replacement program; participates in the NCHA JPA; participates in the Critical Care

Access Hospital Network (CCAHN); participates in the Redwood Med Net Health Information Exchange.

Open Door Community Health Centers (Open Door)

Open Door demonstrates the building of a large rural network of community health centers and, with the aid of telemedicine technology, a broad continuum of services.

Open Door is an FQHC that serves Del Norte and Humboldt Counties and the surrounding rural areas, covering over 6,200 square miles. It operates nine clinics with 37 full time equivalent medical providers, nine FTE dental staff, and nine FTE behavioral health providers. It serves over 40,000 patients, almost half of whom are covered by governmental programs, 60% of whom live on less than 100% of the federal poverty level and 88% of whom live on less than 200% of the federal poverty level. Commercially insured patients account for over 18% of Open Door's patients. Its market area is designated as a Medically Underserved Area (MUA) and Health Professional Shortage Area (HPSA). For its service area overall, Open Door has a market share of primary care of over 40%.

Open Door's greatest challenge is in recruiting and retaining physicians in competition with urban and suburban providers.

Open Door has addressed the challenges of serving the residents of its large rural area in several ways. First, it has built a cooperative and collaborative network of several community health centers. Second, it has sponsored the development of several organizations which provide support and advocacy for rural providers, including the Community Health Alliance of Humboldt and Del Norte Counties. Third, it developed the capability, in collaboration with UCLA and Humboldt State University, of compiling data and producing information which is used to measure its contributions to the community (e.g., market shares), the health status of the community, patient satisfaction, community needs, and to support the procurement of grants. Fourth, it has implemented an EHR in cooperation with the Oregon Community Health Information Network (OCHIN). OCHIN provides EHR support for a large number of FQHCs, including the Alliance Medical Center in Healdsburg. Fifth, it has pioneered the use of telemedicine to provide access to specialty services. In 1999 it created the Telehealth and Visiting Specialist Center (TVSC). TVSC combines both in-person and telehealth consultations. TVSC is used not only by Open Door- affiliated clinics but by others which are located in more than a dozen counties in Northern California and one in Southern California. A financial analysis[xix] of the TVSC indicates that during the year ending in November 2009 TVSC provided 6600 encounters and generated a positive operating margin

Lessons from the case studies

First, there is very little evidence of rural provider intent to participate in the Medicare Shared Savings Program.

Second, there is significant evidence that rural providers are moving deliberately towards developing and participating in commercial ACOs, if not the federal ACO program. This is occurring more frequently and intensely with those providers who are closer to urban areas ---

primarily as a defensive strategy. This movement may also be described as building virtual integrated delivery systems that provide access to a wide spectrum of services. Many have been doing so for years, and many want to accelerate that development. Examples of this direction include:

- Clear congruence between the ACA "triple aim" goals and the providers' mission statements and business plans
- Creation of provider networks and collaborative ventures
- Implementation of several alternatives for hospital-physician business relationships--including development of medical foundations and different forms of hospital-owned clinics such as 1206b and 1206d clinics and Rural Health Centers
- Implementation of EHRs and development of HIEs to connect the EHRs
- Telemedicine links to specialists and tertiary care institutions

Third, there is significant evidence that rural providers are recognizing that urban and suburban ACOs may impact them and that they need to take action in that regard. They are forming collaborative ventures with the purpose of competing with, and providing alternatives to, the existing commercial ACOs. At the very least, they are actively exploring their options and seem to recognize that they have little choice.

Fourth, there are important distinctions between rural communities that need to be considered. It is evident that the categories of "frontier rural", "rural", and "urban" are inadequate. The California Office of Statewide Planning & Development's (OSHPD) defines these categories as follows:

- Frontier – population density of less than 11 persons per square mile
- Rural – population density of less than 250 persons per square mile, and no population center exceeding 50,000
- Urban – population total ranging from 75,000 to 125,000 with similar demographic and socio-economic characteristics

The ACA and ACO regulations do not benefit rural providers in general, but the regulations also pose clear problems for a subgroup of rural communities. For example, many rural providers in California are close enough to suburban and urban areas that the existing commercial ACOs may reduce their market share, their ability to recruit physicians, and their negotiating power with commercial payers.

Fifth, there are some daunting challenges for rural providers who are moving in the ACO direction. These challenges include limited capital--- which may be mitigated in part by the Advanced Payment Program ---, demands on that limited capital by seismic upgrade requirements, limited power in negotiating with larger entities, small scales of operations with consequent problems for operating margins, community desire to have access to services for which there is insufficient demand, and legacy physicians who are resistant to change. Finally, all are experiencing decreases in reimbursement due to budget crises at all levels of government. It is noteworthy that many local communities have provided significant financial support for their local providers in the form of property taxes, general obligation bonds, and philanthropy.
Sixth, as a result of dealing with these challenges, rural leaders are offering consistent advice regarding what needs to be done:

- Assess the local and regional situation and develop a plan now,
- Work with other providers of mutual interest and collaborate to gain bargaining strength ("rurals must aggregate" according to Hermann Spetzler, CEO of the Open Door FQHC in Arcata),
- Evaluate and tighten cost structures: use benchmarks and best practices, challenge sacred cows,
- Do not try to be all things to all people – some services are not clinically or financially feasible to provide locally in the longer term,
- Focus on building a loyal and vital medical staff,
- Develop programs for chronic disease management
- Measure and manage quality as expressed in ACA
- Take care in implementing EHRs and evaluate the impact on productivity and on revenue cycle management.
- Develop ways to promote collaboration between rural hospitals and community health centers such as FQHCs and RHCs

In conclusion, rural providers and communities in California have historically adopted many of the elements of the ACO model specified in ACA. They have done so because of the nature of rural communities and how they have addressed their healthcare needs – cooperation and collaboration, participation in broader geographic networks, community support which includes local taxation, and investment in technology. In some ways, their historical behavior validates the ACA components. At the same time, it is unlikely that rural providers will develop their own ACOs. The costs and requirements are too great. On the other hand, due to the existence in non-rural California of robust commercial ACOs, they are taking actions to prepare for participation in the ACO movement.

Prepared with Support from the California HealthCare Foundation

---

[i] Sources for statistics supporting these statement can be found in the *Dartmouth Atlas of Health Care* and in several publications of the California HealthCare Foundation

[ii] Center for Medicare & Medicaid Services, *Fact Sheet: Medicare Shared Savings Program and rural providers* October 20, 2011.

[iii] MacKinney, A., Mueller, K., McBride, T. *The March to Accountable Care Organizations --- How Will Rural Fare?* The Journal of Rural Health. April 2011.

[iv] Thomson Reuters. August 2011.

[vv] Centers for Medicare & Medicaid. FACT SHEETS

[vi] *Dartmouth Atlas of Health Care*

[vii] Taylor, Margaret. *California's Health Care Districts.* California HealthCare Foundation. April 2006.

[viii] *Dartmouth Atlas of Health Care*

[ix] Sebelius, K. *Report to Congress: physician group practice demonstration evaluation report.* Department of Health and Human Services. 2009.

[x] Moore, K., Coddington, D. *The Work Ahead: Activities and Costs to Develop an Accountable Care Organization.* American Hospital Association. April 2011.

[xi] Robinson, J. *Accountable Care Organizations for PPO Patients: Challenge and Opportunity in California.* Integrated Healthcare Association. 2011.

[xii] Oberlin, s., Thygesen, B., Walters, S. *The Financial Health of California's Critical Access Hospitals.* California HealthCare Foundation. February 2010.

[xiii] Oberlin, s., Thygesen, B., Walters, S. *The Financial Health of California's Critical Access Hospitals.* California HealthCare Foundation. February 2010.

[xiv] Oberlin, s., Thygesen, B., Walters, S. *The Financial Health of California's Critical Access Hospitals.* California HealthCare Foundation. February 2010.

[xv] Hatton, D. *Letter to Donald Berwick Re: Medicare Shared Savings Program: Accountable Care Organizations*. American College of Physicians. June 2011.

[xvi] MacKinney, A., Mueller, K., McBride, T. *The March to Accountable Care Organizations --- How Will Rural Fare?* The Journal of Rural Health. April 2011.

[xvii] National Rural Health Association

[xviii] Size, T. *ACOs Not Ready for Rural Primetime*. Eye on Health. Rural Wisconsin Health Care. May 2011.

[xix] Hook, J.M. and Rodriguez, M.P. *Chronicling an Entry into Telehealth: Open Door Community Health Centers*. California HealthCare Foundation.