Roles for Local Health Departments in Accountable Care Organizations

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Methods

• Comprehensive literature search for/review of literature on role of public health agencies in ACOs
  • Both published and grey literature
  • Identified total of 15 articles

• Web search for examples of formally documented ACO/Public Health partnerships
  • Few examples exist
Accountable Care Organizations

• Accountable Care Organizations (ACOs) play a prominent role in delivery system improvement mechanisms in the PPACA

• An ACO is collection of health care organizations under contract with one or more third-party payers
  • Individual care coordinated by healthcare team

• Triple aim- improve care and population health while containing costs

• ACOs established by CMS to serve Medicare and Medicaid beneficiaries
Three Basic ACO Models

• Medicare Shared Savings Program
  • To be eligible to receive part of savings, ACO must:
    • Meet performance standards
    • Generate shareable savings
  • Advance Payment model
    • Physician owned and rural providers
    • Provides additional funds for infrastructure necessary to participate in Shared Savings program
    • Cost is deducted from future savings

• Medicare Pioneer ACO
  • Prior experience in ACO-esque models
    • Population based payment model instead of shared savings model

• Medicaid ACO-like organizations
  • More varied designs; mostly through State Innovation Model funding
ACO Payment Structures

• “Value not volume”
  • Three basic ACO payment structures
    • Population based payment/capitated- set amount per patient per unit time
    • Shared savings/fee for service with symmetric savings- provider benefits from all savings with some financial risk
    • Shared savings/fee for service with asymmetric savings- provider benefits from savings above 2% with no financial risk
    • All come with financial risk- may be losses
Structural barriers to PHA membership in ACOs

• Substantial barriers to LHD acting as full member of ACO
  • Medicare ACO must have minimum of 5000 beneficiaries
    • Outside the scope of many LHDs
  • Medicare ACO participating organization must be certified Medicare Provider
    • Takes time and money
  • ACO infrastructure is costly to build and maintain
    • Cost for IT systems etc. could be prohibitive for many LHDs
  • ACO provider must be able to assume risk to enjoy shared savings
    • May be outside scope/ability of most LHDs
Population Health ≠ Population Health

• ACO and LHD have different definitions of population
  • LHD population: All who reside in the jurisdiction of LHD
  • ACO population: patients who make up ACO membership
    • ACO population may be subset of population served by single LHD
    • Population served by single LHD may be served by multiple ACOs (possible but unlikely)
    • ACO population may be served by multiple LHDs
  • May be difficult to identify contribution of LHD to shared savings
Extent/Nature of LHD/ACO Involvement

• Formal public health-ACO involvement appears to be rare
• Public health-ACO involvement appears to be manifested most often in Medicaid ACOs
  • LHDs more likely to provide patient services to Medicaid population
    • Safety net services
    • MCH services
    • Vaccination
  • Medicare population is more likely to have access to traditional health care provider
ACO-Public Health Partnerships

• ACOs objectives contain potential mechanisms to encourage public health-health care partnerships

• Improved population health is one leg of the triple aim
  • LHDs have extensive experience in population health
  • Assessment functions help ACO identify community health needs
  • Assurance functions can support ACO objectives relative to coordinated care

• LHDs could play support role or more active role in ACO activities
Support Role

• ACO regulations contain potential mechanisms to encourage public health-health care partnerships

• LHD would largely play a support role
  • ACO must be able to evaluate population health needs
    • LHDs have experience and expertise in community health assessment
  • LHD may share data to support assessment and other ACO activities
    • LHD surveillance functions may provide data regarding health of ACO population
      • LHD population often pool from which Medicaid ACO draws patients
Support Role

• ACO must partner with community stakeholders to improve population health
  • LHDs have experience and expertise in community engagement
  • LHD may serve as convener of ACO with community-based orgs, other support agencies
  • LHD may help “broker” relationships between public sector agencies and ACO leadership viewed as market-based or commercially oriented

• Critical role of trust-building and relationships as ACO partners move into unknown territory
Support Role

• ACO must have plan to address health needs of population
  • LHDs have experience and expertise in community health improvement planning
  • Recall divergent understandings of “population” for which ACOs are responsible
  • Common ground more likely with Medicaid ACOs
Active Role

• Collaborate to coordinate patient care services LHD already provides
  • MCH services
  • Communicable disease (STDs, TB)
  • Family planning
  • Vaccination
  • Home health

• Refer patient to ACO members for patient services not provided by LHD
Active Role

• Collaborate to coordinate preventive services LHD already provides
  • LHD may provide evidence-based preventive services like DSME to ACO members
    • May result in ACO savings relative to diabetes
  • ACO members may benefit from activities focused on prevention
    • LHD efforts to increase physical activity and improve food intake
      • May result in ACO savings related to CHD, DM etc. but difficult to monetize avoided costs
• Refer patient to ACO members for preventive services not provided by LHD
Potential Downsides

• How does LHD take advantage of savings resulting from LHD work?
  • Must be prepared to think like a managed care organization

• ACOs are a business out to make $$$$  
  • ACO could enjoy benefit of LHD activities without sharing savings with LHD  
    • Could simply refer patients to LHD services  
    • ACO would offload costs of these services to LHD  
    • LHD would incur costs associated with larger patient or class volumes  
    • ACO could reap savings
Directions and Trends

• Public health needs to come up with business model(s) that make sense to ACOs
  • How to quantify LHD value to ACO
  • Whether and how to approach risk-sharing
  • Distinguishing among patient groups and funding sources
  • Developing contractual documents, memoranda of understanding, etc.
  • Aligning with both federal requirements and state laws (e.g., certificate of need requirements, bans on corporate practice of medicine, limits on health agency’s ability to bill for some services)
Work-in-Progress

• Currently conducting semi-structured interviews with 9 key informants with expertise in public health and or ACOs regarding the current and potential roles of public health agencies in ACOs, as well as barriers and facilitators to partnerships

• Currently conducting semi-structured interviews with 9 key informants from ACOs that involve public health departments regarding the current roles of public health agencies in their ACOs
Questions?

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