

Rural Health Clinics in Accountable Care Organizations (ACOs)

Rural Health Clinic Technical Assistance Series Webinar September 15, 2016 2:00 pm ET

Coordinator: Welcome and thank you for standing by. At this time all lines are in a listen-only mode until the question-and-answer session. At that time if you'd like to ask a question, you may do so by pressing star then 1 and recording your first and last name.

Today's call is being recorded. If you have any objections, you may disconnect at this time. I would now like to introduce your host for today's call, Mr. Bill Finerfrock. You may begin.

Bill Finerfrock: Thanks, operator and thanks, everyone for participating in today's call. My name is Bill Finerfrock and I'm the Executive Director of the National Association of Rural Health Clinics and I'll be the moderator for today's call.

Couple of things I did want to point-out. On the upper left-hand side of your screen, you will see a link to the presentations if you want to download those for hard copies and also to remind everyone to please complete the poll questions before signing-off that will come-up at the end of today's call.

Today's topic is world health clinics and accountable care organizations, effects on patient outcomes and operational costs. We are honored to have with us several folks from the University of Central Florida, the rural health research group within the College of Health and Public Affairs.

Joining us today are Dr. Judy Ortiz, a Research Associate Professor at UCF; Dr. (Angela M. Bushi), Professor of Nursing at UCF; Dr. Thomas Wan is a Professor of Health Administration and Medical Education at UCF; Dr. Richard Hofler is a Professor in the Department of Economics at UCF; and they're joined by their colleagues (Celeste Boer) and (Jackie Hung).

The series is sponsored by the Health Resources and Services Administration's Federal Office of Rural Health Policy and is done in conjunction with the National Association of Rural Health Clinics who are supported by a cooperative agreement and as you can see on your screen - you will see on your screen later - through the Federal Office of Rural Health Policy and that allows us to bring you these meetings free of charge.

The purpose of the series is to provide RHC staff with valuable technical assistance and RHC specific information. Today's call is the 72nd in the series which began in late 2004 and during that time there have been over 18,000 combined participants on the RHC national teleconference calls now being done also as Webinars.

As you know there is no charge to participate and we encourage you to refer others who might benefit from this information to sign-up and receive the announcements. A recording of the call will be made and transcript available hopefully not long after the completion of this call.

There will also be a Q&A period at the end of the call. During the Q&A period we're going to request that the callers please provide your name and city and state location before asking your question.

In addition on the left-hand side of your screen you can put RHCTA there and you'll see an opportunity to ask questions and you can pose it through that forum as well.

If you have suggestions for topics for future calls, please send those to info that's info @narhc.org. Put RHC TA topics in the subject line. At this point I'd like to turn the presentation over to Dr. Judy Ortiz who's going to kick us off and then she'll be joined by her colleagues. Dr. Ortiz we look forward to hearing what your folks have to say and what your findings were.

Judy Ortiz: Thank you, Bill. Good afternoon, everybody. We're glad you could join us today for this presentation. Before we start telling you about our study I'd like to introduce you to our research group. We cover or conduct a number of research activities including interviews and surveys and analyses of data that we collect and organize.

Also I'd like to tell you something about our study that this presentation is based on so our study is rural health clinics and ACOs impact on disparities. This study was funded through NIH and it is ongoing although we're in the last phase of the study.

And we are studying eight states in Region 4, that's Southeastern U.S. that stretches from Kentucky in the north to Florida in the south and across to Mississippi in the West. Our study had three major goals and a bit later I'm going to convert those goals into research questions that we're going to answer in this presentation.

We also had some minor goals we added toward the end of the study but before we go any further I'd like to review with you about accountable care organizations, ACOs.

ACOs are a relatively new model for healthcare delivery and one description of Medicare of ACOs of which there are a number of types is the one that CMS offers for Medicare ACOs so this type of ACO is a group of doctors and other providers that come together voluntarily to give coordinated high-quality care to Medicare patients that they serve.

There are a number of types of ACOs and we'll talk a bit about those but overall they have two goals in common. They are to provide high-quality care and to achieve cost savings in the process of providing that care.

In this slide is a composite diagram or a picture of an ACO. The idea is that the focus is on a population of for example Medicare beneficiaries or persons. Several healthcare providers collaborate in providing care and holding their held responsibility for providing that care such as rural health clinics, physicians groups, hospitals, critical access hospitals and so on.

This is a composite picture. An ACO could be composed more homogeneously of just rural health clinics for example. There are two basic branches of ACOs although there are many types. The public sector branch such as the Medicare ACOs, the Pioneer ACO and the Medicare Shared Savings Program ACO and there are others as well.

The second branch are the private sector branch and these are those that are supported by or sponsored by insurance companies for example, Blue Cross Blue Shield, Anthem and the like. While ACOs have proliferated throughout

the United States and as of January of this year, there was an estimated 838 of all types in the United States.

This is an estimate given by the Levitt Partners recently. Within the Medicare Shared Savings Program ACO, which started in 2012 initially with 27 ACOs, that type of ACO has grown to include 433 in January of this year or about 16 times the number that there were initially.

And just for a point of clarification, our study focused on the eight southeastern states that were Region 4 as I said and on clinics that participated in the Medicare Shared Savings Program ACOs in those states. Our study or our presentation today focuses on analyses of data we collected and organized into a dataset.

In other presentations we presented on our results from surveys and interviews but today we're presenting on our statistical analyses so let me tell you something about the dataset. It included 705 clinics throughout the Southeast and covers about a quarter million Medicare beneficiaries.

We included Medicare beneficiaries in our study. It covers seven years from 2007 through 2013 and for each of those years we have about 180 variables including characteristics on the patients, on the RHCs in terms of their organization, costs and demographics of the counties in which the clinics are located and so on.

So in this next slide we list the four research questions we're going to address in this presentation so let's take those questions one by one and I will respond to one of them and my colleagues to the second, third and fourth.

So Question 1, we were interested in how many of the rural health clinics participated in the Medicare Shared Savings Program ACO. That is in Region 4 and what are their characteristics?

To put this in context, there are an estimated less than 10% of clinics in Medicare Shared Savings Program ACOs throughout the United States. Within Region 4 as of January of last year, there were an estimated 35 in this type of ACO.

And again our analyses were for the experiences of rural health clinics after one to two years participation in Medicare Shared Savings Program ACOs. That is for 2012 and 2013 so in 2012 there were six clinics to join ACOs, that is, shared savings program ACOs.

In 2013 there were an additional 14. We were interested in where those clinics and ACOs were to show you the distribution of clinics to however throughout the region in this slide but pie chart on the left shows you the distribution of clinics throughout Region 4.

There's a higher percentage in Florida, Kentucky, Mississippi, whereas the right pie chart shows you the distribution of clinics in Medicare Shared Savings Program ACOs so 70% of the clinics in this type of ACO were in Florida and an additional 15% were in Tennessee.

There's reasons for this. There are higher percentage of this type of ACO in serving Florida, Georgia, Kentucky and Tennessee and the right pie chart shows you that there were a higher percentage of Medicare beneficiaries in Florida also.

We were curious about the classification of clinics that participated in ACOs. Were they independent or provider-based so this slide shows you the classifications and their participation? If you'll look at the green bars, the green bar on the left shows that about 74% - 73.7% - of the clinics participating in this type of ACO were independent.

Whereas on the right you see the percentage of clinics that were not in ACOs and you'll look at the green bar and see that 71% were independent so a slightly higher percentage of ACO RHCs were independent.

Finally I'd like to summarize answers to this first question in this slide. We show that the largest percentage were in Florida and Tennessee. A higher slightly higher percentage were independent. A larger portion we found were for-profit. They appear to be larger clinics and most were between five and 10 years full, that is, RHC-certified.

And finally there appear to be a higher percentage of whites and a lower percentage of African-American beneficiaries served by the ACO RHCs so with that I'd like to turn the presentation over to my colleague, (Angie Bushy) who will respond to Question 2.

(Angela Bushy): Good afternoon. Question 2 was what impact does ACO participation have on RHC patient outcomes? A few points of clarification in the background. We use data and services that was received by RHC focusing on older adult patients. These services may have been provided by medical facilities other than RHCs. Today we're going to present only a few of the findings that we have to date. Analyses are still continuing.

Terms and definitions. In reference to patient outcomes or preventive care effectiveness is defined as the condition of a patient at the end of disease process as measured by one admission rate which refers to the admission rate for numbers of patients discharged.

The readmission rate which refers to the risk-adjusted rate for the number of patients readmitted within 30 days per 100 patients that are hospitalized. Ambulatory care sensitive conditions or ACSCs refers to avoidable hospitalizations of 100 patients with a specific ACSC related to COPD/asthma, diabetes or heart failure. Some factors related to patient outcomes. For the 705 RHCs in our study, we statistically analyzed various factors that were related to patient outcomes.

Some of the many factors/variables that we used included fixed variables (such as year, rurality and the age or the length of certification of the RHC), demographic variables for each county where the RHC is located (such as the poverty rate, percentage of older adults, racial and ethnic composition of the community), organizational variables (such as size, ACO affiliation, etcetera, and patient-related variables, age, gender, diagnosis, mix, etcetera).

And this next graphic is an example of the statistical model which we'll going into a little bit later. In summary of the findings for Question 2, RHCs participating in an ACO were located in areas with higher percentages of older adults and that were less rural.

For African-American Medicare beneficiaries, ACO participation was associated with a higher ACSC COPD rate. For white Medicare beneficiaries, there was higher preventive care utilization and this was associated with

higher risk-adjusted ACSC rates, and there was no participation effect on ACSC rates. Now I defer to Dr. Wan for Question 3.

Thomas Wan: Thank you. Question 3: What impact does the ACO participation have on health disparity or rural population served by RHCs? Few terms need to be defined. Health disparity. Disparity refers to differences in health between specific population and the average general population.

And the disparities measured in terms of 1) preventive care use, and 2) risk adjust hospitalization as related to ambulatory care sensitive conditions for the two broad population groups, mainly African-Americans and whites .

We utilize Andersen's classification of predictors of service utilization and outcome mainly in terms of the predisposing factors that predisposed individuals more likely to use services or likely to have different experiences of outcomes, such as age, gender, demographic attributes, social and economic status, attitudes and beliefs.

However, in this study we do not have data on attitudes or beliefs. The second predictor category is called enablers or enabling factors. This includes the conditions that either enhance or impede service utilization, including insurance coverage, income and access to a regular source of care.

As most of you realize that enablers are external to an individual and that can facilitate or impede the service utilization and experience different outcomes. The third category is the need for care that is really consolidated into the risk adjustments in terms of acuity level and the complexity of experienced chronic conditions.

The primary purpose of this part of our larger study was to examine the impact of health disparity associated with enabling factors; we are looking particularly at how ACO participation would enable the RHC beneficiaries or Medicare beneficiaries to gain access to preventive care services. Secondly, we investigated how participation ACO enables to generate different ratios of disparity, i.e. the ratio of differences in regard to preventive care and patient experiences/ patient outcomes.

Initially, we designed a longitudinal study, using a time series study design. Mainly, we used a seven-year database of individual Medicare beneficiaries by pooling the data together at an aggregate level (RHC level) for cross-comparison.

We have more than just cross-sectional data. But, for this particular presentation, we are analyzing from a cross-sectional basis since we only focus intervention group in the last two years of our study (2012-2013).

The measurable indicators include preventive care use, such as influenza, and pneumonia/ pneumococcal immunizations, and colorectal cancer screening. Those are the specific information documented in the Medicare beneficiary files.

For the patient care outcomes measure, we adjusted patient attributes in order to compare the differences observed in the RHC level so removal of the bias may be related to individual differences for RHCs demographic composition; therefore, we can conclude more precisely in examining the distributional disparities.

Here is a brief summary of preventive care benefits. There are seasonal vaccination rates that we gathered. The influenza vaccination rate was not influenced by the ACO participation. When we compared the two ethnic group, mainly African-Americans and white populations, for pneumonia immunization rates, we found a positive impact of ACO participation for both population groups.

However, there is a distinctive difference in immunization by state; in a sense, there are state variabilities in service utilization. For example in South Carolina, we found very low incidents of influenza immunization or pneumonia immunization.

In the rural areas a higher proportion of white beneficiaries were immunized against influenza and pneumonia. In examining the colorectal cancer screening, we found again there's state variability. When we compared each state, we found statistically meaningful differences.

Examining the colorectal cancer screening for the white population beneficiary group, we found there's a positive influence of ACO participation in this category. The second outcomes results examined the hospitalization for COPD/asthma. We didn't analyze COPD versus asthma. We combined them together as the same category of ambulatory care sensitive condition.

The incidence rate or prevalence rate increased with RHC participation in ACO. There were differences by location, particularly in the African-American population group. There were increased percentages of the population in having immunized if they were more dually eligible patients in RHCs, meaning the Medicaid/Medicare eligible. Therefore, in this particular

population group we found that they benefitted by immunization for pneumonia.

The variabilities in diabetes hospitalization or diabetes care were documented in the literature. There are tremendous differences of the geographical disparity, particularly between white and non-white groups. The differences for the white group show that an increased hospitalization rate was observed if a higher proportion of the dually eligible served by RHCs. In rural communities such as the isolated areas and small rural areas patients had a lower hospitalization rate for diabetes.

Lastly, we examined the impact of the chronic condition such as heart failure. There were variabilities in geographical differences, particularly in the African-American population. The next report is by Dr. Hofler.

Richard Hofler: Thank you very much. I'm going to talk about the last question, what impact does ACO participation have on clinic operational costs? In part that question was stimulated by us looking at the data for cost per visit for two groups of clinics, the few that joined an ACO in 2012 and those that didn't.

And when we were looking at the data on average annual cost per visit from 2007 through 2011, we noticed that the costs per visit for the two groups were essentially stable. They weren't going up or going down much.

However, when we looked at 2012 compared to 2011, we noticed that there was a big jump in cost per visit for the clinics in both groups, clinics that joined ACOs and those that didn't but we noticed that the rise in cost per visit

for those who joined ACOs was almost twice as high so quite naturally we were curious, is that bigger jump in cost per visit due to joining an ACO?

That led us to measure costs and try to figure-out the factors that could be influencing those costs including ACO participation so first of all, how do we define cost per visit? Its total cost of health services plus total reimbursable costs plus total facility overhead for each RHC over the year divided by their total visits and that gives us the cost per visit.

Then we tried to figure-out what are the factors, what are the things that might influence cost per visit? We came-up with a list such as the size of the clinic, whether it's provider-based or independent, and the type of ownership. Is it for profit, is it non-profit or is it government?

How many years it's been certified as an RHC and a measure of whether it's in a rural area or not in a rural area. Once we had all those definitions and variables in place, then we decided we were going to look at two different possible impacts of being in an ACO.

Could being in an ACO affect cost per visit and second could it affect the cost efficiency of the different clinics? We tried a number of different methods to try to answer both those questions. What does ACO participation do to cost per visit? What does it do to cost efficiency?

The reason we tried different methods is that we didn't want to make a mistake in what we were learning because we only tried one analysis method. Maybe possibly that one analysis method would give us misleading results so we figured let's try many different analysis methods and if we begin to see the

same sort of answers across all of them, maybe we're learning something that really is close to the truth.

What I'm going to talk about next is three different tables. Each table corresponds to either a different group of clinics or a different year for the same group. In other words let me explain what I'm talking about.

This first table that I'm looking at is for the first group of RHCs. These are the clinics that joined an ACO in 2012 and what we're looking at in this table is the impacts on cost per visit in the first year that they were in an ACO. In other words, they joined in 2012, what's the impact on cost per visit of being in an ACO in 2012?

We compared those ACO clinics with non-ACO clinics so everything that I'm going to be saying to you is here's how the ACO clinic cost per visit was compared to the non-ACO clinics and as I said, we tried a number of different methods but let me just give you the bottom line, sort of the summary.

We found that the average increase in cost per visit in the clinics that joined an ACO was nearly 21% higher than the cost per visit in the non-ACO clinics so in the first year that they joined an ACO, their costs were almost 21% higher than in the same year for similar clinics except clinics that did not join and ACO.

The second slide - the second table - is for the same clinics the ones who joined in 2012 but this is their second year of being in an ACO and once again this'll be what's their cost per visit compared to similar clinics not in an ACO so we found in the second year that their cost per visits was about 14% higher than other similar non-ACO clinics.

Finally the third table shows a different group of RHCs. These are clinics that joined an ACO in 2013 so this is what happens to the cost per visit of the second group in their first year of being in an ACO and what we found was a similar story to the other group that joined in 2012.

In this group that joined in 2013 in their first year, their cost per visit was about 17-1/2% higher than the clinics that were like them but didn't join an ACO so in summary then what are we seeing?

We compared cost per visit for the clinics that joined an ACO and cost per visit for similar clinics but that weren't in an ACO and we compared their cost per visit in 2012 and 2013. In the first year for those who joined in 2012, their costs were almost 21% higher compared to the non-ACO clinics.

In their second year their cost per visit was about 14% higher and then for the second group the ones who joined in 2013, in their first year their costs were a little over 17% higher than the non-ACO clinics.

Now we have to be careful. You probably know that scientists are notorious for being cautious when they're talking about their results and we have reasons to be cautious. For example we've got a small sample. We've only got six in our region remember Dr. Ortiz said we're talking about just those eight states in the Southeast region.

We've only got six clinics that joined in 2012 and 14 that joined in 2013 plus as I said only two years of data, 2012 and 2013 so we need to do a lot more investigating to learn. We've got few clinics and only a short period of time.

Are the results that we found going to extend to more clinics over a longer period of time? We don't know yet so we do need to do some more analysis.

So let me take a breath and sort of look at what we've been trying to tell you and what does it all mean? How does this make sense? Keep in mind the context. It's a limited group of clinics, 20 of them in eight Southeastern states but we did see some common characteristics of those clinics that joined ACOs.

They tend to be larger, 85% of those that joined ACOs were in Florida and Tennessee and they had been certified as clinics about five to 10 years. What were the general lessons we learned about the ACO impacts on patient outcomes? Well, being in an ACO seems to be associated with higher COPD rates for African-Americans but no discernible effect that we could find on ACSC rates for whites.

As far as preventive care, higher pneumococcal immunization rates for African-Americans but again we couldn't find any effect of ACOs on preventive care for whites. What about the ACO impacts on costs?

Those seem to be pretty dramatic and pretty consistent across every kind of method that we tried. Anywhere between 14 to almost 21% higher cost per visit if a clinic joined an ACO compared to similar clinics that didn't.

If there's some good news to balance the seemingly bad news about cost per visit, it looks like joining an ACO really doesn't have any noticeable impact on cost efficiency so if there is good news, maybe that's some of it.

So what does this all mean? Does it surprise you that for instance cost per visit went up after joining an ACO? Would you expect patient outcomes to improve right away or would you think well, maybe it's going to take a little bit of time for that to happen and should we expect costs to be higher?

Is that really shocking or is that more in line with what you would expect so I want to thank everybody who's listened and if I'm right in understanding where we are now, should I turn it back to Dr. Ortiz and I think she'll lead us to the next stage.

Judy Ortiz: Thank you Dr. Hofler. In this last couple of slides just show you some of the papers we've published recently on this topic of rural health clinics and ACOs and we also have produced the in the slide that has the very tiny, tiny font a list of some other related papers if you're interested in looking into those they are available for free online.

And we are the rural health research group at UCF in Orlando. We are an interdisciplinary team from students and faculty from different colleges, the College of Health and Public Affairs, College of Business and Nursing, College of Medicine and we have several very talented students that work with us as research associates and assistants.

We thank you for your time today and you're welcome to follow-up with questions now or by e-mail later. My e-mail address is listed as is my phone number and you're welcome to follow-up with your questions.

Bill Finerfrock: That said, thank you Dr. Ortiz and to all those at the rural health research center there. We will open it up for questions. Operator, could you give the instructions for folks who want to ask by phone and also remind them where

they can put their questions if they want to post those in writing on the Webinar screen?

Coordinator: At this time we'd like to begin the formal question-and-answer session of the call. If you'd like to ask a question, please press star then 1 and record your first and last name. To withdraw your question, you may press star then 2. Again to ask a question at this time, please press star then 1 and record your first and last name. If you'd like to type your question, please type it into the chat pod of your Webinar. One moment for the first question, please.

Bill Finerfrock: And also please put the city you're calling from and the state. That would be helpful for us to just have that information.

Nathan Baugh: So the first question we have is from (Camilla) who asks if the team over at Central Florida anticipates publishing data for years after 2013. Are you guys looking at that?

Judy Ortiz: Yes, we appreciate that question and we certainly have been thinking about that as well. We will be publishing and analyzing more data as our funding permits essentially so we're hoping that that will materialize and we can continue with this study. We have so many questions we would still like to answer.

Bill Finerfrock: Okay, this is a question that I have before we go back to the others or check on the phone line. It was to Dr. Hofler your question about, you know, were we surprised and I think certainly on the cost issue where you determine that the cost per visit was higher.

Richard Hofler: Yes, I think that's a really good question. Probably a question a lot of people have in mind. We didn't have the means to actually analyze that but here's what we did. As we've been going around to different conferences and talking with different people, we've been telling them what we've been learning and asking that question why?

Yes, you're right, some of the answers we're hearing are yes, it relates to EHR establishing and maintenance. Sometimes additional staff to meet the regulatory or other expectations. Medicare ACOs require that data be compiled, analyzed and submitted so while we can't say yes, definitely here's why, we're getting feedback from people who are saying those are certainly some of the reasons, yes.

Bill Finerfrock: Okay, and then some of the questions posted already, you can see that folks are saying, you know, was it a higher administrative cost increase in the infrastructure which are things that you just touched on so it's interesting. So operator, do we have any folks on the phone?

Coordinator: I'm currently showing no questions.

Bill Finerfrock: Okay.

Nathan Baugh: Okay, the next question online is from (Cynthia) who wants to know is there any increase in payment for Medicare if the RHC's a member of an ACO? Did you guys do that, do you guys want to handle that?

Judy Ortiz: So our study concerns this one topic the ACO the shared savings program ACO. There are some types of ACOs that have received additional payment for infrastructure for the groundwork so to speak. As far as the Medicare

Shared Savings Program ACOs, the part of the incentive is that those ACOs that achieve cost savings will achieve a share in that cost savings so in that way there's that incentive.

Richard Hofler: But those dollars occur at the system level, not at the unit level of the individual provider, hospital, clinic so an individual RHC would not see any change in their payments for Medicare, however, if the entire organization were to have obtained and achieved scorable savings, the organization would have been rewarded for that and those organizational rewards could depending upon how the ACO was organized flow down to the RHC.

Judy Ortiz: Yes. Thank you.

Nathan Baugh: I have a question. Did you guys look at the cost per visit of those RHCs that joined an ACO prior to then joining an ACO? In other words was it if I had a high cost per visit, was I more likely to want to join an ACO versus the control group so basically over time if you went back and you looked at those RHCs that did join the ACO, would they still have had higher costs or did their costs jump up when they joined the ACO?

Richard Hofler: Yes, that's a really good question. What we did was we compared the groups that eventually ended-up joining an ACO, just the 2012 group, and we found that there wasn't a noticeable difference in the average annual cost per visit for those who eventually joined versus those who never joined.

So that's a really good question, we wondered the same thing but it doesn't look like yes, these RHCs had a higher cost per visit and that explains part of why their cost per visit was higher after joining an ACO. It based on what we've seen, it doesn't look like that's the case.

Nathan Baugh: Okay, so just to be clear you're saying that those RHCs saw their costs per visit go up after joining an ACO?

Richard Hofler: Yes, that's right and not only that their cost per visit went up almost twice as much as those that didn't join an ACO.

Nathan Baugh: Okay, we have another question that's in the chat box. (Longer, yes). What percentage of ACO member RHCs were in ACOs that generated shared savings? I've read that only a very small percentage of ACOs generated shared statements. Do you guys have that percentage?

Judy Ortiz: There has been within the Medicare Shared Savings Program ACOs a certain percentage that have achieved that savings and I believe it's a quarter. However, we have not determined the RHCs and what was their portion of the shared savings if that's the question.

Nathan Baugh: Right, yes. Yes, I think yes, I was just at a meeting recently and there was some data on the shared savings and I think it was 25 to 30% achieved sharable savings but and a larger number had achieved savings but were not sufficient to be the beneficiary of some of that.

In other words so you had to achieve savings but in order to get some of that back, the savings had to exceed a certain threshold level and so there were many who saved money which was good for Medicare but didn't save enough in order to get some of that back in the form of bonus.

The one thing the national data showed was that a very high percentage of the ACOs were able to achieve the quality measure thresholds that would have allowed them to share because it's a two-part process.

You not only have to save money but you also have to reach minimum quality standards in order to do that so the first test was did you meet the quality measure and I want to say 85% of the ACOs did that, then did you save money, I want to say 60% and some were in that neighborhood did that.

Of those did you save enough to get some back and that dropped it down to about that 25-30% level.

Bill Finerfrock: Operator, any on the call, on the phone?

Coordinator: I'm still showing no questions.

Bill Finerfrock: Okay. Any other questions from the folks who are with us online and I want to remind you if you are logging-out, there are question. You'll see them up on the screen now.

Please take a few minutes to respond to the questions so that we can, you know, moving forward we know what types of programs you're interested in and what it is you'd like to have us try and present. Any concluding thoughts from any of the folks at UCF?

((Crosstalk))

Judy Ortiz: Well, we're researchers and so all of our research is interesting to us and just seems to prompt more and more questions so we feel like we have our careers

cut out for us with understanding about clinic participation in ACOs. It's been a very interesting study for us and we look forward to continuing and interacting with clinics not only in the Southeast but in other parts of the United States and see what their experiences have been.

Bill Finerfrock: Absolutely. The other thing I'd mention on Tuesday I was up at NIH for the National Advisory Council for the National Institutes for Minority Health and Health Disparities and they are looking Dr. Perez-Stable and then also Dr. Collins, the head of NIH were there.

And they really talked about the cross-collaboration that they are interested in that health disparities and minority health issues not be exclusively looked at through NIMHD but rather the other institutes so as you're looking that may be something you want to think about is there particular focus that you can look at to dig deeper on some of the health disparity minority health issues that you were teasing-out in this initial study.

Judy Ortiz: Thank you, good comments.

Nathan Baugh: It looks like we have another question come in. (Donna Ashby) asks isn't ACO a population fee for service claims? How does that mesh with an RHC claim?

Bill Finerfrock: I can take a crack at that if you'd like but if you want to ...

Judy Ortiz: Please, Bill, yes, we're talking about Medicare Shared Savings Program ACOs then it is fee for service so the RHCs are continuing to be reimbursed if they had been through fee for service.

Bill Finerfrock: Well, the RHCs get a cost-based payment and that is a scenario where there's been some confusion but to the larger point, rural health clinics are recognized providers for ACOs. They would continue to get paid by Medicare the way that you always have in the form of a cost-based whatever your all-inclusive rate payment methodology is.

There are some patient attribution issues. There early on were some issues with regard to patients having to be under they could only be attributed if their care was principally provided by a physician and as you know we have large numbers of PAs and NPs that we have working in RHCs.

We had to try and work through those to ensure that RHCs were fully able to participate but yes, there is nothing that being an RHC would preclude you from participating in the ACO shared saving or the Pioneer ACO initiatives.

Nathan Baugh: Another question from (Jennifer O'Riley), she wants to know what are the different types of ACOs, tracked in she says Track 2 or Track 3, what's the difference? Are there pros and cons of participating in any specific type of ACO?

Judy Ortiz: The two the different tracks the first track being the ACOs receive a share in savings and the Track 3 not only do they share in savings but they share in losses as well. Pros and cons of participating in a specific type of ACO, Bill?

Bill Finerfrock: Well, the as you've noted the different tracks really dictate what level of risk you as a provider are willing to undertake so in the initial track shared savings it's a one-sided risk in which you have the opportunity to recoup additional dollars and there's no downside risk for failure to meet your savings target for meeting, yes, in Track 1.

As you move to Track 2, you begin to go into the downside risk. Now the risk reward is that you can get a higher level of savings that more of those savings can accrue to the ACO by moving into a higher-risk model versus the no-shared savings but are then subject to downside risk.

I believe currently with the Track 1 and Track 2 of the 400 and some odd plus Medicare ACOs, I think it's about 430 Medicare ACOs, only three of them are in downside risk or Track 2. Track 3 is the newest ACO model and I believe that just was rolled-out this year. That too has downside risk and has some other components.

I confess I don't know enough about it to speak but again as you move through the tracks if the key difference is that downside risk assumption that you move into that you are exposing yourself to having to pay back to Medicare money if you failed to achieve the requisite savings.

Nathan Baugh: Another pro for the Track 2 and Track 3 ACOs versus Track 1 of the Medicare Shared Savings Program. Track 2 and Track 3 are considered advanced APMs for the (MACRA) law and that gets into some complicated territory because rural health clinics are generally exempt from (MACRA).

However, you know, in the future should this (MACRA) being applying more directly to rural health clinics, the Track 2 and Track 3 downside risk models would be considered advance APMs and they qualify for the formal incentives from the government for joining those.

Nathan Baugh: Looks like we have a few more people are typing so we have about four minutes although we can go a little bit over for questions so we'll give those

typing some time. All right the next question is from (J.B.). This is a future topic, we might take this offline.

Bill Finerfrock: Yes, it's about some additional ACO and primary care provider and looks like maybe some physician centered models. It's not really a question, it's a suggestion. Operator, any questions on the phone?

Coordinator: I'm still showing no questions.

Bill Finerfrock: Okay, well if we have no more questions on the phone and no one's typing in, we'll go ahead and wrap this up. Again I want to thank all of our participants today, Dr. Judy Ortiz, Dr. Angeline Bushy, Dr. Thomas Wan, and Dr. Richard Hofler as well as your colleagues there at UCF that helped put all of this together.

I want to thank all of our participants as well for your questions and for your attentiveness. Please again as we've said before encourage others who be interested to register for the RHC technical assistance series. In addition we welcome you to e-mail us with your thoughts and suggestions for future call topics.

You can send those to info that's I-N-F-O @narhc.org and either put RHC TA topic or RHC TA questions in the e-mail subject line. We'll be scheduling the next RHC technical assistance call within the next 30-45 days so look out for a notice about that time and topic.

Again, thanks all for participating and thank you to our speakers and thank you to the Office of Rural Health Policy for helping us to put this on and make it available to folks free of charge. Operator that concludes our call today.

Coordinator: This concludes today's call. You may disconnect at this time.

END