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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