The Evolving Nature of Accountable Care

Results from the 2015 ACO Survey

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BACKGROUND

Accountable care organizations (ACOs) are voluntary networks of healthcare providers that have agreed to work together to address the goals of the Triple Aim – better outcomes, lower costs and improved population health – for a defined patient population. They are intended to counteract decades of uncoordinated approaches to healthcare driven by the fee-for-service (FFS) payment system by holding providers accountable for the per capita costs, quality and outcomes of delivering care to their patients. To motivate participation in ACOs and help defray the costs associated with fundamentally transforming the way they practice medicine, insurers often offer providers financial incentives in the form of shared savings or performance-based bonus payments that reward quality, satisfaction and cost management efforts.

The 2010 Patient Protection and Affordable Care Act helped spark the growth of ACOs nationwide. Section 3022 set forth requirements for the development of a program that "promotes accountability for a patient population and coordinates items and services under [Medicare] parts A and B, and encourages investment in infrastructure and redesigned care processes for high quality and efficient service delivery."[1] The ensuing Medicare Shared Savings Program established rules for the creation of accountable care organizations (ACOs) for Medicare patients and accelerated the process of ACO formation.

Since the passage of the Affordable Care Act, the number of ACOs in the US has grown dramatically. In addition to the more than 400 Medicare ACOs created through the Shared Savings Program, hundreds of hospitals and health systems have signed ACO contracts with commercial insurers. In all, there are more than 700 commercial and Medicare ACOs in the United States, and many more are likely to form in the coming years.[2]

Although there is tremendous diversity in the size, scope and payment models deployed by different types of ACOs nationwide, they share a common need to leverage health information technology (health IT) to help facilitate data exchange for collaboration and coordination. A robust health IT infrastructure enables ACOs to integrate data from multiple sources to create up-to-date, comprehensive views of their patients' records. ACOs also rely on data to measure, monitor, analyze and improve performance, as well as observe utilization of healthcare services and clinical outcomes. Many ACOs analyze their claims and EHR data to identify the costliest patients that have the most to gain from intensive care management, while applying lessons learned to the broader patient population.

To better understand the growth and development of ACOs and assess their use of health IT, eHealth Initiative and Premier, Inc. have surveyed public and commercial ACOs for the last three years. This report details findings from the 2015 survey, which focused on interoperability and data use among ACOs.

ABOUT THE SURVEY

The 2015 ACO Survey consisted of 19 questions, including demographic data about the ACO, their health IT infrastructure, measures of interoperability, integration and data use, and related challenges. The survey was sent to members of eHealth Initiative, members of the Premier Population Health Management Collaborative and public contacts at Medicare Shared Savings Program ACOs. The survey was administered electronically in August of 2015. Sixty-eight accountable care organizations responded to the survey. Not all respondents completed every question. Percentages offered below reflect the number of respondents who answered a given question.

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[1] http://www.iha.org/pdfs_documents/home/IHA_PPACAACOSummary.pdf
[2] http://healthaffairs.org/blog/2015/03/31/growth-and-dispersion-of-accountable-care-organizations-in-2015-2/

ABOUT THE ACOs

Survey respondents included a mix of Medicare and commercial ACOs. Seventy-nine percent of surveyed ACOs provide care to Medicare patients, 44 percent to commercially insured patients and 24 percent to Medicaid patients. Sixty percent provide care to beneficiaries of multiple payers. Among those that only cover a single patient population, most were Medicare-only ACOs.
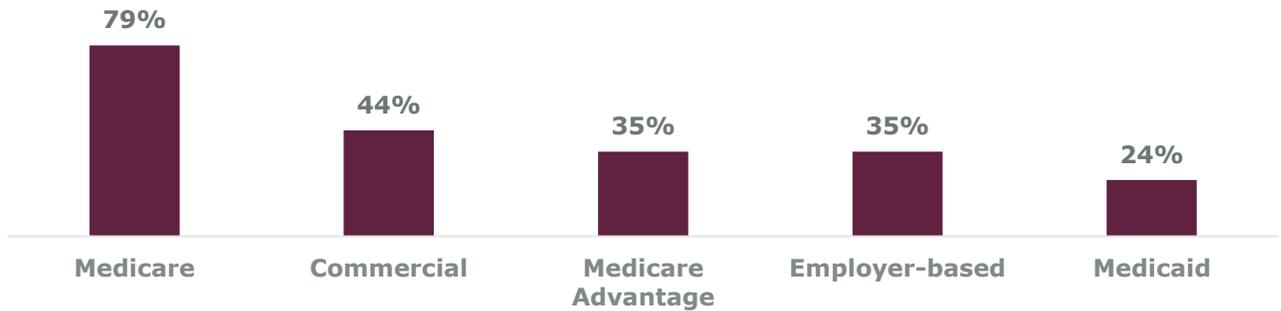

Figure 1: Composition of ACO Patient Population, by Payer

Most ACOs in the sample are relatively small. Approximately half (46 percent) cover 25,000 or fewer patient lives. Twenty-eight percent cover between 25,000 and 100,000 lives, and 24 percent cover more than 100,000 patients. Likewise, 34 percent of the surveyed ACOs include 250 or fewer physicians. Thirty-one percent have between 250 and 500 physicians, and 34 percent have more than 500 physicians.
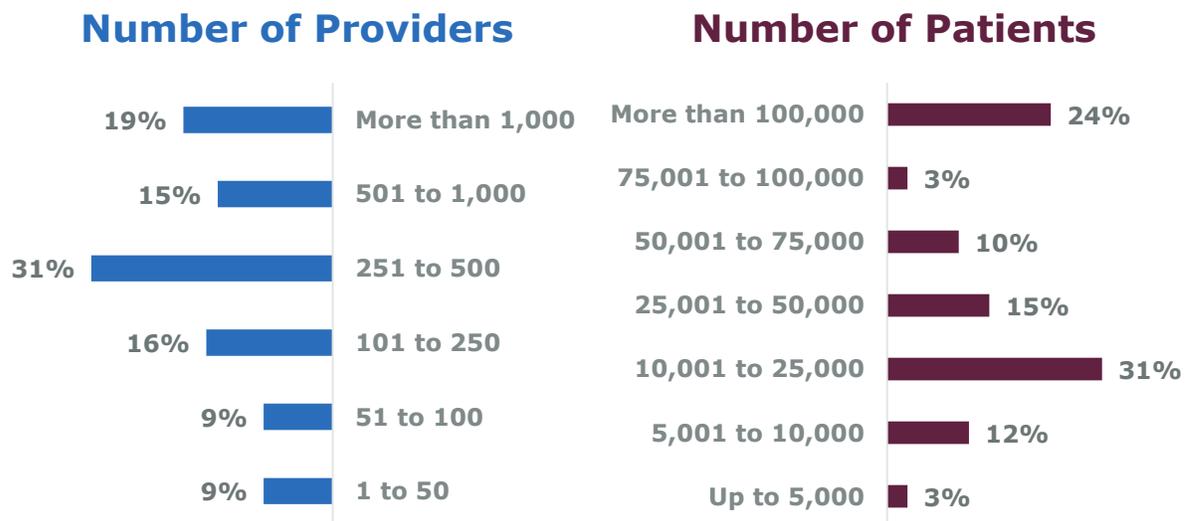
Number of Providers

19%	More than 1,000
15%	501 to 1,000
31%	251 to 500
16%	101 to 250
9%	51 to 100
9%	1 to 50

Number of Patients

More than 100,000	24%
75,001 to 100,000	3%
50,001 to 75,000	10%
25,001 to 50,000	15%
10,001 to 25,000	31%
5,001 to 10,000	12%
Up to 5,000	3%

Figure 2: Number of Providers & Patients Participating in Surveyed ACOs

PAYMENT

ACOs are often viewed as an important means for transitioning the healthcare system away from fee-for-service (FFS) and toward value-based payment models. Under the traditional FFS reimbursement system, most providers are not held financially accountable for patient outcomes, especially when a patient moves to a new point along the care continuum. Providers in FFS generally have few incentives to follow-up with a patient to gauge the effectiveness of a treatment, or to check-in after a referral. Because providers are paid on a per-service basis, they have little financial motivation to avoid repeat diagnostic procedures or tests, which runs counter to national goals to reduce overall healthcare spending and improve the patient's experience.

Under an ACO, however, providers must contain healthcare costs and meet quality and performance benchmarks for their patient populations. As a result, they are financially responsible for ensuring that their patients receive only the highest-value, most-effective care.

This transition to value-based care can be extremely disruptive to practices that are accustomed to FFS reimbursement. Success requires a greater degree of care coordination and team-based care, and places new demands on a provider's limited time and resources. Activities like care planning and follow-up that are not traditionally reimbursed under FFS are essential to ensuring better outcomes in value-based payment models. Moreover, providers participating in these models must purchase and learn to use complex health IT systems that support data exchange for cost and quality outcomes monitoring, performance measurement and care coordination across the continuum.

Recognizing the difficulty of this transition, the Centers for Medicare & Medicaid Services (CMS) designed the Shared Savings Program as a multi-track program to help limit an ACO's downside risk (i.e. the financial risk of a reimbursement penalty for ACOs that underperform expectations). Most ACOs under the program use an upside-only payment model (Track 1), which includes the opportunity to share in savings accrued to Medicare if the ACO successfully reduces costs while meeting performance requirements. All savings past a pre-determined "minimum savings rate" are eligible for bonus payments. If a Track 1 ACO fails to reduce Medicare spending, they are responsible for their potentially sizeable investment in developing the ACO, including the costs associated with practice transformation, health IT procurement, care management, and other internal expenditures, but do not receive a penalty or have to pay back reimbursement. Many commercial insurers have adopted upside-only models for their ACOs, with the understanding that as providers grow more proficient in managing their patient populations, they can eventually share in greater risk.

Track 2 ACOs utilize a two-sided payment model in which the ACO is eligible for shared savings bonuses but also faces penalties if spending is greater than their cost benchmark by more than their pre-determined "medical loss ratio." Track 2 ACOs can earn a greater percentage of saving than Track 1 ACOs if they meet their performance thresholds. In June 2015, CMS updated the Shared Savings Program to offer a third track for more advanced ACOs. Track 3 is also a two-sided model, but with higher rates of savings and losses than tracks 1 or 2.

Today, the vast majority of surveyed ACOs are participating in shared savings programs with a limited amount risk. Seventy-eight percent are contracted under shared savings arrangements and 37 percent employ a FFS model in which the ACO receives bonus payments based on achieved savings. Only a small number of ACOs are utilizing payment models that require a greater acceptance of risk, such as a shared savings with downside risk model (i.e. two-sided; 18 percent) or global budget model (6 percent). Likewise, few ACOs have phased out FFS approaches to payment and adopted capitation (18 percent) or bundled payment (15 percent) models. A majority of ACOs (54 percent) use a single payment model, usually shared savings.

HEALTH INFORMATION TECHNOLOGY

In 2009, Congress passed the Health Information Technology for Economic and Clinical Health Act (HITECH). HITECH included funding to support the adoption and use of electronic health records (EHRs) and heralded an era of widespread health IT development. Since HITECH, the number of hospitals, health systems and provider practices using EHRs has grown dramatically, paving the way for new approaches to care delivery and payment. Although often still rudimentary, EHRs enable healthcare providers to capture a wealth of clinical data electronically. Once captured, data can be more readily shared to facilitate care coordination and analyzed to generate new insights. Other health IT tools, like telemedicine, care management software, performance analytics, and mobile devices and applications, have also proliferated in recent years.

Health IT enables ACOs to collect the data they need to deliver high-quality care and improve operational efficiency. Tools like analytics software enable ACOs evaluate population-level data to compare spending and outcomes across different groups of patients and providers. Administrators can use the results to determine which practices are less efficient and intervene to ensure providers are using appropriate evidence-based guidelines for care. Clinical decision support tools can incorporate learnings derived from analytics to further improve clinical care delivery, alerting providers to potential patient safety issues or recommending an appropriate course of action. ACOs can also use data analytics to stratify their patient populations, identify patients that are consuming the most resources or at the highest risk of getting sicker or being readmitted, and intervene as necessary.

Electronic records offer clinicians a comprehensive up-to-date account of the care their patients have received, which enables them to make more decisions. Telemedicine and mobile health devices and applications can expand a patient's access to care away from the provider's office. These tools can facilitate patient-provider communication, enable patients to monitor and manage their conditions at home, and relay important data about a patient's status to clinicians. Telemedicine has also been used to overcome geographic barriers to care, improve access to specialists in underserved areas, and facilitate information sharing and collaboration among teams of providers. Telemedicine and mobile health can often be delivered at a lower cost than more traditional approaches.

ACOs responding to the survey use a variety of health information technologies to support their operations. Most prevalent are analytics software (84 percent), EHRs (74 percent), care management software (61 percent), computerized physician order entry (57 percent) and a data warehouse (55 percent). Nearly half of all ACOs also use other tools that facilitate population health management, including integrated claims and clinical databases (48 percent), disease registries (44 percent) and a population health dashboard (44 percent) that providers can use to visually compare performance. Despite the potential of telemedicine for collaboration and communication, relatively few ACOs currently use the technology (26 percent). Fewer still utilize remote monitoring tools (16 percent) to facilitate care management outside of clinical settings.
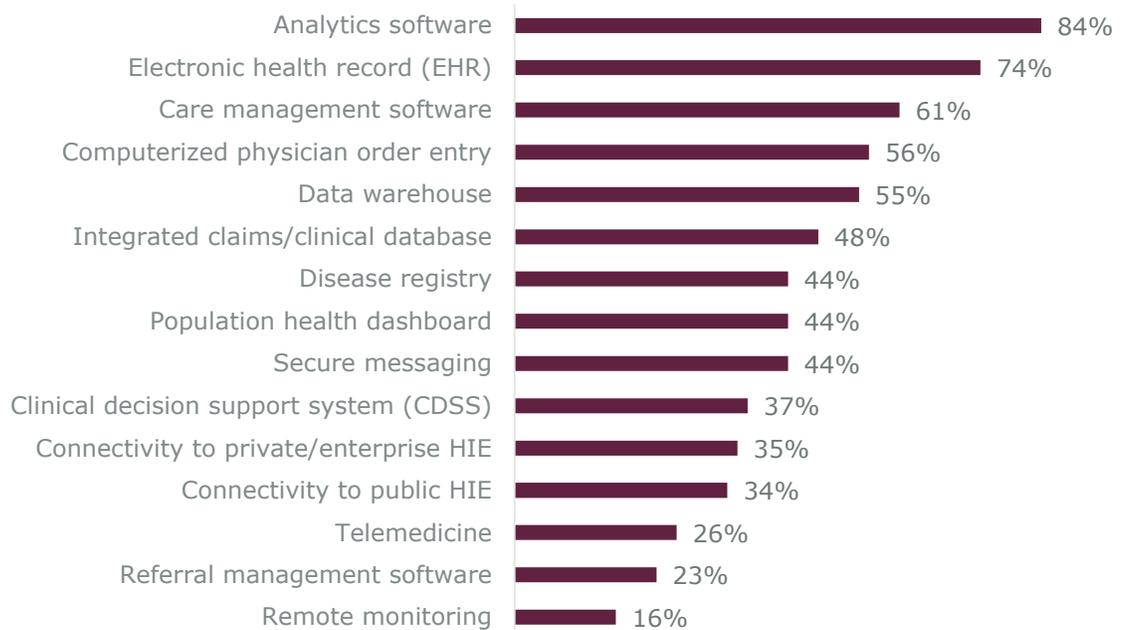
Figure 3: Health IT Infrastructure Used by Responding ACOs

PATIENT ENGAGEMENT

Patient engagement is rapidly becoming a core strategy of value-based care delivery. Organizations are increasingly leveraging health IT tools and comprehensive care management interventions to help their patients play a greater role in staying healthy. Given the limited time providers have with patients in clinical settings, enabling them to manage their care at home is an effective way to keep patients well and out of more expensive care settings. Offering patients access to their records can increase satisfaction and empower individuals with the information they need to take greater ownership over their health. Health IT can help enhance patient engagement by delivering new tools that patients can use to monitor biometric health data, communicate with their doctor, receive social support, access their records, learn about their condition and make healthier choices. Particularly with the increase in the prevalence of chronic diseases that require a greater degree of self-management, healthcare organizations are looking to increase patient engagement to improve outcomes and reduce costs.

ACOs have embraced patient engagement by developing coaching and care management programs and providing patients access to their health records. Sixty-five percent of ACOs offer coaching to help patients better understand what is required of them for successful treatment, and 37 percent offer general health and wellness coaching. Care management software (one of the most common components of an ACO's health IT infrastructure) can help coaches and care coordinators integrate data about a patient's health and track their progress to support these efforts. Sixty-one percent of surveyed ACOs offer patient portals through which patients can view their medical records. Fifty-eight percent employ care navigators who can follow-up with patients and help guide them through a range of issues including transitions of care and payment. ACOs also offer services to alert patients to preventive care (55 percent) and gaps in care (48 percent). Some ACOs offer secure messaging tools to increase patient-provider communication (32 percent).
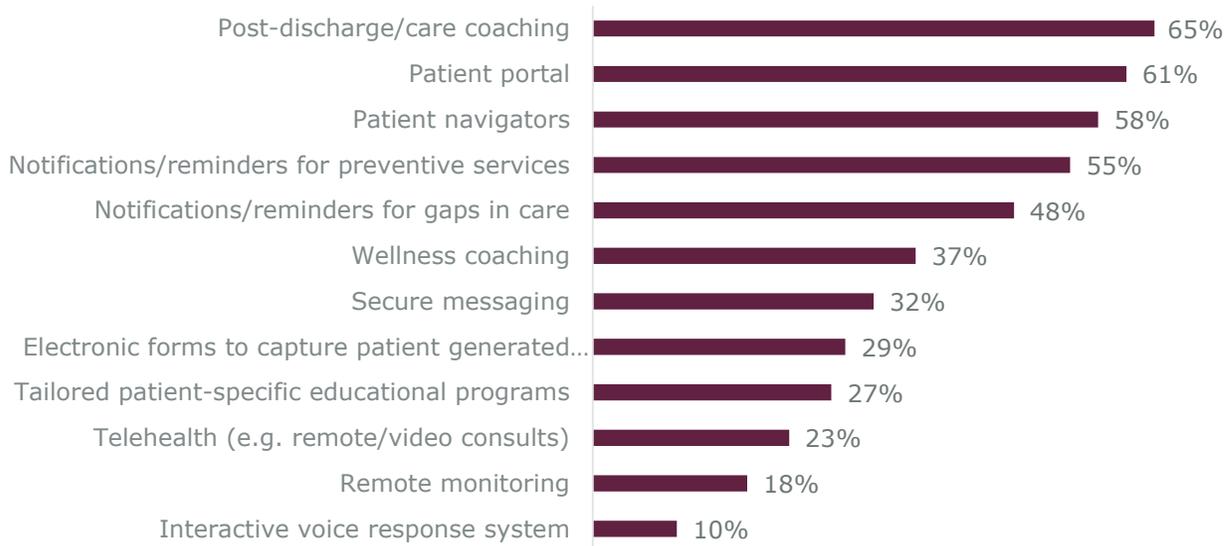
Post-discharge/care coaching	65%
Patient portal	61%
Patient navigators	58%
Notifications/reminders for preventive services	55%
Notifications/reminders for gaps in care	48%
Wellness coaching	37%
Secure messaging	32%
Electronic forms to capture patient generated...	29%
Tailored patient-specific educational programs	27%
Telehealth (e.g. remote/video consults)	23%
Remote monitoring	18%
Interactive voice response system	10%

Figure 4: Consumer Tools Used by Responding ACOs

However, there is still much room for growth. Today, tools like patient portals are typically limited to viewing, and may only display a portion of the patient's record. Likewise, patients are generally not offered capabilities for amending their records or contributing new data; remote monitoring is rare, and only 29 percent of ACOs use electronic tools for capturing patient-generated information. In fact, given their existing health IT infrastructure, 48 percent of ACOs believe that patient engagement is the most difficult activity to perform, as compared to other activities like quality measurement (40 percent), care coordination (39 percent) or chronic disease management (21 percent).

INTEROPERABILITY

One possible reason that ACOs have largely been unable to incorporate patient-generated data is that they are already struggling to integrate data from disparate clinical sources. As with the transition to value-based care, health IT adoption is a fairly recent phenomenon that poses a host of challenges to healthcare organizations. Aside from the costs of IT procurement and interruptions to workflow associated with the use of new technology, ACOs are burdened with integrating diverse clinical and administrative information systems that were designed to function independently.

Until recently, providers typically practiced medicine independently, only referring a patient when their needs exceeded the provider's training and skills. Patient records are separately housed at each hospital or practice and usually incorporate only a limited subset of data from other care settings, if they include any at all. Information systems are designed for the unique needs of different settings and specialties, lacking a common language through which to communicate patient data. As a result, interoperability between systems is often non-existent or requires complex interfaces for standardizing and transmitted data.

Unfortunately for ACOs, their need to manage entire patient populations also requires that they integrate data from many of these disparate systems. According to the survey findings, 39 percent of ACOs integrate data from 1-10 health information systems, 44 percent integrate data from 11-50 systems and 11 percent from more than 50 systems. Integrating data can be complex and expensive. Eleven percent of ACOs have spent at least $500,000 to achieve systems interoperability, and 26 percent have spent more than $1 million.

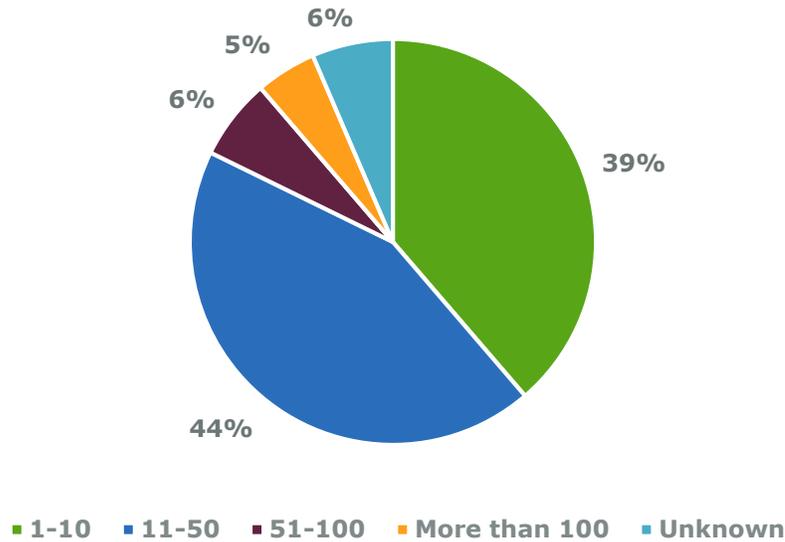**1-10 ■ 11-50 ■ 51-100 ■ More than 100 ■ Unknown**

Figure 5: Number of Integrated Health Information Systems

Some systems are more difficult to integrate than others. EHR adoption has started the process of standardizing primary care data, and ACOs reported having an easier time integrating data from primary care settings (63 percent). Likewise, the widespread adoption of standards like LOINC (used primarily to describe medical laboratory observations), SNOMED (a broad clinical terminology standard), and RxNorm (used to describe medications) has simplified the process of integrating laboratory and diagnostic information (61 percent) and pharmacy data (42 percent).

Other settings pose a greater challenge. Traditionally, the farther a patient progressed along the care continuum, the less likely it was that their data was sent back to other care providers along the way. Primary care information systems, for example, weren't developed to incorporate data from specialists. Consequently, ACOs have struggled to integrate data from these settings. Sixty-nine percent of ACOs report having a harder time integrating specialty care data, almost double the number for any other care setting. Compounding the problem is that many specialty care settings lie outside of the ACO network to which a patient is assigned.[3] Obtaining data from settings outside a network requires complex data sharing agreements and new interfaces between systems. Often, these practices lack the proper incentives to share their data. Obtaining data from outside the ACO network was regarded as the biggest challenge facing ACOs (79 percent).

In other cases, ACOs simply have not tried or have not been able to integrate data from other settings. Behavioral health and substance abuse data, for instance, is protected by complex informed patient consent rules and other legal restrictions that complicate integration. More than half of ACOs (53 percent) have not integrated data from behavioral health providers. Forty-eight percent haven't integrated data from long-term and post-acute care settings, and 46 percent haven't integrated data from palliative care and hospice. Of all care settings, surveyed ACOs would most like to have greater interoperability with behavioral health (67 percent) and long-term/post-acute care (67 percent) to support operations. ACOs that have attempted to integrate data from these sources rate the experience as more difficult than other settings.

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[3] Outpatient Care Patterns and Organizational Accountability in Medicare - http://www.ncbi.nlm.nih.gov/pubmed/24756690

	Easier	Harder	Not Integrated
Primary care	63%	28%	8%
Laboratories/Diagnostics	61%	20%	20%
Specialty care	16%	69%	15%
Public payers	45%	38%	17%
Private payers	30%	42%	28%
Long-term/post-acute/skilled nursing	13%	38%	48%
Behavioral health	10%	36%	53%
Palliative/hospice	24%	31%	46%
Home Health	22%	39%	39%
Pharmacy	42%	28%	30%

Figure 5: Experience Integrating Data from Different Settings

Overall, data integration may be the greatest barrier to the success of most ACOs. Sixty-four percent reported that data integration was a challenge to developing and operating their ACO.

DATA USE

Despite the hurdles presented by a lack of interoperability, many ACOs have successfully been able to start capturing and using data from different sources. Given that an ACO is ultimately a financial mechanism to reshape care delivery, it's not surprising that claims data was the most common type of data analyzed to support operations. Claims data is the most effective way for ACOs to measure spending on healthcare delivery. Similarly, clinical data from EHRs is the most effective way to measure quality and outcomes. Seventy-nine percent of ACOs analyze data from EHRs.

Analytics are primarily used by ACOs to drive improvements in care by identifying areas for targeted interventions. For example, surveyed ACOs analyze claims, clinical and other types of data to identify gaps in care (86 percent) and outliers in cost or utilization (81 percent). Eighty-four percent of ACOs use the results of their analytics to craft programs aimed at addressing high-cost and high-utilization patient populations. Sixty-seven percent of ACOs use analytics to predict different types of risk and stratify their patient populations according to their risk scores. Patients at higher risk of readmission, service utilization or worsening, among others, can be targeted with specialized care management activities. Eighty-two percent of ACOs offer care transitions and care coordination programs based on analytic findings, and 74 percent offer specific disease management programs.

Shared savings and other financial incentives are frequently contingent on meeting quality and performance benchmarks, so many of the surveyed ACOs use analytics to measure and improve their performance. Seventy-five percent apply analytics to compare metrics on individual providers, or to measure and report on quality. Fifty-eight percent of ACOs use data to drive the development of clinical guidelines and best practices to help reduce variability across providers and improve the standard of care.

These efforts are beginning to show results. A majority of ACOs responding to the survey reported cost savings (68 percent), improvements across clinical quality measures (54 percent), fewer hospital readmissions (53 percent) and better preventive healthcare (53 percent). Slightly fewer reported improvements in healthcare utilization (49 percent), the number of emergency department visits (47 percent) and chronic disease management (47 percent).

BEGINNING THE JOURNEY

Results from the 2015 ACO survey suggest that although ACOs may struggle with interoperability, many are well positioned for the journey toward value-based care. Today, more advanced ACOs are only beginning to experiment with evolving their payment mechanisms to accept greater financial risk as they continue to build out their health IT infrastructures, integrate data from new sources and transform the nature of care delivery. Results from the survey demonstrate the impact ACOs are having on improving various cost and quality metrics, even with limited data. ACOs are also striving to be better partners to their patient populations, offering a variety of tools and programs designed to engage patients and improve health and well-being.

ACKNOWLEDGEMENTS