

# Health Plan–Provider Accountable Care Partnerships: How Have They Evolved?

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## ABSTRACT

**OBJECTIVES:** To understand the expansion of health plan–provider accountable care organization (ACO) partnerships and the evolution of the characteristics of these partnerships.

**STUDY DESIGN:** Qualitative data collection and survey.

**METHODS:** We used a 2-pronged data collection approach. We collected qualitative data from the 8 plans who participated in our 2011 study on health plan–provider partnerships using the same set of interview questions. In addition, we fielded a survey on alternative delivery and payment models to 105 member plans from America’s Health Insurance Plans (AHIP), including specific questions on health plan ACO implementation.

**RESULTS:** Our survey showed health plan expansion of ACO implementation with increased use of shared risk and widespread provision of analytic reports and other types of technical assistance to providers. The cohort of 8 health plans reported improvements in quality of care since 2011 while evolving their program components, such as use of more readily measurable provider eligibility criteria, ongoing emphasis on health plan–provided technical assistance, and greater collaboration between health plans and their provider partners, to continually re-evaluate quality and utilization measures.

**CONCLUSIONS:** Our analysis shows maturation of private sector ACOs since 2011, with shared risk playing an increasing role in changes to reimbursement. We also saw continued emphasis on provider readiness to assume downside risk, expansion to smaller provider groups, and an increase in the scope and depth of technical assistance made available to providers in these contracts. Some challenges continue to exist, including alignment of quality measurement and reporting, broader inclusion of smaller practices in alternative delivery and payment models, and developing tools and materials to assist consumers in realizing the benefits of value-based care.

To help accelerate delivery and payment reform across the public sector, HHS Secretary Burwell announced the federal government’s goal to tie 30% of traditional, fee-for-service (FFS) Medicare payments to quality and value through alternative payment models (APMs) by the end of 2016, and 50% of payments by the end of 2018.<sup>1</sup> Implementation of APMs in the private sector has been underway for the past 5 to 6 years. Examining the experience of health plans with such models can be useful to policy makers as they seek to transition the healthcare system to value-based payment through implementation of the Health Care Payment Learning and Action Network<sup>2</sup> and Medicare Access & CHIP Reauthorization Act of 2015 (MACRA).<sup>3</sup>

In 2011, we published a study on key characteristics and initial lessons from 8 health plans that were early adopters of accountable care organization (ACO) models.<sup>4</sup> Re-examining their experience with these models over the past 4 years can yield useful insights for policy makers and other healthcare stakeholders; specifically, we sought to understand how ACOs implemented by these 8 plans have evolved. We were also interested in examining the widespread adoption of ACOs in a more systematic manner. To achieve these objectives, we used a 2-pronged data collection approach. We collected qualitative data from the 8 plans who participated in the 2011 study using the same set of interview questions. In addition, we fielded a survey on alternative delivery and payment models to 105 member plans from America’s Health Insurance Plans (AHIP), including specific questions on health plan ACO implementation. In this article, we describe key findings from the second round of data collection from the original 8 plans and a total of 28 plans who responded to the survey.

### Expansion of ACO Implementation

Findings from our member plan payment survey showed that all 28 health plans that responded to the survey had ACO contracts in effect. We also found that these ACO contracts were present in 43 states and spanned commercial, Medicaid, and Medicare Advantage product lines. In addition, several of our 8 case study plans, which cover approximately 80 million commercially enrolled lives, reported extending their partnerships beyond the largest health systems and provider groups to smaller physician groups. Some case study health plans have lowered the requirement for minimum patient panel size from 10,000 to 5000 patients.

### Improvements in Quality Since 2011

The cohort of 8 case study plans with several years of experience implementing ACOs reported improvements in quality and costs. Specifically, some of the observed improvements, shown as ranges experienced by the 8 case study plans, include:

- Improved performance on clinical quality measures for specific conditions (up to 20% improvements), such as diabetes (19%-25% increase) and medication adherence (27% increase).
- Reduced readmission rates (11%-32% improvements).
- Increased prescribing of lower-cost medications (21%-52%) through approaches such as generic prescribing.
- Achieved a significantly higher referral rate to high performing specialists than the market referral rate (81% higher).
- Reduced emergency department visits (19%-50% improvements).

Health plans reported actively seeking to incorporate patient satisfaction measures into their ACO contracts by conducting patient satisfaction surveys. In conducting these surveys, one plan reported that patients attributed to the ACO experienced better access to urgent care, higher satisfaction with the amount of time they spend with providers, and higher satisfaction with how well their providers listened to them compared with members not attributed to the ACO. Finally, some plans reported observing “spillover effects,” where patients not attributed to the ACO experienced improvements in outcomes, and greater access to care through extended provider office hours due to re-engineering of care delivery.

These improvements in quality of care were also accompanied by other key changes in the design and implementation of ACOs, which are highlighted below.

### Provider Eligibility

As health plans have expanded their ACO contracts, provider eligibility criteria for such contracts have also evolved. Although the 8 case study plans reported using some of the same criteria as in the 2011 study, such as strong leadership and commitment to transformation, several new and more readily measurable criteria have emerged. **Table 1** lists some of these criteria.

### Reimbursement Methods

Survey results indicate that health plans use a mix of reimbursement methods in ACO contracts, and our case study plans provide

**Table 1. Provider Eligibility Criteria**

Criteria	How Applied
Demonstrated experience	<ul style="list-style-type: none"> <li>• NCQA or URAC certification of the ACO</li> <li>• Participation in CMS demonstrations</li> <li>• Contracted HMO risk arrangements</li> <li>• Participation in collaborative learning opportunities (eg, webinars, local market virtual sessions)</li> </ul>
Health IT capabilities	<ul style="list-style-type: none"> <li>• Use of EHR and disease registry</li> <li>• Meeting “Meaningful Use” requirements</li> </ul>
Commitment to care delivery transformation	<ul style="list-style-type: none"> <li>• Documented ACO and clinical management and governance processes</li> <li>• Detailed clinical action plans including approaches to improving patient safety and patient health status</li> <li>• Ensuring 24/7 availability of providers</li> </ul>

ACO indicates accountable care organization; EHR, electronic health record; HMO, health maintenance organization; IT, information technology; NCQA, National Committee for Quality Assurance; URAC, formerly Utilization Review Accreditation Commission (now just URAC).

some insight into the rationale for the variation in payment methods. Consistent with previous findings, plans still emphasized the need for flexibility to tailor reimbursement to providers’ ability to assume risk. Health plans reported that it is important for provider organizations to have time to gain both confidence and experience with new approaches before taking on financial risk. As a result, health plans allow for a transition from traditional FFS to APMs by first introducing shared savings only, and then increasing the share of such potential savings as providers gradually accept downside risk. Over time, financial incentives associated with accepting risk significantly outweigh gains from shared savings only and traditional FFS payments.

Although flexibility is emphasized, we observed increased movement toward shared savings and risk contracts, with 43% of plan respondents including shared savings, and 50% including shared risk, as part of the reimbursement structure.

### Emphasis on Technical Assistance

Data collected through the survey and 8 case study health plans continue to show plan emphasis on technical assistance to providers. Technical assistance usually consists of sharing timely data and analytic reports in addition to infrastructure development and support. Timeliness of shared information is deemed essential for providers in ACO contracts with financial risk, so that they may quickly identify areas for quality and cost improvement, thus mitigating their risk.

Survey results indicate that a vast majority of health plans provide technical assistance to provider partners in areas of disease and care management (96%), exchanging health informa-

**Table 2. Types of Technical Assistance**

Types	How Implemented
Data	<ul style="list-style-type: none"> <li>• Claims history</li> <li>• Claims extracts for attributed population provided continually</li> <li>• Hospital and emergency department census</li> </ul>
Analytic reports	<ul style="list-style-type: none"> <li>• Predictive analytics and early identification of members at risk for disease or condition exacerbation</li> <li>• Identifying high-risk members who can benefit from care management support</li> <li>• Benchmarking reports—compare ACO performance on quality and costs to targets and peers</li> <li>• Reports that allow ACOs to assess performance of other providers and determine appropriate referrals</li> </ul>
Care management	<ul style="list-style-type: none"> <li>• Care transition programs for patients discharged from hospitals</li> <li>• Referrals to Centers of Excellence</li> <li>• Disease and case management</li> </ul>
Consultative support	<ul style="list-style-type: none"> <li>• Assistance with development of first-year plans for ACO</li> <li>• Staff resources that help providers use the data and analytic reports and identify opportunities for improvement</li> </ul>

ACO indicates accountable care organization.

tion (96%), population health management (89%), infrastructure needs/data platforms (82%), and managing financial risk (64%). We found that utilization reports, inpatient census reports, and clinical quality rates were the most common types of data shared with ACO providers; data on care gaps, financial targets, and patient experience also were being shared by a majority of the plans surveyed.

Data collected from the 8 case study plans provide a more nuanced view of the scope and breadth of technical assistance made available to their provider partners. **Table 2** summarizes these key findings.

Within the past several years, greater integration of clinical and electronic health record (EHR) data, as well as medical and pharmacy claims, has allowed plans to identify at-risk members earlier and generate a more comprehensive view of a patient’s health. Beyond acquiring the data, there appears to be interest among some ACOs to use these data and analytics to identify appropriate referral partners. For example, one case study plan reported heightened ACO interest in using the health plan’s data to gauge how a referral partner might perform in a shared savings relationship. As provider organizations have matured, plans place more emphasis on leveraging the combined strengths of both plan and provider groups, with experienced provider groups taking on leadership roles within programs traditionally implemented by plans.

**Role of Performance Measurement**

Most health plans continue to use a “quality gate” to ensure that providers achieve performance targets before they earn financial rewards. Additionally, data collected from the case study plans show incorporation of patient experience measures in their ACO contracts either currently or in the near future. We also found that 32% of plans responding to our survey require ACO physicians to meet

patient experience targets to be eligible for incentive payments.

As plans have had more years to refine performance measurement and provider partners gain experience with measurement, a collaborative process is established to continually re-evaluate quality and utilization measures to ensure alignment around incentives for quality improvement. One health plan noted that they are increasing the amount of risk tied to performance measures such as potentially preventable events.

**CONCLUSIONS**

Our analysis shows maturation of private sector ACOs since 2011 with shared risk playing an increasing role in changes to reimbursement. We also saw continued emphasis on provider readiness to assume downside risk, expansion to smaller provider groups, and an increase in the scope and depth of technical assistance made available to providers in these contracts.

Although our data show significant progress and expansion of ACOs, some challenges continue to exist, including alignment of quality measurement and reporting, broader inclusion of smaller practices in alternative delivery and payment models, and development of tools and materials to assist consumers in realizing the benefits of value-based care. Work is currently underway through the Core Quality Measures Collaborative to address quality measure alignment across public and private sectors.<sup>5</sup> Going forward, increased emphasis on patient engagement and communication strategies will be central to the success of these alternative delivery and payment models. Finally, additional scientific research is needed to identify which combinations of interventions have led to the reported improvements in quality and cost measures among private sector ACOs, as well as to identify the types of data most useful to providers in achieving these improvements.

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