Connecticut Health Policy Project

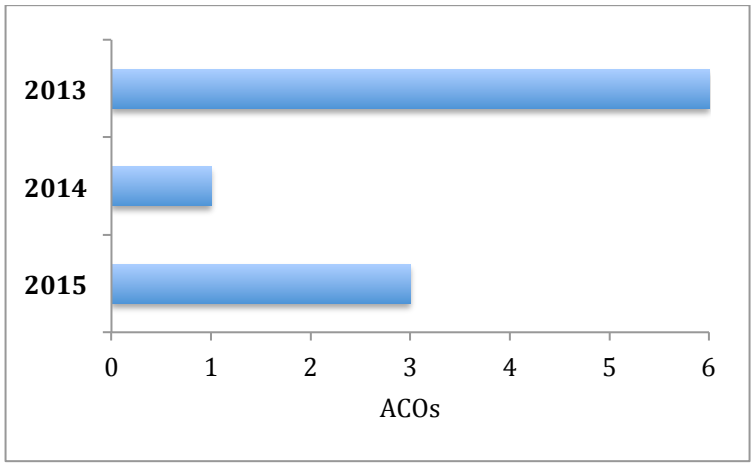
March 2016

Survey of Connecticut Accountable Care Organizations

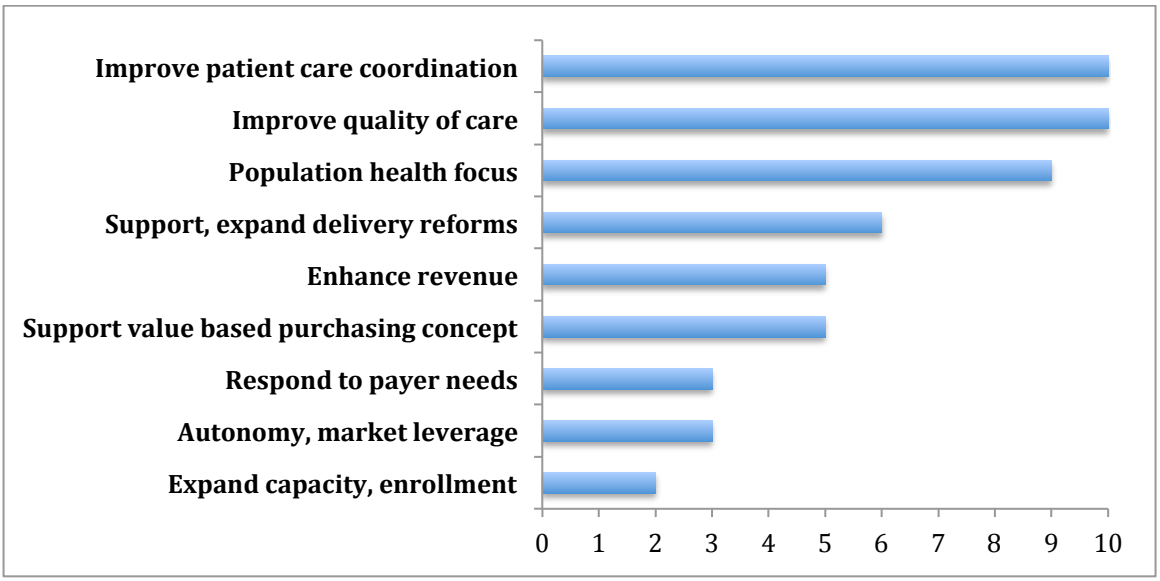
Accountable Care Organizations (ACOs) are a relatively new health care delivery structure serving Connecticut residents. ACOs are voluntary groups of health care providers working together to provide high quality care to their members and spend scarce health care dollars more efficiently. When they succeed, ACOs can share in the savings generated by coordinating patient-centered care and delivering evidence-based treatment.

ACOs offer great potential to move Connecticut's health system from a payment model that rewards volume to one that rewards value. To get a better understanding of the development of ACOs in our state, the Hartford Business Journal and the CT Health Policy Project conducted a survey in late 2015 to early 2016. Nine ACOs provided full survey responses and another provided a partial response.

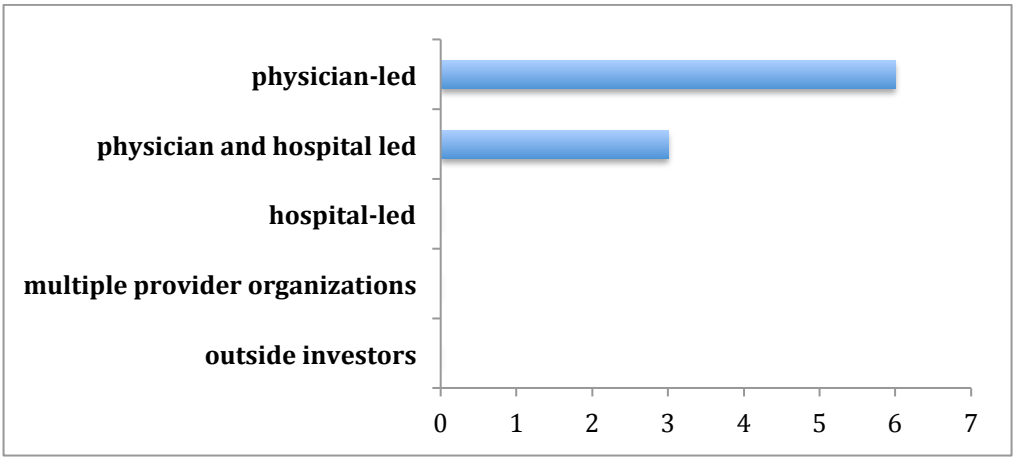
When was your ACO formed?



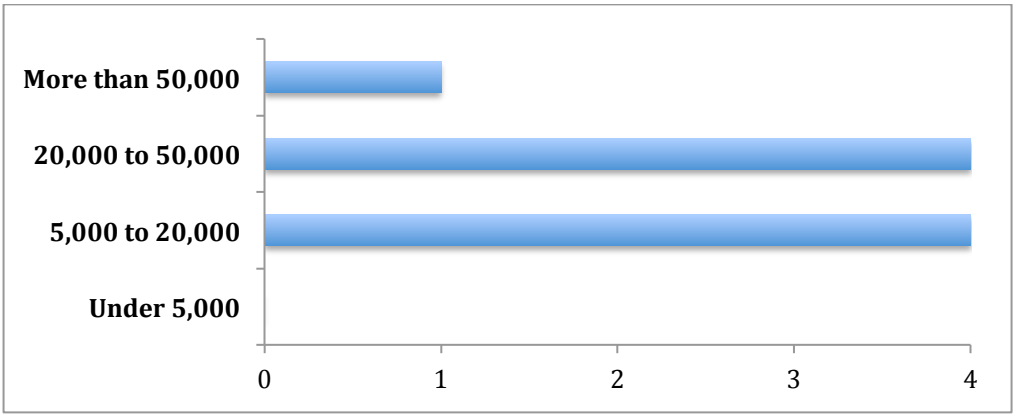
What are the goals of your ACO? (check all that apply)



What is your ACO's governance/ownership structure?



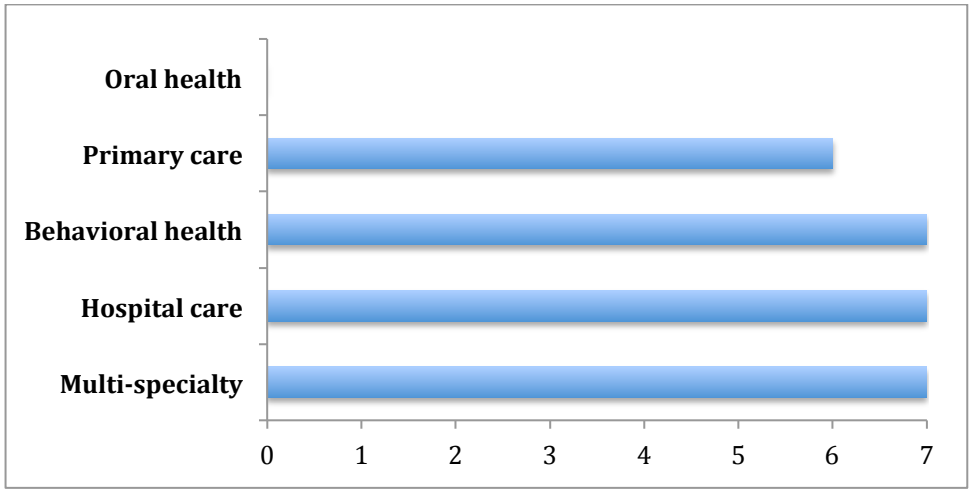
How many people in Connecticut does your ACO cover?



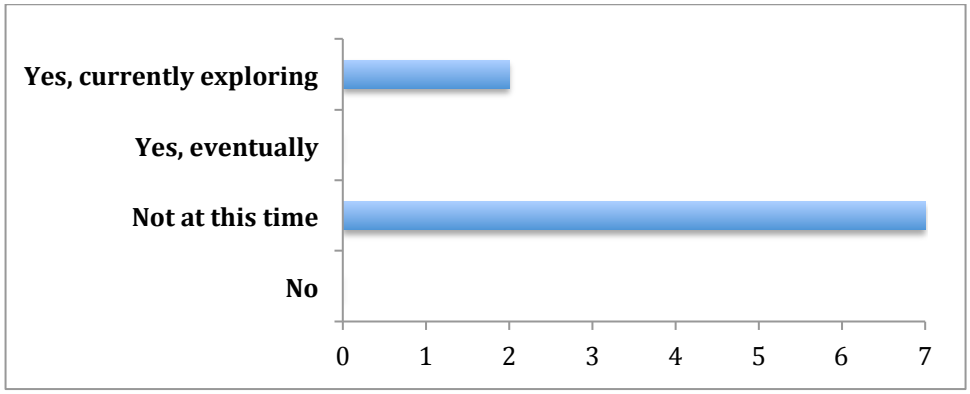
How many providers participate in your ACO?

		Median	Range
Primary care		150	60 to 465
Specialists		180	10 to 1,100
Hospitals		1	0 to 80

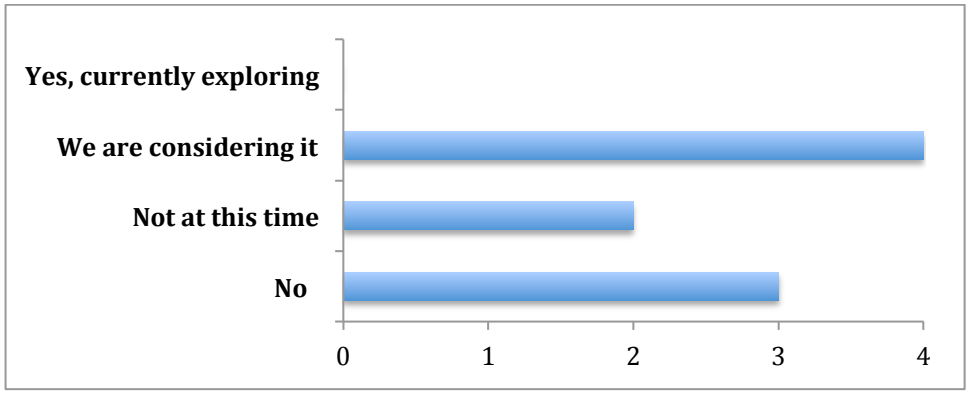
What services are provided by your ACO's network?



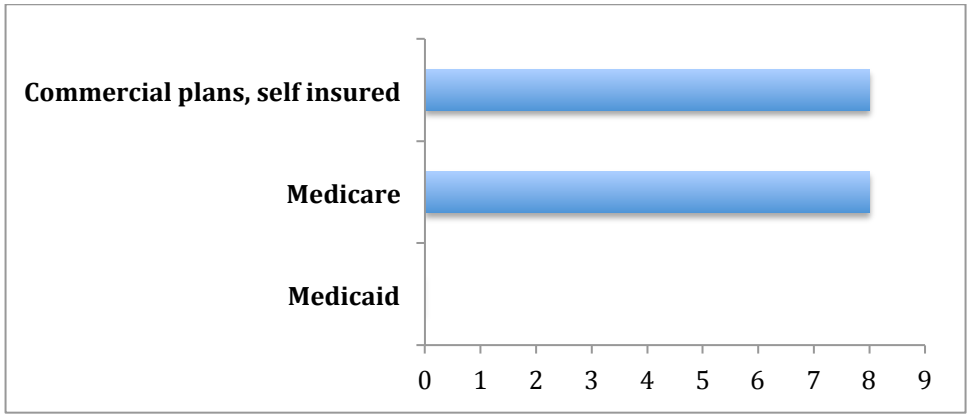
Do you intend to pursue NCQA or other accreditation as an ACO?



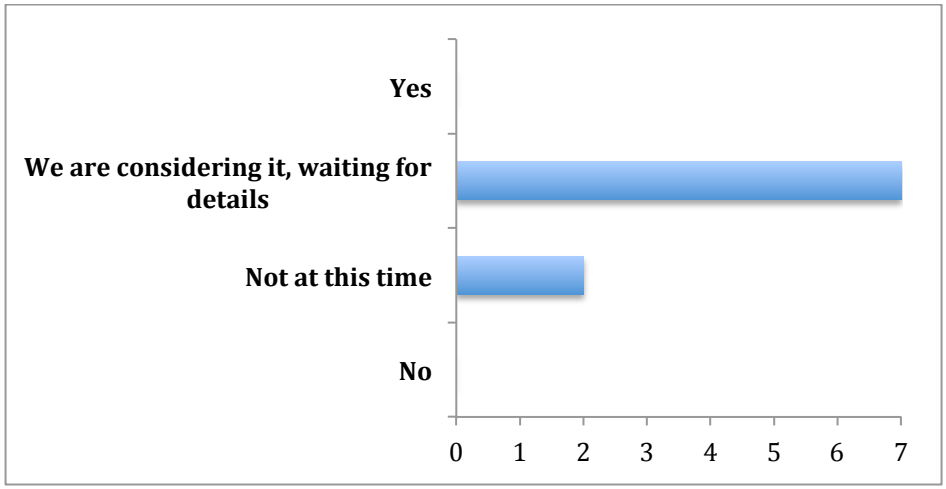
Is your ACO considering entering the health insurance business or pursuing insurance company financing?



Which payers do you have value-based contracts with now?

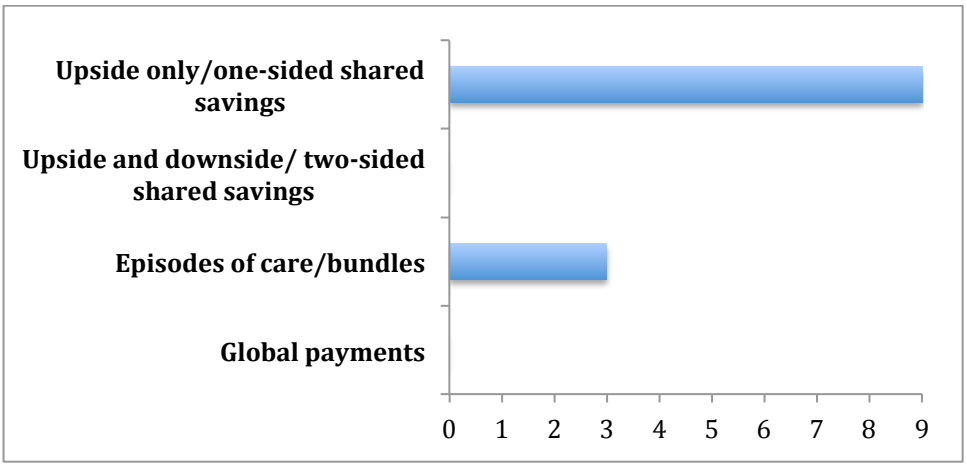


Does your ACO have an interest in participating in Connecticut's new Medicaid shared savings program?

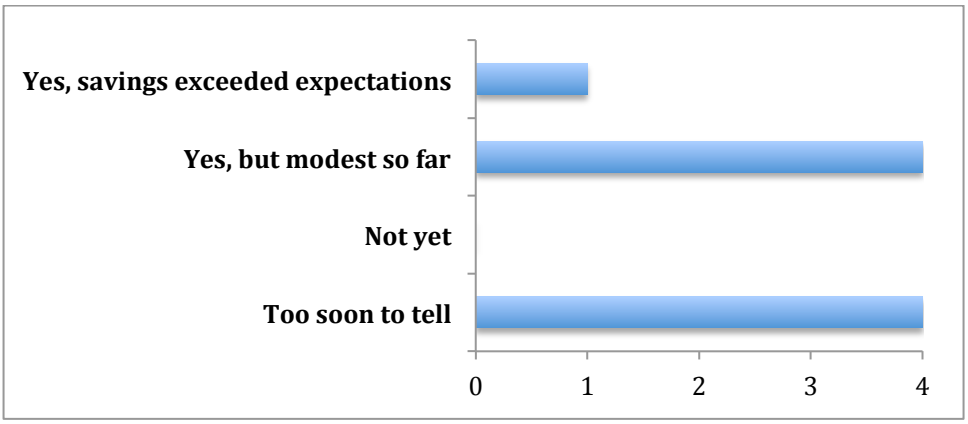


Comment: It really depends on how the program is structured

What types of risk sharing arrangements do you currently have?

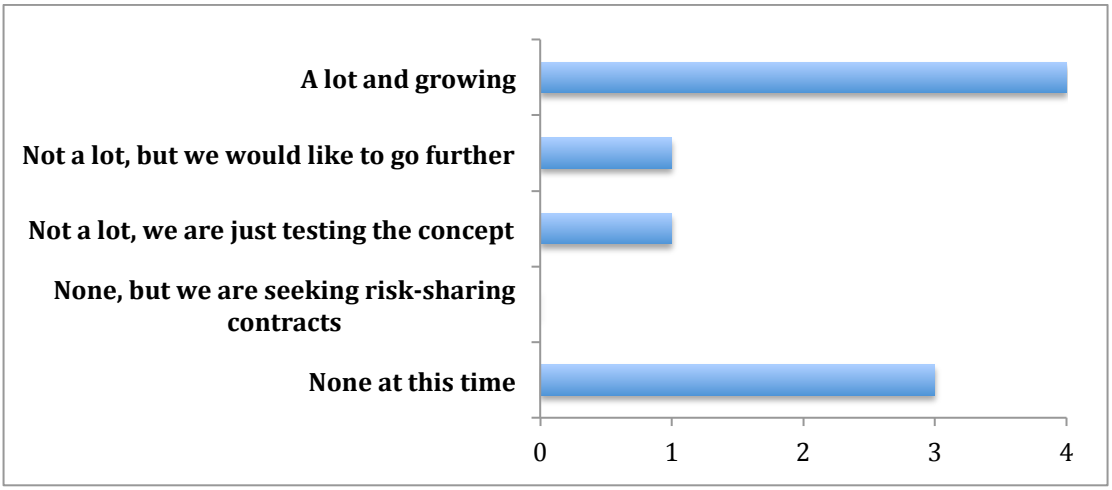


Has your ACO achieved savings yet?

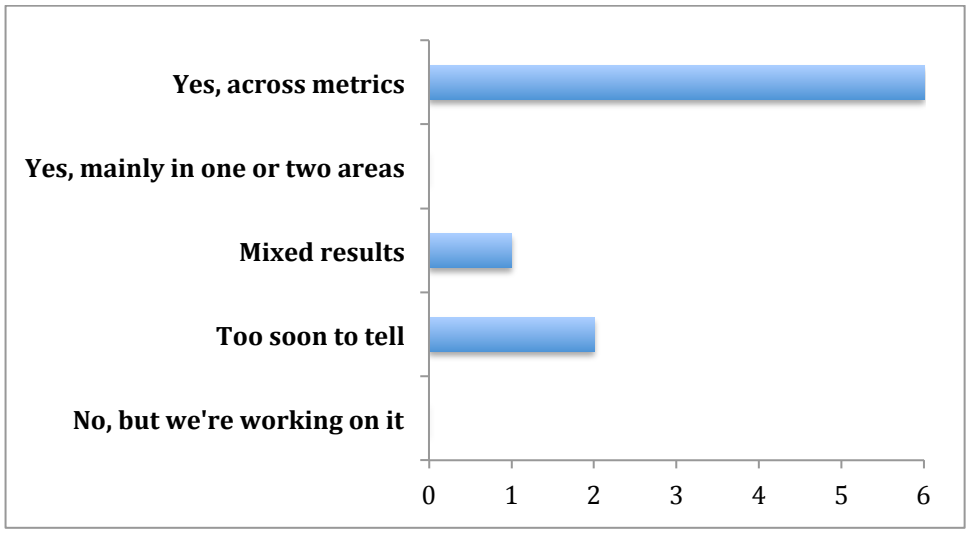


Comment: Though our data suggests we are exceeding the required benchmarks, it is too soon to say definitively.

How much of your ACO's revenue is in risk-sharing arrangements?

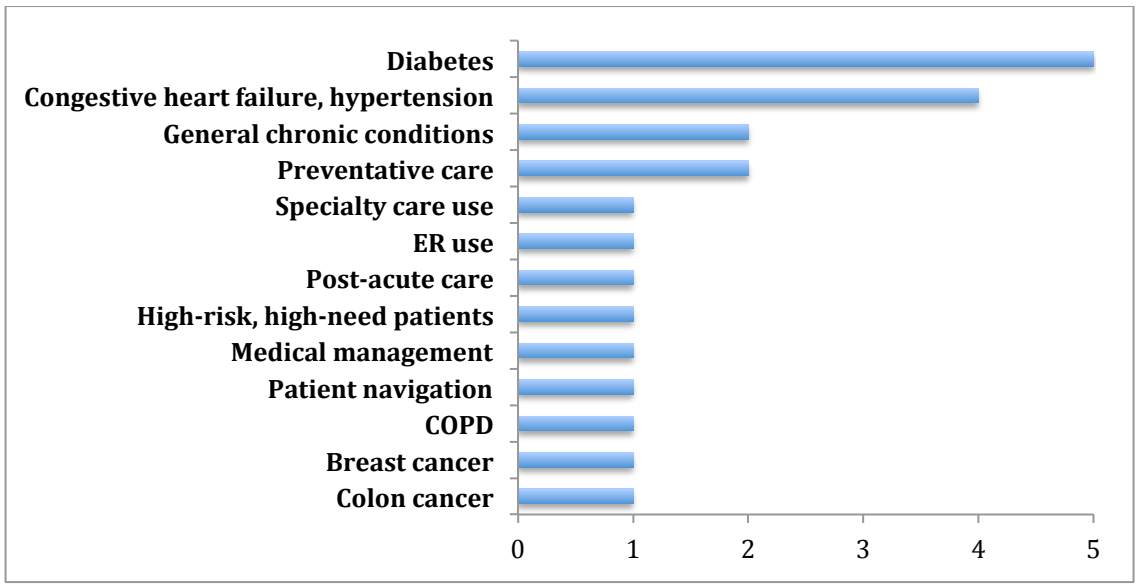


Has your ACO demonstrated quality improvements?

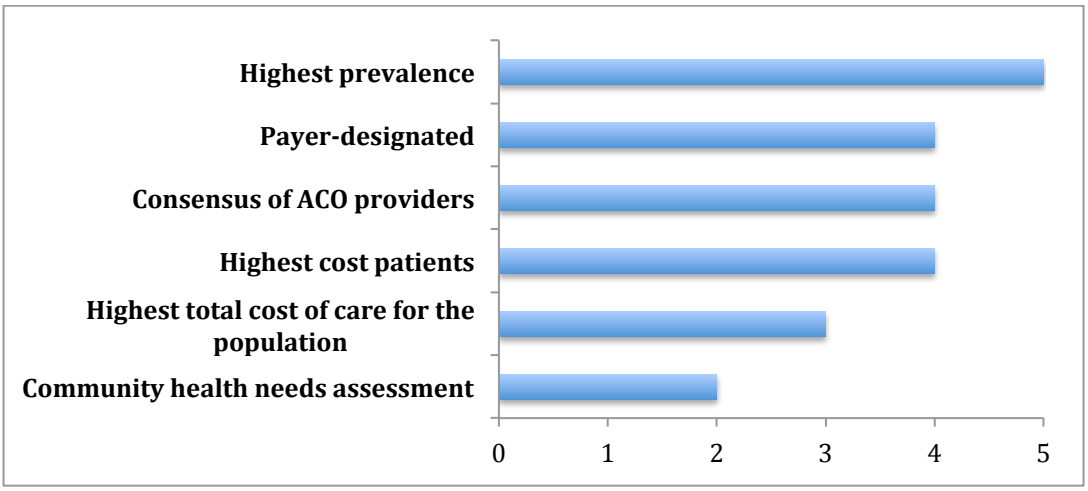


Comment: It depends on the metrics and in some cases too soon to tell but [there] is clear progress and improvements are being made.

What conditions are you focusing population health efforts on? (open question)



How did you identify population health priorities?

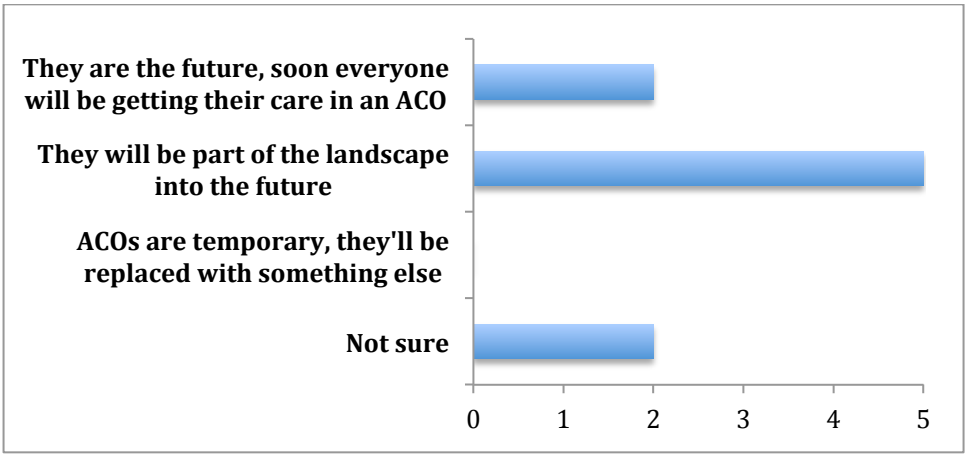


How do you define and develop best practices for the ACO?

Answers:

- We have a Clinical Initiatives Committee and Specialty Quality Councils
- We use nationally recognized recommendations
- Through process improvement and using evidence-based guidelines
- We have been working on best practice model development tied to those practices that are demonstrating better results - we are using weekly training and informational updates.
- Discussions and process review

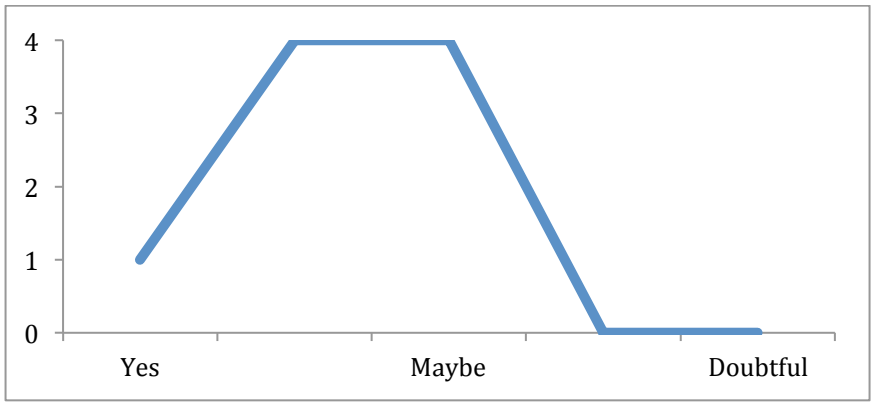
What does the future hold for ACOs?



Comments:

- Expensive infrastructure with possibility of no ROI
- ACOs come in different structures and I anticipate that some of the structures or models will demonstrate both cost savings and quality improvements and others will not.

Will ACOs achieve the goals of the Triple Aim?



Comment: Patient engagement just as important

What are the biggest challenges your ACO has encountered?

Data challenges

- Timely data
- Data analytics
- Timely performance data on quality - claims data is not very useful
- Understanding utilization and the cost of care in our attributed patient population
- Data aggregation/analytics difficulties
- Data systems
- Time lag in claims, reported outcomes, quality measures

Funding Challenges

- Funding the infrastructure required to manage care across the continuum
- Financial - Infrastructure costs
- Cost of infrastructure
- High MSR [minimum savings rate]
- Care Coordination: expensive undertaking

Technology challenges

- Health information technology connectivity and adaptability
- Technology limitations
- EMR integration
- Not having a common process or method of using the provided health information technology

Provider challenges

- Having only a subset of the physicians in any given area participating, causing some care to be provided outside of the ACO
- Engagement of independent physicians and practices across broad network
- Physician overload

Consumer challenges

- Poor incentive for patient engagement
- Beneficiary understanding

Administrative challenges

- Attribution stabilization
- Payer alignment

What lessons have you learned?

Patience

- One step at a time
- Patience - results take more time than anyone anticipates
- Hard to change practice processes in such a short time frame
- Can't move too fast

Data lessons

- Aggressive prospective gap identification and resolution
- Claims lag easily 3-6 months behind
- No robust data analytics exist
- Need to set up better data mining & collection from ACO members, especially from electronic medical records
- Misattribution of patients can lead to missed care coordination opportunities
- Data is powerful if provided timely and in a usable format

Provider lessons

- Physicians need to be highly engaged
- Clinical leadership is a critical success factor
- Changing the physician culture is challenging
- Advance practice nurses critical
- Providers feel the additional burden
- Our care coordinators play a critical role in cost reduction and quality improvement - probably need to expand capabilities
- Face to face conversations with physicians help promote improvement in processes and change.

Financial lessons

- Requires financial & personnel resources
- Need revenue sources

Other lessons

- Consumers: Better one-on-one communication with ACO members needed
- Technology: Lack of a statewide health information exchange
- Administrative: Probably need to expand capabilities
- Clinical: Manage renal disease more effectively

How could payers or the state support your ACO?

Financial support

- Improve payments for ACO work
- Need advance payment model
- Increase care coordination fees to cover some expenses
- Offer PMPM or other modified payment models that recognize the care improvements provided through an ACO model

- From payers - need more infrastructure support (PMPM)
- Up front capital for infrastructure
- Improve payments for results
- Make it easier to realize shared savings
- Provide funding for care management services
- Cost savings should not be viewed on an annual basis but over the term of an ACO arrangement because with certain populations there may be service increases in the short term (and short term is first year to 18 months)

Data support

- Payers need to share cost data more readily - can still be in aggregated form
- Provider validated data
- Supplying data faster
- Some consensus on quality metrics and limit on number would be nice
- Provide standardized patient-level, actionable data

Technology support

- Implement a statewide HIE [health information exchange] ASAP
- Providing the health information exchange to connect practices across locations between and among ACOs and help with real time data feeds from facilities
- HIE

Administrative support

- Require that patients choose a PCP so attribution is more accurate
- Set realistic goals

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and Ellen Andrews, PhD
Executive Director

Methodology Representatives of Accountable Care Organizations serving Connecticut residents were surveyed online between November 24, 2015 and January 13, 2015. Full responses were received from nine separate ACOs and one partial response from another. Respondents included multi-state and Connecticut-specific ACOs as well as large hospital systems, independent hospital, and physician-led ACOs. The invitation list was collected from Medicare, the Office of State Comptroller/State Employee Plan, and news reports.