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findings brief

key findings

- ACOs at provider workforce extremes—few primary care providers or many specialists—performed worse on measures of preventive care quality relative to those with more PCPs and fewer specialists.
- Upfront investment in ACO formation is associated with higher performance in preventive care quality.
- ACOs with a higher proportion of minority beneficiaries performed worse on disease prevention measures than did ACOs with a lower proportion of minority beneficiaries.
- ACOs facing barriers to quality performance may benefit from organizational characteristics such as electronic health record capabilities and hospital inclusion in the ACO

Certain Organizational Characteristics Affect ACO Preventive Care Quality Performance

Overview

During the past decade, preventive care in medicine has become a national priority. Coverage of preventive services has gained traction, exemplified by the Affordable Care Act's (ACA) elimination of cost-sharing for all preventive services; however, provider performance and quality of care vary widely. Accountable Care Organizations (ACO) emerged as a novel payment model to create a coordinated health system whereby providers contract together to take collective responsibility for managing the cost and quality of care for a population of patients.[1] Preventive care is critical to ACOs' success. Evaluating ACOs' strategic choices in terms of their organizational structure and early performance provides an avenue to a better understanding of the factors behind preventive care quality.

In a HCFO-funded study, Valerie Lewis, Ph.D., of Dartmouth College and colleagues conducted a cross-sectional study examining Medicare Shared Savings Program (MSSP) and Pioneer ACO Program participants and the association between preventive care quality performance and ACO characteristics. Their goal was to inform strategies for preventive care quality management.[2]

Sample and Methods

To identify the underlying relationship between performance in preventive care quality and ACO organizational characteristics, the researchers drew on two sources of data: (1) quality performance and limited descriptive data for Medicare ACOs publicly available from the Centers for Medicare & Medicaid Services (CMS) and (2) data from the National Survey of ACOs (NSACO) describing ACO composition, characteristics, and capabilities.

CMS publishes quality performance data for all Medicare ACOs on 33 measures, 8 of which are related to preventive care. The researchers conducted exploratory factor analysis on the 8 preventive care quality measures for Medicare ACOs in order to describe patterns of preventive care quality performance. The 8 measures lent themselves to consolidation into a smaller set of composite measures covering all Medicare ACOs that reported on all 8 preventive care measures (n = 246) and the subset of NSACO respondents (n = 177).

Robert Wood Johnson Foundation

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The researchers then used linear regression to examine associations between composite measures of quality performance and ACO characteristics and created multivariate models for each underlying factor. They built models around five conceptual groups, established a priori: (1) beneficiary composition, (2) provider composition, (3) general characteristics, (4) electronic health record (EHR) capabilities, and (5) quality management capabilities and looked for correlations between variables.

Results

Provider and Beneficiary Composition

The researchers found that preventive care quality may be reduced to two subgroups of related measures—disease prevention and wellness screening. They found that ACOs at provider workforce extremes—few primary care providers (PCP) or many specialists—performed worse on preventive care quality measures relative to those with more PCPs and fewer specialists. They also found that a higher ratio of ACO beneficiaries to PCPs was associated with better performance on both disease prevention and wellness screening. Further, the researchers found that ACOs with a higher proportion of minority beneficiaries performed worse on disease prevention measures than did ACOs with a lower proportion of minority beneficiaries.

Organizational Characteristics

The researchers found several organizational characteristics associated with performance in preventive care quality. For both disease prevention and wellness screening, participation in the Medicare Advanced Payment Model, in which rural MSSPs were awarded upfront investment to assist with ACO formation, was associated with better performance on both disease prevention and wellness screening measures. In addition, inclusion of a hospital in an ACO, extensive EHR capabilities, and experience with quality reporting (e.g., pay-for-performance or public reporting) were associated with better performance on disease prevention measures.

Limitations

The researchers acknowledge several important methodological limitations in their study. While the researchers drew on quality data from the full population of Medicare ACOs, the main limitation is small sample size primarily because of the relatively small number of organizations that formed Medicare ACOs and nonresponse to survey questions of interest. In addition, the analyses represent a cross-sectional perspective of the first year of operation by organizations with varying degrees of pre-existing cohesiveness and different development timelines. However, the study data represent a true and largely complete view of the early state of Medicare ACO development.

Discussion and Policy Implications

Charged with managing the cost and quality of care for a population of patients, ACOs are incentivized to deliver high-quality preventive care. While only in their infancy, early evidence suggests that ACOs are beginning to improve quality and reduce costs. In this study, the researchers found that performance in preventive care quality may be reduced to two subgroups of related measures—disease prevention and wellness screening—that are related but that may vary by (1) eligibility determination, (2) service administration, (3) documentation, and (4) data management. The study's findings indicate that preventive care quality is linked to several ACO characteristics, particularly the composition of providers in terms of the ratio between specialists and PCPs and upfront financing for ACO formation through the Medicare Advanced Payment Model.

The researchers highlight that ACOs can improve the quality of preventive care by making certain that all patients are connected to PCPs, especially providers that serve many beneficiaries, helping ensure that patients do not miss preventive services. Specifically, disease prevention measures, such as vaccine and cancer screenings, are more dependent on organization structure than are annual wellness screenings, likely due to the complexity associated with eligibility determination and service administration. Finally, evidence has shown the persistence of racial disparities in quality among Medicare ACOs,[3] and the researchers found that ACOs with a higher proportion of minority beneficiaries were associated with worse performance on disease prevention measures than were ACOs with a lower proportion of minority beneficiaries. While ACOs with fewer resources or more minority beneficiaries may face added barriers to performance, some of the organizational characteristics associated with improved performance, such as EHR capabilities and hospital inclusion in an ACO, represent choices made during ACO formation.

Conclusion

By eliminating cost-sharing for preventive care services, the ACA made prevention a priority that can be easily assessed through process measures. In their first year of operation, ACOs— and their varying organizational characteristics—provide an opportunity for better understanding the drivers of preventive care quality performance. The researchers found that performance in preventive care quality is associated with provider composition in terms of the ratio of PCPs and specialists. They also found that performance benefits from upfront investment in ACO formation.

For More Information

Contact Valerie Lewis, Ph.D., at valerie.a.lewis@dartmouth.edu.

About the Author

Caroline Ticse, B.A., is a research assistant at AcademyHealth with the Changes in Health Care Financing and Organization (HCFO) initiative. She may be reached at 202-292-6795 or at caroline.ticse@academyhealth.org.

Endnotes

1. Fisher ES, Saiger DO, Bynum JP et al. "Creating Accountable Care Organizations: The Extended Hospital Medical Staff." Health Affairs (Millwood), 2007;26:w44-w57.

2. For complete findings, see Albright BB, Lewis VA, Ross JS, and Colla CH. "Preventive Care Quality of Medicare Accountable Care Organizations: Associations of Organizational Characteristics with Performance." Medical Care, 2016;54(3):326-335.

3. Anderson RE, Ayania JZ, Zaslavsky AM et al. "Quality of Care and Racial Disparities in Medicare among Potential ACOs." Journal of General Internal Medicine, 2014;29:1296-1304.