Comparative Health System Performance Initiative

Agency for Healthcare Research and Quality

Provider-Offered Medicare Advantage Plans Among U.S. Health Systems, 2016

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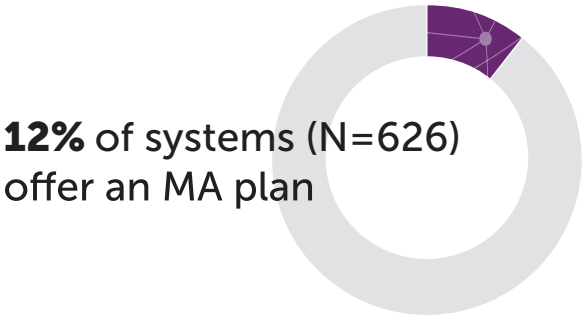
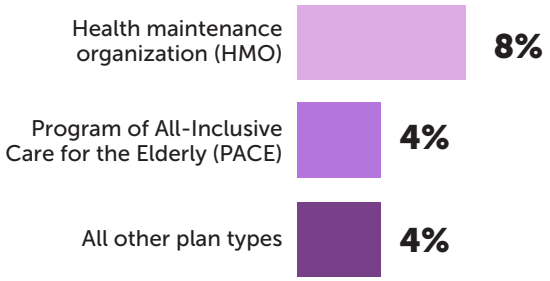
Systems offering a Medicare Advantage (MA) plan

About 12% of systems offer an MA plan. HMO plans are most common, followed by PACE.



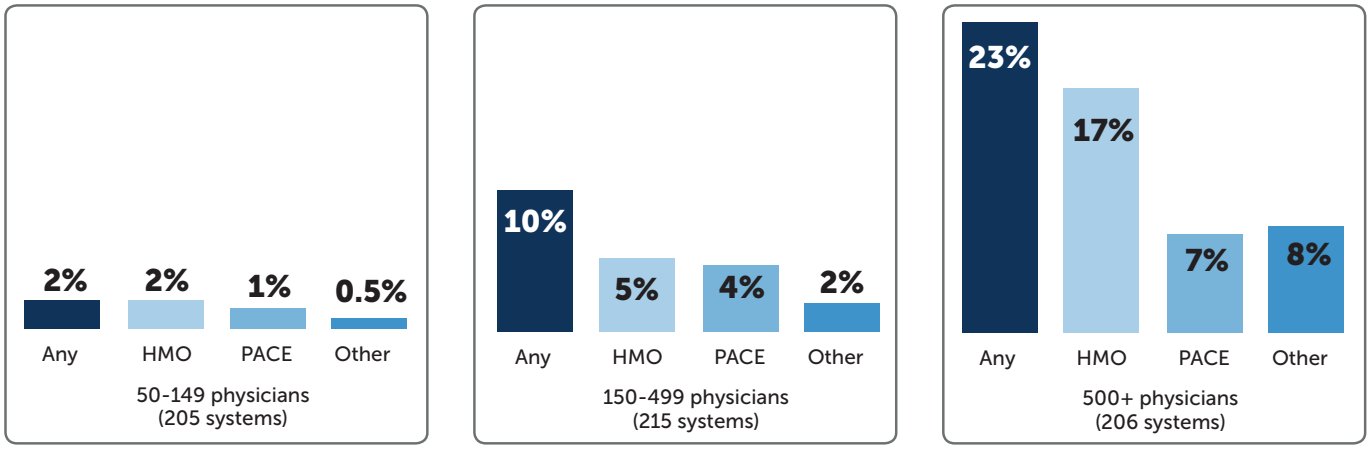


Percentage of systems offering an MA plan, by plan type

Note: Systems may offer more than one type of MA plan.

Variation in systems offering an MA plan, by number of physicians in the system

Systems with more physicians are more likely to offer an MA plan. Across systems of all sizes, HMO plans are more common than PACE or other plans.



Percentage of systems offering an MA plan, overall and by plan type

*This analysis is based on AHRQ's Compendium of U.S. Health Systems, 2016. Developed as part of the Comparative Health System Performance (CHSP) Initiative, the Compendium is a resource for data and research on health systems. For the purposes of the Compendium, **health systems include at least one hospital and at least one group of physicians that provide comprehensive care (including primary and specialty care) and are connected with each other through common ownership or joint management.** The CHSP Initiative includes a robust set of research activities that draw on several other definitions of health systems. For more information about these definitions, visit: https://www.ahrq.gov/chsp/chsp-reports/resources-for-understanding-health-systems/defining-health-systems.html.

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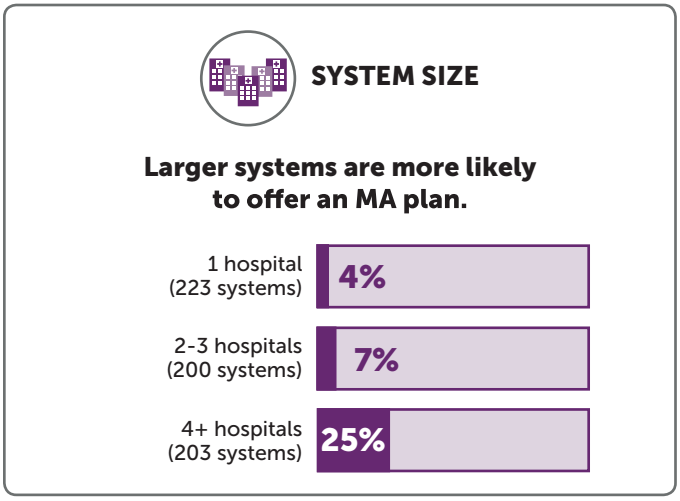
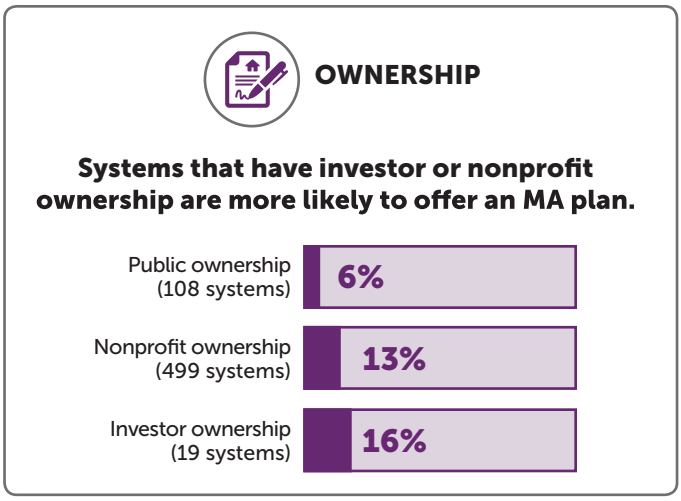
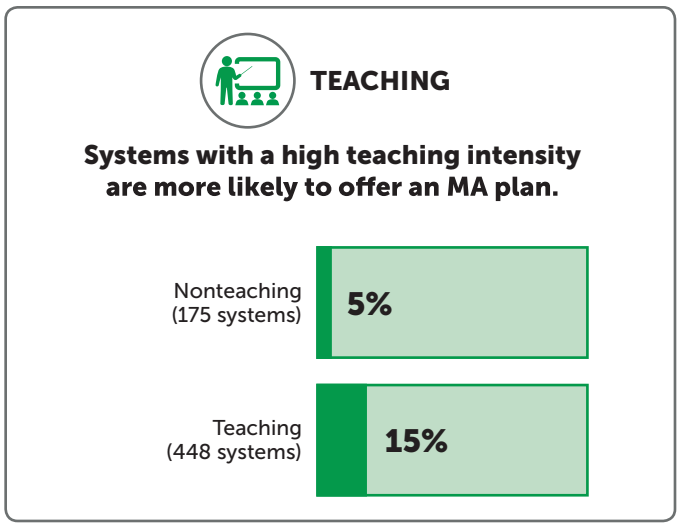
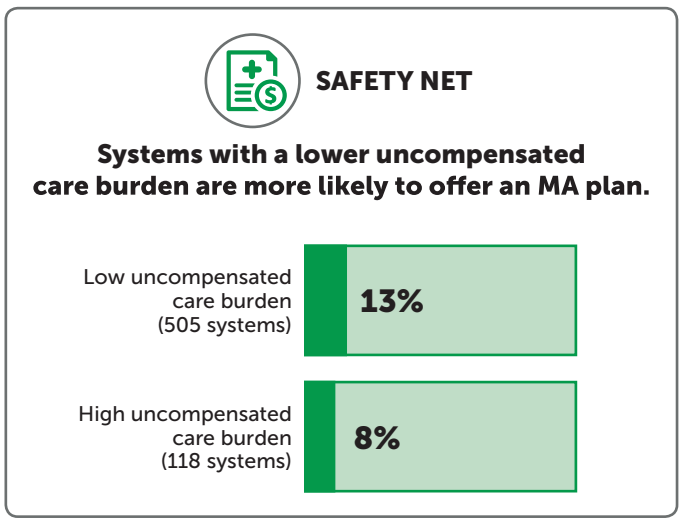
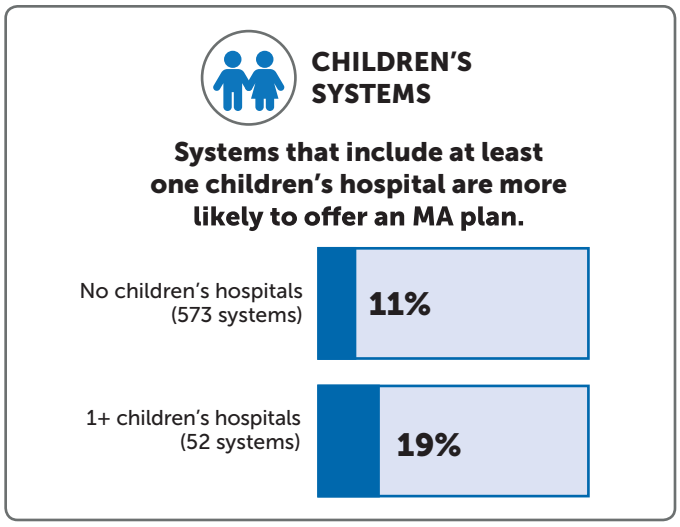
Percentage of systems offering an MA plan, by system type

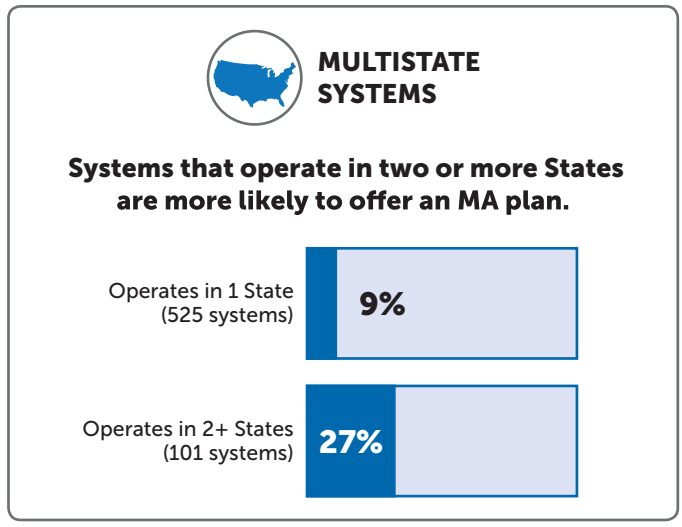












The shaded portions of the bars represent percentages of systems that offer an MA plan. There are 626 systems in the Compendium of U.S. Health Systems, 2016. Three systems are missing results for the safety net and teaching system variables; one system is missing information for the children's system variable. These systems are excluded from relevant calculations. The relationships between system type and offering an MA plan do not adjust for system size or any other system characteristics. For example, large systems and multistate systems might be more likely to offer an MA plan because they have more hospitals that could offer an MA plan.

Percentage of systems offering an MA plan, by system type

System type	Number of systems offering an MA plan	Total number of systems	Percentage of systems
System size			
1 hospital	10	223	4%
2-3 hospitals	13	200	7%
4+ hospitals	51	203	25%
Ownership			
Public ownership	7	108	6%
Nonprofit ownership	64	499	13%
Investor ownership	3	19	16%
Teaching			
Nonteaching	8	175	5%
Teaching	66	448	15%
Minor teaching	47	286	16%
Major teaching	19	162	12%
Safety net			
Low uncompensated care burden	65	505	13%
High uncompensated care burden	9	118	8%
Without a high DSH patient percentage hospital	36	430	8%
With a high DSH patient percentage hospital	38	193	20%
Children's systems			
No children's hospitals	64	573	11%
1+ children's hospitals	10	52	19%
At least one children's hospital	10	21	48%
Predominately children's system	0	31	0%
Multistate systems			
Operates in 1 State	47	525	9%
Operates in 2+ States	27	101	27%
Operates in 2 States	11	58	19%
Operates in 3+ States	16	43	37%

DSH = disproportionate share hospital.

Notes: Three systems are missing results for the safety net and teaching system variables; one system is missing information for the children's system variable. The results are missing for these systems because all of the hospitals in the systems have missing values. These systems are excluded from relevant calculations.

METHODS

This analysis is based on the Compendium of U.S. Health Systems, 2016, which presents a list of U.S. health systems. To operationalize the definition of health systems described above, we identified systems using the following data sources:

- American Hospital Association (AHA) annual survey of hospitals data, 2015
- SK&A integrated health system database, 2016
- QuintilesIMS™ Healthcare Organization Services (OneKey Organizations [HCOS]), 2016

In addition to being identified in one of the data sources, systems had to meet these three criteria to be included in the final list: have at least one non-Federal general acute care hospital; have 50 or more total physicians; and have 10 or more primary care physicians.

We used the publicly available January 2016 Medicare Advantage (MA) Plan Directory from the Centers for Medicare & Medicaid Services (CMS) website to construct the measure of whether the system offered an MA plan.

To construct a variable indicating whether a system offered an MA plan, we began by identifying MA plans owned by a provider organization, such as a health system, hospital, or medical group. Then, we matched the MA Plan Directory to the Compendium's consolidated list of U.S. health systems. In doing so, we identified systems that offered an MA plan, the MA contracts associated with each system, and the plan and organization type for each MA contract.

In our work, we used all plans in the MA Plan Directory. MA plan types reported on page 1 are defined as follows:

- HMO: Local coordinated care organization offering an HMO or HMO Point of Service plan.
- PACE: National PACE organization offering a national PACE plan.
- All other plan types: Organization offering one of the following: preferred provider organization plan, section 1876 cost contract, section 1833 health care prepayment plan, demonstration plan, regional coordinated care plan, private fee-for-service plan, or medical savings account plan.

Health system types were calculated using data from the Centers for Medicare & Medicaid Services' Healthcare Cost Report Information System (HCRIS) and reflect all U.S. non-Federal general acute care hospitals. Health system types are defined as follows.

Ownership: Systems are categorized as primarily public, nonprofit, or investor owned based on the majority of non-Federal general acute care hospital beds in the system. We compared HCRIS data on investor-owned status with AHA data on investor-owned status. For cases in which the two data sources disagreed, we considered the system to be not investor owned. For systems with missing HCRIS ownership data, we filled in information from the AHA annual survey.

Teaching: Systems are categorized as nonteaching, minor teaching, or major teaching based on their resident-to-bed ratio across systems' non-Federal general acute care hospitals. Systems with no residents are considered nonteaching systems, systems with a resident-to-bed ratio greater than zero but less than 0.25 are considered minor teaching, and systems with a resident-to-bed ratio greater than or equal to 0.25 are considered major teaching systems.

Safety net systems: Systems are categorized as serving the safety net using two measures: (1) systems with a high systemwide uncompensated care burden calculated as the ratio of total uncompensated care to total operating expense across systems' non-Federal general acute care hospitals and (2) systems with at least one hospital with a high DSH patient percentage. In both cases, "high" is defined as the top quintile among U.S. health systems.

Children's systems: Systems are categorized as having no children's hospitals, having a children's hospital but not predominately serving children, and predominantly delivering care at children's hospitals. Systems are considered to predominately serve children if a majority of non-Federal general acute care hospital beds in the system are in children's hospitals.

CAVEATS AND LIMITATIONS

Because the list largely relies on the definitions of systems in the three data sources and systems' members specified in the data, systems may be included in this analysis that may not precisely align with the working definition. Similarly, we approximate delivery of comprehensive care using the hospital and physician type and count information, which may lead to inclusion of systems that do not provide comprehensive care in the manner intended by the definition. Further, we rely on hospital reporting in the HCRIS data for the system types and attributes, for which information about some hospitals is missing.

It can be difficult to determine the exact nature of the relationships between an MA parent organization or MA plan and a health system. In particular, it is challenging to determine precisely whether a health system has an equity interest in the MA plan. If inaccuracies exist in the identification of systems offering an MA plan, the most likely reason is that we could not confirm that a health system should be matched to a particular CMS record and erroneously identified the system as not having an MA plan. Thus, the variable that indicates whether a system offers an MA plan could undercount systems offering plans.

For more information about the methodology to construct and analyze the national list of health systems and a more detailed summary of caveats and limitations, visit: https://www.ahrq.gov/chsp/data-resources/compendium/technical-documentation.html.

About the Comparative Health System Performance Initiative

The Agency for Healthcare Research and Quality (AHRQ) created the Comparative Health System Performance (CHSP) Initiative to study the characteristics of high-performing health systems and to understand how health systems use evidence-based practices, including patient-centered outcomes research (PCOR). The effective adoption and use of PCOR evidence holds promise as a way to improve clinical outcomes and reduce costs. However, little is known about the characteristics of high-performing health systems and the role of PCOR evidence in health system performance.

The CHSP Initiative aims to address these knowledge gaps and accelerate the diffusion of PCOR evidence among health systems. Specifically, the objectives of the CHSP Initiative are to:

- Classify and characterize types of health systems and compare their performance on clinical and cost outcomes.
- Identify characteristics of high-performing health systems.
- Evaluate the role of PCOR in health system performance.
- Promote the diffusion of PCOR evidence across health systems nationally.

The Compendium of U.S. Health Systems, which presents a list of health systems in the United States, is a step toward classifying and characterizing health systems and is a data resource to help advance research on health systems. The Compendium is intended to be a resource for researchers, policymakers, health system leaders, and others who seek to study health systems and will be updated over the course of the 5-year initiative to reflect the evolving health care delivery environment.

For more information about the CHSP initiative, visit https://www.ahrq.gov/chsp/index.html.

Suggested Citation

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