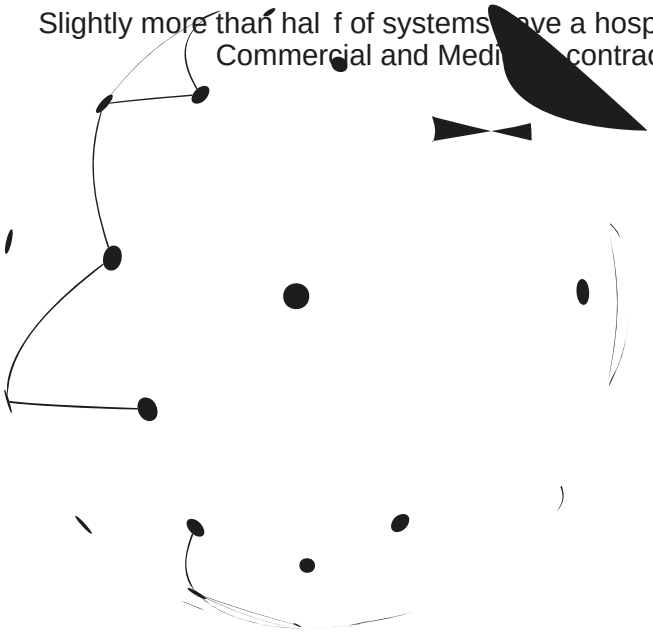
Medicare

1% 9% 4%

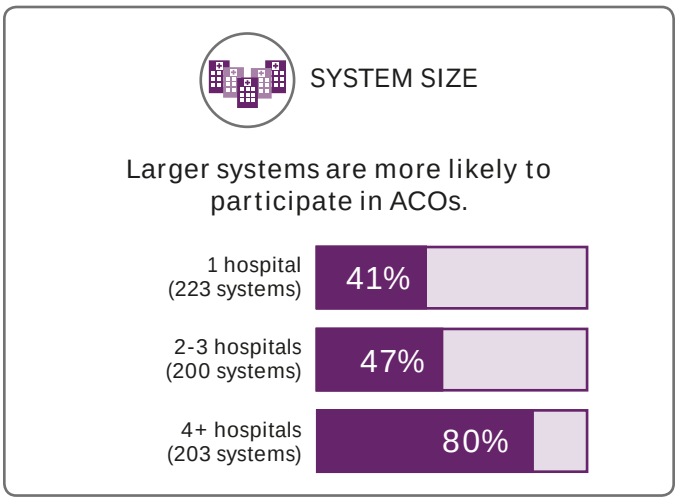
Percentage of hospitals participating in ACO contracts, by type of contract

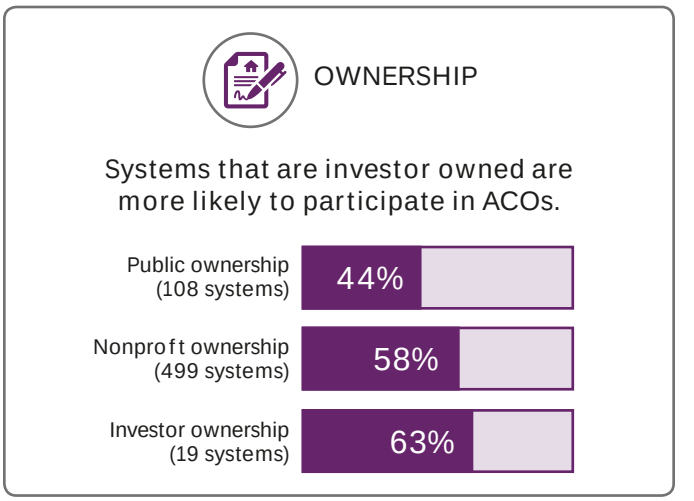
System participation in AC O contracts

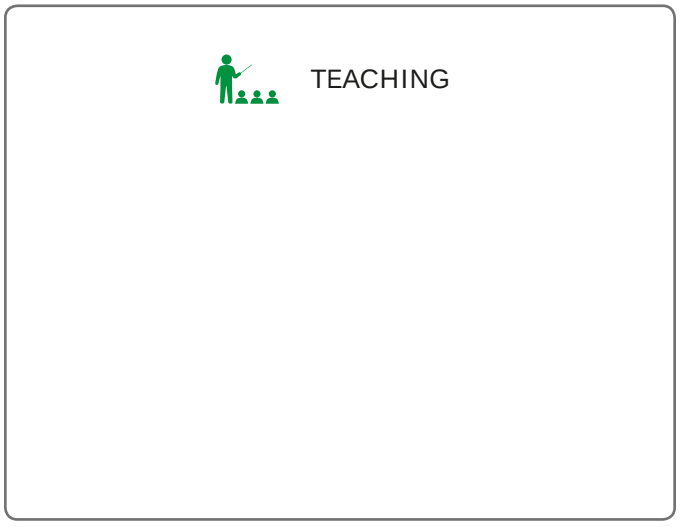
Slightly more than hal f of systems have a hospital that participates in an ACO contract. Commercial and Medi contracts are the most common.



Percentage of systems participating in ACOs, by system type







Number and percentage of systems participating in ACOs, by system type

System type	Number of systems in ACO contracts	Total number of systems	Percentage of systems
System size			
1 hospital	92	223	41%
2-3 hospitals	94	200	47%
4+ hospitals	162	203	80%
t CSpanSpanMCID 12DC3111 1 Tf70 0 m2600			

METHODS

is analysis is based on: (1) the Compendium of U.S. Health Systems, 2016, which presents a list of U.S. health systems and (2) the Hospital Linkage le, which provides information on hospitals and links hospitals to systems. To operationalize the de nition of health systems described above, we identi ed 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 identi ed in one of the data sources, systems had to meet these three criteria to be included in the nal 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 data from the Leavitt Partners 2016 Torch Insight tool to construct measures of system participation in ACOs. We considered a system to participate in an ACO contract if any of their non-Federal general acute care hospitals participated in the relevant ACO contract type (Medicare, Medicaid or commercial).

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

- Ownership: Systems are categorized as primarily public, nonpro t, 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 to 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 lled 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 de ned 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 de nitions of systems in the three data sources and systems' members speci ed in the data, systems may be included in this analysis that may not precisely align with the working de nition. 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 de nition. Further, we rely on hospital reporting in the HCRIS data for the system types and attributes, for which information about some hospitals is missing.

Our approach to measuring system participation in ACOs relied on indirect measurement of system participation via systems' hospital participation. However, ACOs can have participants at other levels. erefore, we are not capturing all aspects of systems' participation in these models. For example, if a system has a physician group participating in an ACO, but none of their hospitals participated in the contract, the system's participation would not be captured.

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/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.