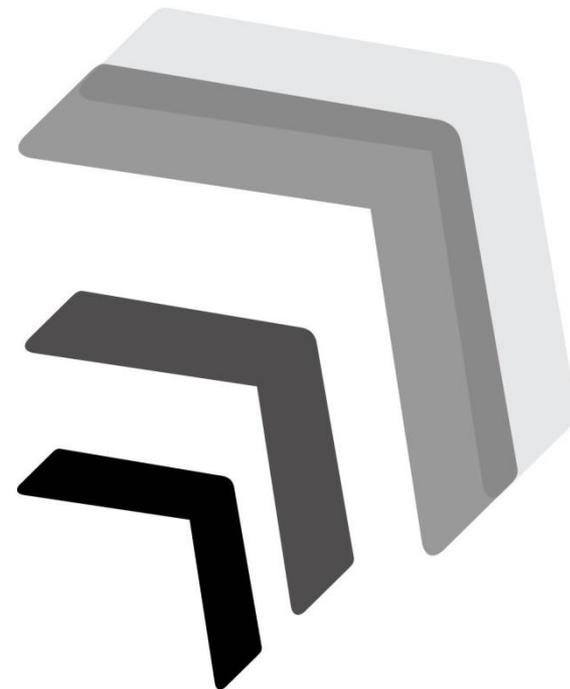


# What are ACOs and how are they performing?



# What is an accountable care organisation (ACO)?

- › ACOs involve groups of providers taking responsibility for all care for a given population within a capitated budget, under a contractual relationship with a private or public insurer
- › ACOs were created under the Affordable Care Act in the US with the aim of improving quality while reducing growth in healthcare costs
- › Development of ACOs should be seen in the context of managed care in the US in 80s and 90s, where groups of providers were responsible for care under risk-based capitated contracts
- › These efforts were largely unsuccessful for a variety of reasons, including because many providers failed to develop capabilities required to manage risk, align incentives and—most importantly—develop new models of care for people with complex needs
- › ‘Accountable health communities’ are now being developed too

# What are the different types of ACOs?

- › Broadly speaking there are three types of ACOs (see Shortell et al 2014):
  - Larger, integrated systems that offer a broad range of services
  - Smaller, physician led practices based in primary care
  - Moderately sized, joint hospital and physician groups that offer a relatively broad range of services
- › While this taxonomy is a useful way of thinking about different types of ACOs in theory, in practice there are a **wide** variety of organisational and governance models being developed
- › ACOs normally include physician practices and at least one hospital, but they may also include other providers like nursing homes, home health agencies, community groups and a range of others
- › Worth recognising that most ACOs are not integrated organisations

# How are ACOs performing?

- › In 2014 there were more than 750 ACOs serving a collective population of around 20 million people (Muhlestein 2014)
- › Early evidence about their impact on cost and quality is mixed:
  - Results for the second year of the Medicare Pioneer and Shared Savings ACOs report savings of around \$372m (£250m) (savings of less than 1%)
  - Results show mean improvements in quality of care and patient experience
  - Most of the savings were made by a small number of high performing ACOs
  - For some ACOs it has proved difficult to make early savings and some have dropped out of the programme
  - Best results seen in private payer BCBS's AQC contract after 4 years (around 7% savings). More on this model later.

# Some key points

- › ACOs come in a variety of different forms—and they aren't simply integrated providers
- › Early evidence suggests that ACOs are doing OK, but it's early days
- › The best results can be found in places that have been doing this stuff for a long time—well before they started being called ACOs
- › Lessons can be learnt from some of the technical components being developed both on the payer and provider side—including capitated budgets, aligning incentives, measuring quality, etc
- › But the relational elements are far more important than the technical detail. The role of clinical leadership is vital
- › We need to recognise the advantages we have in the NHS over these systems in the US because of the structure of our system

# What does this mean in practice?



# Example ACO: MACIPA

# MACIPA

## Basic structure

- › Mount Auburn Independent Practice Association (MACIPA) is made up of 514 doctors—1/3 primary care and 2/3 specialists
- › MACIPA works in partnership with Mount Auburn hospital (c.200 beds) to manage care under capitated contracts (c40,000 people under risk based capitated contracts; c10,000 people under FFS).
- › The IPA and the hospital are separate legal entities—they haven't merged—but make decisions jointly: 'two organisations in it together'
- › Contracts with payers are negotiated jointly and the IPA and the hospital agree how risks and rewards will be shared *ex ante*
- › While part of this relationship is formalised contractually, in practice the arrangement is fundamentally governed by strong relationships and the commitment of leaders to work together

# MACIPA

## Model of care

- › Primary care physicians are clustered into geographical pods (of around 8), working closely with specialists and other professionals
- › Social workers provide support for patients in the community, as well as linking with other services like mental health and housing
- › Health coaches work with patients with chronic conditions and complex needs (population is segmented by risk not disease)
- › For the top 0.5% of patients with the highest need, MACIPA contracts with specialist nursing teams to provide care at home
- › IPA pharmacy programme helps physicians choose appropriate drugs, improve medicines compliance, switch from branded to generic drugs and to reduce unnecessary polypharmacy
- › Hospital teams work closely with out of hospital teams to coordinate care across settings

# MACIPA

## Capabilities required

- › MACIPA have developed significant capabilities to help them manage contract risk and quality within their network. This includes:
  - sophisticated data warehouse to analyse claims and clinical data
  - a large quality team to turn this data into actionable information at a practice and clinician level
  - contracts and finance team to work with insurers and monitor activity vs their budget (note: FFS billing vs virtual budget)
  - Investment in integrated EHR in collaboration with the hospital
- › MACIPA provides each practice and physician with detailed analysis of utilisation patterns over time and against their peers to reduce unnecessary care and ensure activity stays within budget
- › Surplus yield of all contracts after running costs goes to: (a) reinvestment in new care models, then (b) split between IPA docs

# **Example ACO-style contract:** Alternative quality contract (AQC)

# BCBSMA and AQC

## Background and key components

Blue Cross Blue Shield MA is a commercial insurer who has developed the 'alternative quality contract' (AQC) for its providers. This pre-dates the Pioneer and Shared Savings ACO Programmes

### Global budget

- Population based budget covering all care
- Budget is adjusted based on health status and historic claims
- Risk/reward is shared between payer and provider
- Baseline spending is set for year 1 with the aim of reducing spending growth vs trend
- Sometimes payments are front-loaded to allow investment in new care models
- Providers still bill fee-for-service but this is tracked against the virtual capitated budget (so, annual retrospective settlement)
- Capitated budget creates clear efficiency incentive

# BCBSMA and AQC

## Key components

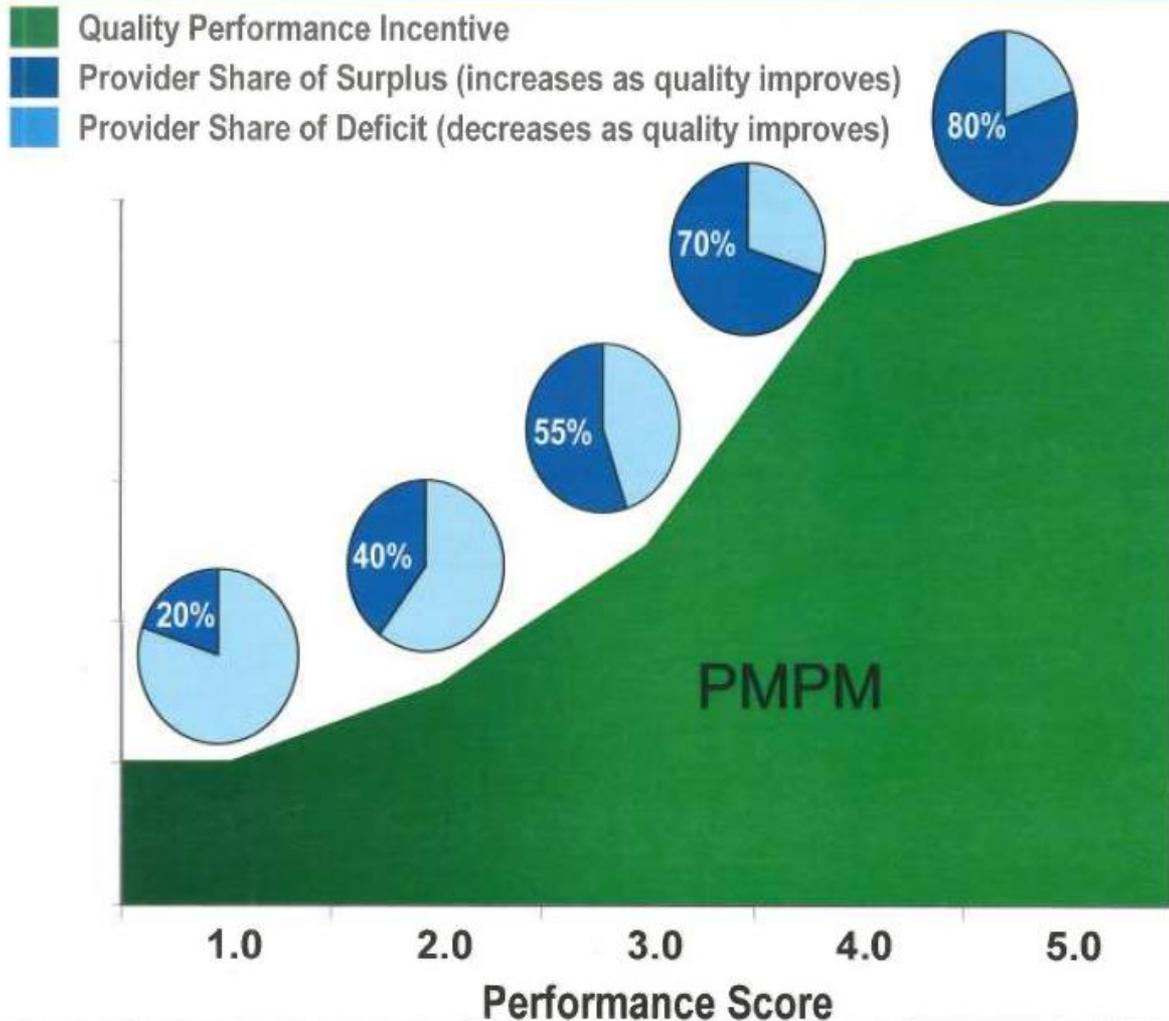
### Quality incentives

- c.60 measures split 50:50 between primary care and hospital
- Measures relate to process, outcome and patient experience. Outcomes measures are triple-weighted
- Nearly all measures based on what was already reported (eg through HEDIS) and a small number of new measures
- Quality measures are absolute, not relative
- Providers get upside payments worth up to 5% of total budget based on performance against quality measures (ie 100+5%)
- Share of surplus/deficit vs budget is also dependant on quality scores (see next slide), linking quality and efficiency incentives
- Quality measures will be developed and improved over time

### Long term contact

- 5 year contract and long term partnership

# As quality improves, provider share of surplus increases/deficit decreases



## Linking Quality and Efficiency

The 2011 AQC ensures that providers have a strong incentive to focus on both objectives.

## PMPM Quality Dollars

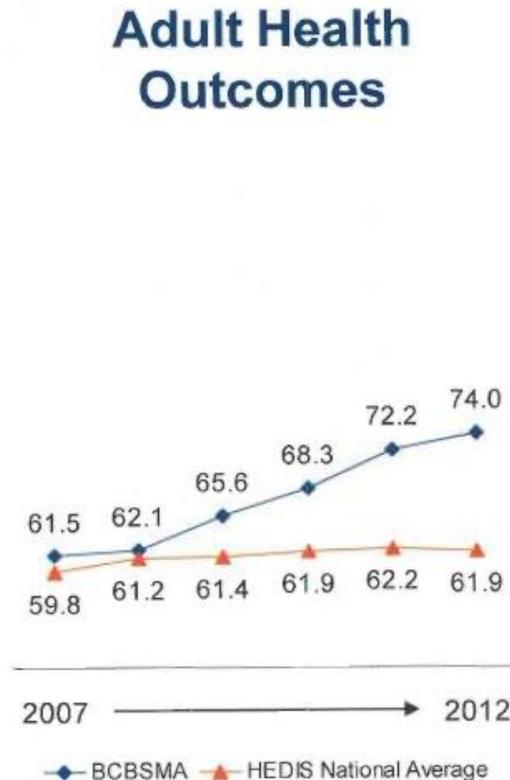
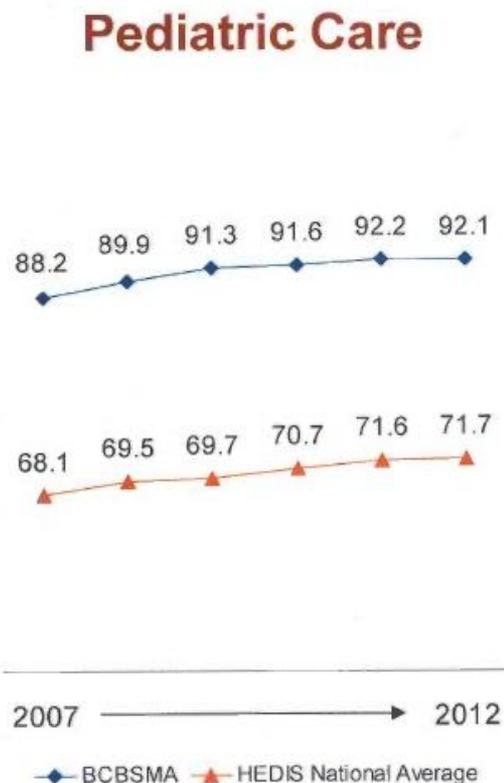
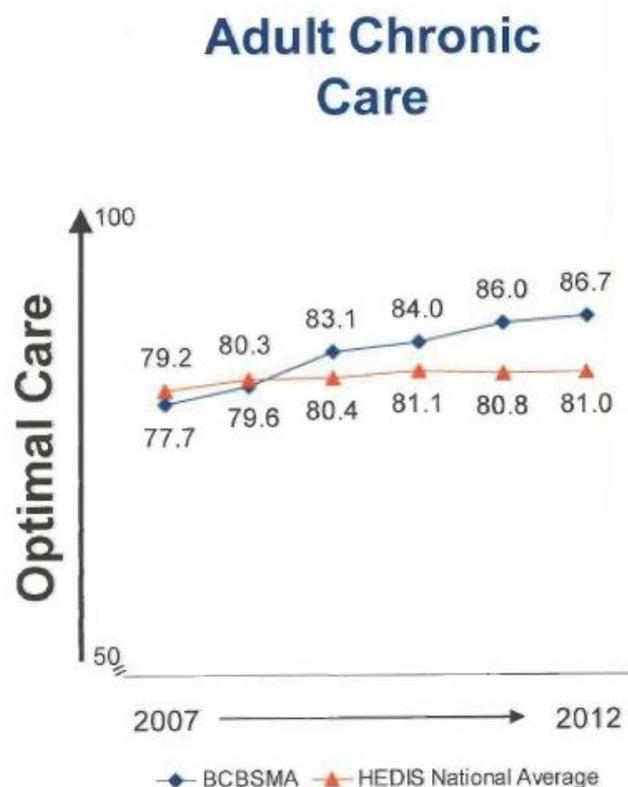
The 2011 AQC also allows groups to earn PMPM quality dollars regardless of their budget surplus or deficit. High quality groups earn more PMPM quality dollars.

# BCBSMA and AQC

## Impact

- › Study compared spending and quality among people whose provider entered the AQC from 2009 through 2012 vs control group
- › Cost growth was reduced: spending on medical claims grew at around \$62 per quarter less than the control group
- › This is equivalent to around 6.8% savings
- › Most savings were made in outpatient settings and in procedures, imaging and tests
- › Quality improved: performance against measures of chronic disease management improved from 79.6% to 84.5%, compared with 79.8% to 80.8% in control group
- › Improvements vs trend in other areas too—see following slide

# Quality scores vs HEDIS average

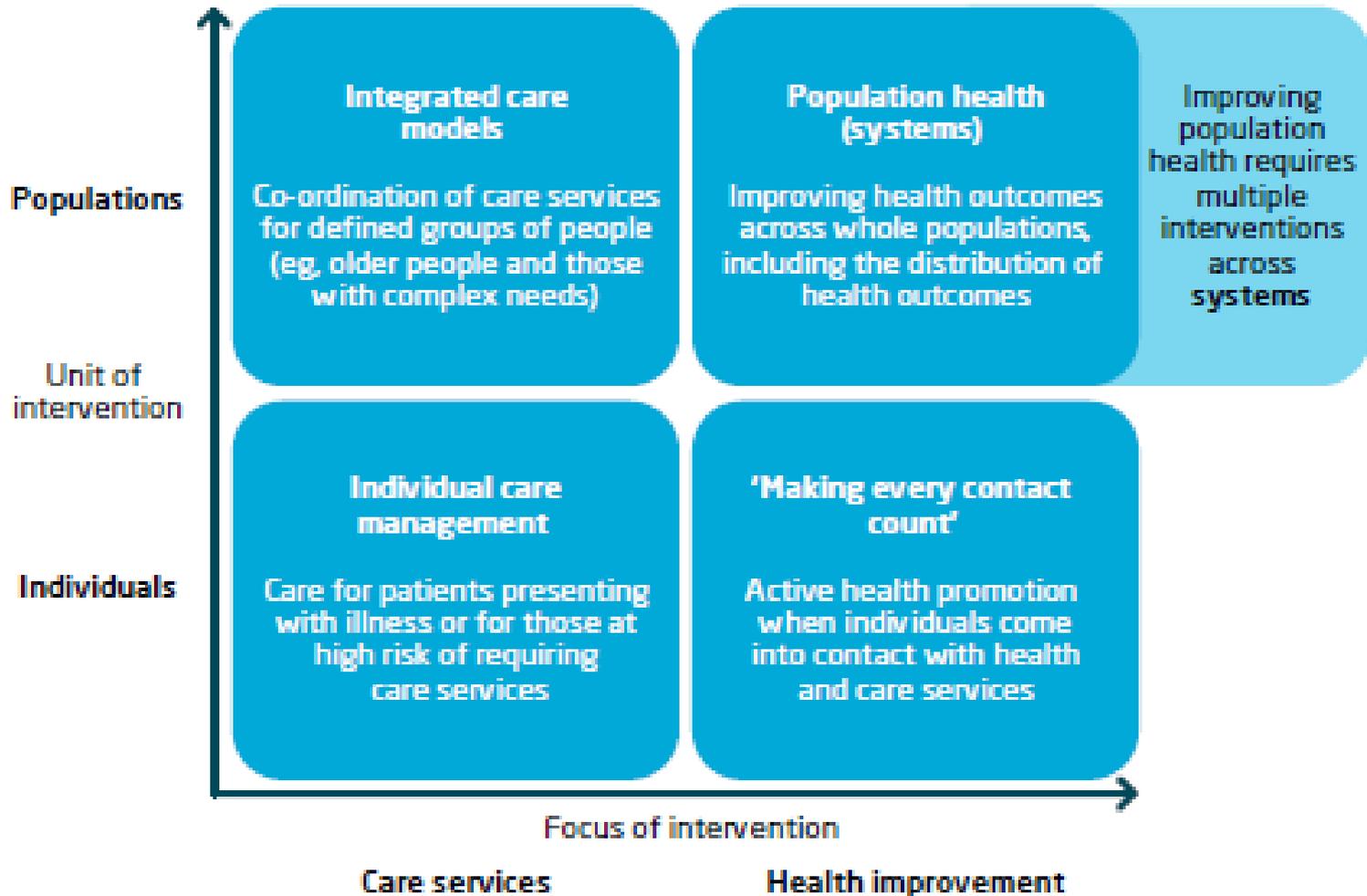


# What does 'population health' mean?



# Defining population health

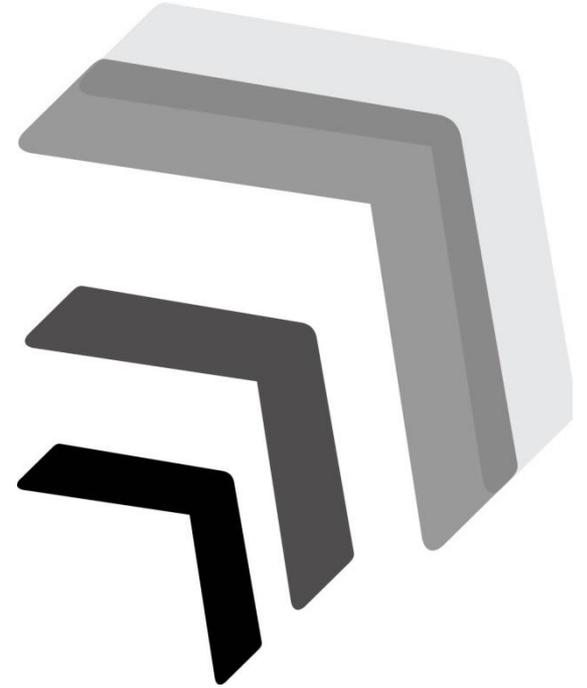
- › Broadly defined as 'the health outcomes of a group of individuals, including the distribution of such outcomes within the group' (Kindig and Stoddardt 2003)
- › While access to health services plays important part in determining population health, this isn't as important as our lifestyles, local environment and the wider determinants of health
- › This means that accountability for population health is spread widely across communities, not concentrated within traditional health and care services or the boundaries of single organisations
- › Improving population health requires collective action across organisations and communities, working together across systems



# What's the relationship between ACOs and population health?

- › Improving population health is broadly seen as the job of ACOs in the US, and the language of population health is commonly used
- › But for many ACOs, efforts to improve population health have largely focused on 'attributed' patients rather than all of the people living in their local community
- › They have also primarily focused on medical interventions rather than also working to address patients' non-medical needs
- › This kind of approach might be better referred to as 'population health management', and is not necessarily the kind of approach to be emulated in the NHS
- › 'Accountable health communities' are now being developed in the US which seek to address patients' social needs too

# What do we mean by place-based systems of care?



# Place-based systems of care

A way forward for the NHS  
in England

Authors

Chris Ham

Hugh Alderwick

November 2015



# The basic idea

- › Place-based systems of care involve organisations working together to improve health and care for a geographically-defined population, collectively managing common resources
- › The alternative is for NHS organisations to take a 'fortress mentality', fighting for their own survival. This is a rational response in the existing NHS environment
- › This risk of the fortress mentality is that organisations descend into a 'war of all against all', and the common pool of NHS resources is used unsustainably
- › The challenges facing health systems and society require collective action across systems and local communities
- › We set out some 'design principles' to support this kind of approach

# 1. Define the population group and the boundaries of the system

- › The starting point for place based systems of care is to define the population served and the system's boundaries
- › This will be easier in some cases (eg Isle of Wight) than others (eg in London)
- › Some providers are likely to be involved in overlapping systems (eg teaching hospitals), and some systems may exist within regional systems (eg Greater Manchester)
- › Whatever boundaries are chosen, place-based systems of care should focus on the whole of the local population, rather than only focusing on specific medical conditions

## 2. Identify the right partners and services

- › While place-based systems of care will have a strong NHS focus, they should also involve local authorities, third sector organisations and other community groups
- › The right partners and services will in part be determined by the objectives of the group—for example, improving population health and wellbeing requires a wide coalition
- › Our argument centres on providers taking the lead in establishing place based systems of care
- › Commissioners still have a role to play in creating the right incentives for systems to emerge, but this role will change

# 3. Develop a shared vision and objectives

- › Partners need to agree their shared vision and objectives, reflecting local challenges and the level of ambition
- › In most cases, the initial objective for NHS and partners in social care will be achieving financial and clinical sustainability and developing new models of care
- › Over time, the focus needs to shift towards the broader aim of improving population health and wellbeing
- › The system's objectives fundamentally need to be informed by the needs and wants of patients—but in most cases we don't meaningfully measure these preferences

## 4. Develop an appropriate governance structure

- › Organisations need to develop an appropriate governance structure to enable them to collaborate and provide a foundation for collective action
- › These governance arrangements must to be inclusive enough to ensure that those involved in delivering and receiving services are involved in decision-making
- › They must also be strong enough to coordinate the range of activities involved in meeting the group's objectives
- › Partners will need to cede some of their own sovereignty and agree how decisions will be made collectively

# 5. Identify the right leaders and develop a new form of system leadership

- › Ensuring that the right leaders at the appropriate level of seniority are involved in managing the system is essential
- › Much will depend on the strength of relationships between leaders and the extent of mutual trust and respect
- › A new form of system leadership must be developed based on negotiation and influence rather than direction—which in turn must be underpinned by clinical leadership
- › Leadership of this kind is often best developed through teams rather than individuals, involving a guiding coalition taking responsibility to lead system-wide change

## 6. Agree how conflicts will be resolved

- › Governance arrangements need to allow for the possibility of conflict and give direction on how it will be handled
- › Conflicts should be resolved locally, with an emphasis on informal mechanisms like mediation rather than legal action
- › Wherever possible, conflict should be seen as a healthy reflection of the state of collaborative working
- › At the same time, partners will need to be clear about the consequences for organisations who fail to play by the agreed rules of the system

# 7. Develop a sustainable financing model

- › Creating a sustainable financing model is not simple and requires commissioners and providers to work together. A new approach should be developed across three levels:
  - (1) Local partners agree the collective resources available for meeting the system's objectives. This is likely to mean health and social care commissioners pooling budgets
  - (2) Commissioners create a single, capitated budget covering all of the population's care, for providers to manage under a long term contract. Payments under the contract (eg prime or alliance contract) should be linked to outcomes
  - (3) Providers work together to agree how to they will allocate resources and share costs, risks and rewards

## 8. Create a dedicated team

- > A dedicated team should be created to support the work of the system and implement decisions taken by its leaders
- > Evidence from other sectors suggests that this is best done by a team able to focus solely on the work of the system, rather than by individuals simultaneously trying to managing ongoing operations of individual organisations
- > The dedicated team can't work independently of others; new ideas will only make a difference if they can actually be implemented in routine practice
- > People will be needed who have the ability to 'join the dots' between different parts of the system

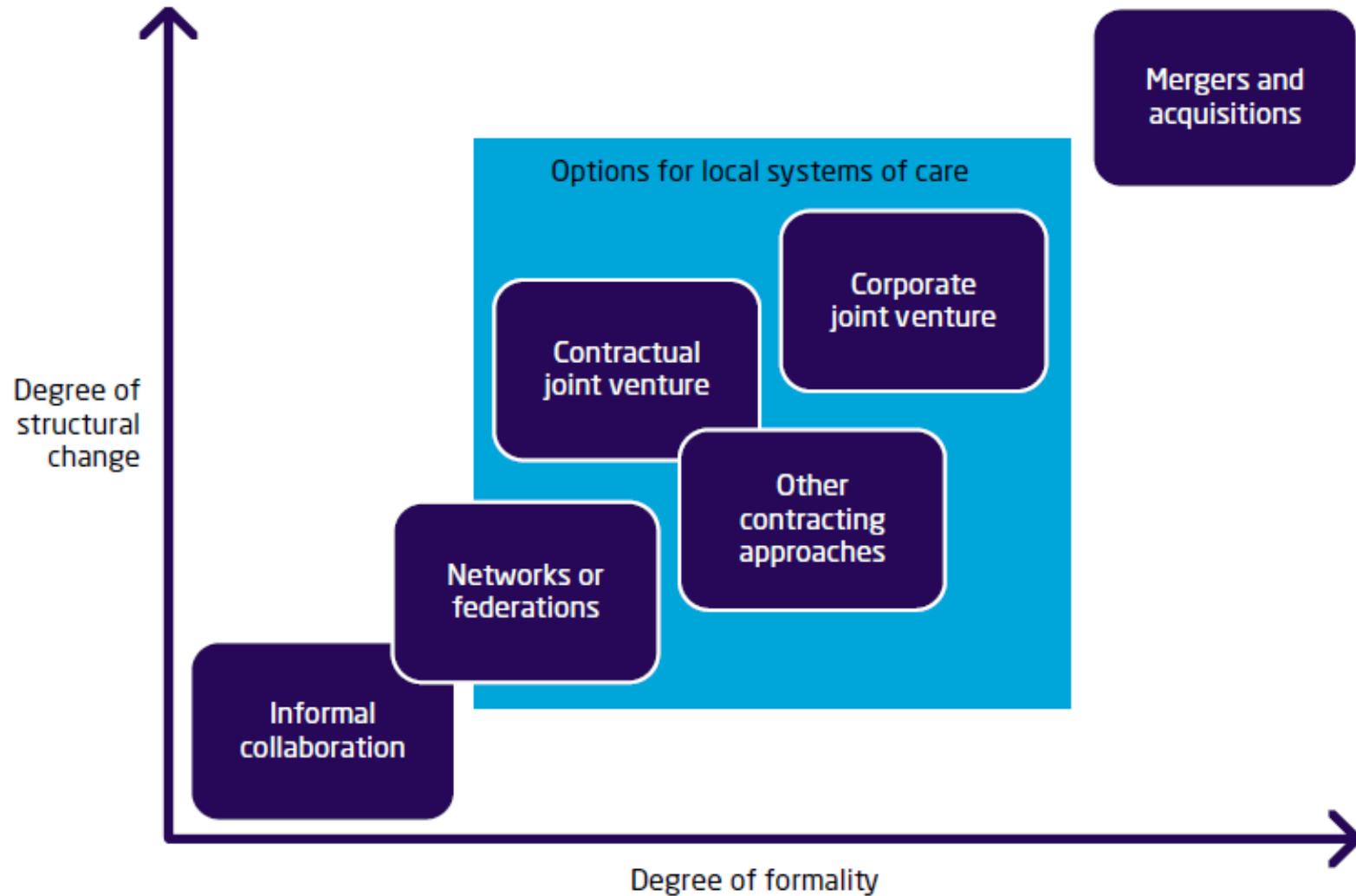
## 9. Develop systems within systems

- › In working to meet common objectives, different partnerships will emerge to address particular issues
- › For example, one group might work together to manage demand on urgent care services, another might focus on interventions to tackle obesity, while another might focus on end of life care—and some might work on all three
- › ‘Systems within systems’ will be needed to meet these different goals, drawing on skills and resources from across the community
- › The challenge lies in ensuring that all of these activities form part of a coherent, mutually reinforcing approach

# 10. Develop a single set of measures

- › The system needs a single set of measures to underpin its shared objectives and understand progress
- › This might mean agreeing a small set of metrics to assess overall system performance, as well as a larger set of metrics to support improvements in care
- › This should include measures to test whether the system is behaving in a way that aligns with its agreed values and behaviours (eg collaboRATE and integRATE)
- › Experience of high performing health systems illustrates the importance of clarity about the system's goals and systematic measurement of progress against them

Figure 3 A high-level framework for organisational collaboration



## What does our proposed approach mean for commissioning in the NHS?

- Commissioners taking a strategic role, defining outcomes and measuring the performance of the system as a whole.
- Commissioners in many parts of England working together across larger geographies than they do today.
- Health and social care commissioners pooling budgets and working together to commission services jointly.
- Commissioners developing capitated budgets covering the whole of a population's care, for local providers to collectively manage.
- Commissioners setting clear outcomes expected for providers to deliver using the resources available.
- Commissioners negotiating longer-term contracts with providers in order to reduce transaction costs.
- Commissioners doing less detailed contract negotiation and performance management of multiple providers.
- The existing boundary between commissioning and provision becoming increasingly blurred, with many traditional commissioning responsibilities falling under the remit of systems of care.