

## CONFERENCE ABSTRACT

# Integration form, financial and non-financial incentives and impact on Health Care Delivery: a mixed-method design on US Accountable Care Organizations and learnings for France

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**Background:** USA: policies have been implemented in US healthcare system to strengthen primary care delivery, improve coordination and integration and introduce value-based. These efforts include experiment of the Accountable Care Organization (ACO), a payment and delivery system model using pay-for-performance and risk-sharing mechanisms. ACO intended to improve integration and coordination between networks of primary and secondary care providers held responsible for the total quality and cost of care for a defined population. Despite is dramatic diffusion, over 800 ACOs for at least 28 million beneficiaries in 2016, there is a lack of knowledge on the determinants of ACOs performance.

**France:** Like US, France experience lack of integration and fragmentation issues and has developed policies aiming to promote integration and coordination. First, with the recognition of care and services delivered in new primary care organizational forms (Multi-professional Group Practices, MGP, health care networks, HCN). The diffusion of these are exponential with over 800 MGP or HCN today against 10 in 2008. Second, with prospective remuneration schemes pilots in addition to fee-for-service payments, to date for 400 MGP or HCN volunteers. Third, with the recent healthcare Law (2016) that supports the creation of a new intermediate level between hospital and primary care providers and payors.

**Methods:** We identify key dimensions of ACOs performance based on a mixed-method design that combines: qualitative interviews of executives in 16 ACOs; factor and cluster analysis based on waves one to three of the National Survey of ACOs (N=398) merged with Medicare claims (N=248) and quantitative explanatory design to estimate differential impact of ACO clusters on efficiency outcomes.

**Results:** ACO regional and local contexts, risk bearing and patient characteristics, depth and breadth of integration, capabilities and incentives appear to be key factors do differentiate ACOs and their impact on efficiency outcomes. The results are mixed depending on the outcomes and ACOs cluster. ACOs with complete integration are more efficient in terms of quality of care and health care utilization, but less efficient in terms of productivity.

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Implication for the US: ACOs are heterogeneous in their capacity to impact performance. Policy should, first, consider that an accurate qualification of integrated delivery systems and their context is required prior to estimate their impact and, second, recognize that the impact of ACOs vary depending on the outcomes, and then the policy aims.

**Implication for France:** The US findings strength the importance to get traction on integration and value-based payment of simultaneous reform of health care delivery at a meso level and payment reform. These require creating the condition for the emergence of an intermediate level of regulation between payors and providers as well as a large transfer of a set of capabilities and investment around the selection of providers, the data collection and analytics, the management of care and transition, the diversification of health human resources, and the utilization of financial and non-financial internal incentives.

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**Keywords:** integration; acos; evaluation; mixed-method

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