Accountable Care
What every employer needs to know about the potential of today’s new care models.

Introduction
The last several years have brought about a dramatic transformation in the health care industry—from greater information sharing through electronic health records to new methods for provider reimbursement. Nowhere are these changes more evident than in accountable care models, which merge quality-improvement programs, new technology and innovative provider payment structures.

The impetus for these new models is most often attributed to the continued rise in unsustainable health care costs. Health care spending has reached $3 trillion in our nation according to recent estimates.1 Left unchecked, this trend is likely to continue given the increased incidence of chronic illness among Americans. According to the Centers for Disease Control and Prevention (CDC), one in four adults have two or more chronic conditions.2 The CDC goes on to state that 86 percent of all health care spending is attributed to people with one or more of these health issues.

To address this widespread challenge, many health plans and providers are working together to develop accountable care models that closely resemble the accountable care organizations (ACOs), which Medicare developed as a result of the Affordable Care Act. These models provide financial incentives to providers in exchange for meeting the goals of health care reform’s Triple Aim: improving care, better managing costs and creating a better patient experience. Some models also incorporate risk sharing, which means that providers take on some of the financial risk associated with caring for a given population in addition to sharing financial rewards.

To enable these efforts, insurance carriers typically give providers access to the resources, technology and support needed to actually meet these important objectives. These resources often include data about the health of individuals and populations, as well as care management programs for patients and health information exchange tools, among others outlined in more detail in the following pages.

As health plans and providers explore new models of accountable care, employers certainly have a vested interest in their success. Rising costs aren’t just a problem for health plans and government payers; these costs directly impact the premiums passed on to employers and consumers who purchase health insurance. At the same time, improving care delivery leads to better health for individuals, and a happier, more productive workforce for employers. Savvy employers will be looking to contribute to these models in a variety of ways—from educating their employees about how these programs work to engaging these individuals in health improvement efforts that complement accountable care goals.

The following analysis gives companies of all sizes a deeper understanding of how these models work, and details how employers and consumers each have a role to play in their future success.
From ACO to PCMH

While the term “accountable care” is often used in reference to the Medicare program, it’s also used to describe a wide variety of models in the private sector that serve individuals with all types of insurance coverage. Understanding these differences is essential, since more than half of all Americans have employment-based health insurance. So while Medicare ACOs were a good first step in tackling the triple aim of health care reform, the commercial market also needed to keep pace with these changes.

Different accountable care models may have varied structures depending on what type of providers are involved (e.g., hospitals, large health systems and primary care providers). Each model also has unique attributes, including the type of quality measures used to track provider performance and the method of financial incentive and/or risk sharing involved. The two most common models offered to employers through innovative health plan offerings are patient-centered medical homes (PCMHs) and ACOs.

Patient-Centered Medical Homes

PCMHs actually pre-date health care reform, but are considered by many to be a helpful building block toward full accountable care models. Other accountable care models may also include networks of PCMHs as one element of their approach.

In these programs, primary care providers (PCPs) serve as “quarterbacks” for a patient’s care needs and focus on a holistic approach to care rather than managing each health condition separately. So whether a patient is seeking care through a specialist, a hospital or any other type of provider, their family doctor stays involved and oversees these elements of their treatment. As a result, care is more coordinated and the person who a patient sees most—their primary care provider—is empowered to make decisions based on their firsthand knowledge. This emphasis on coordination not only helps improve a patient’s treatment, it helps avoid duplication of efforts like lab testing, unnecessary services and inefficiency— all of which lead to rising costs. In addition, it creates a better experience for the patient, since they are supported in navigating the complexities of the health care system and receive more personalized services.

Participating PCMH providers are usually responsible for tracking quality and reporting back to the health plan with regard to these measures. In return, they may receive additional financial incentives, either through per-member per-month fees or a “bonus payment” based on performance.

ACOs in the Private Sector

Accountable care organizations also focus on improving quality, better managing costs and improving the patient’s experience, but they usually operate on a much broader scale than a PCMH. In this way, they are more similar in structure to Medicare ACOs.

According to a 2014 study, 90% of payers and 81% of providers are already using some mix of value-based reimbursement combined with fee-for-service.

These models bring together providers from across the continuum of care: PCPs, specialists, ER and urgent care doctors, and hospital staff. All of these participating providers are responsible for their performance against the ACO’s goals. These goals frequently include a mix of quality, utilization and patient satisfaction measures. Given the wider reach of accountable care organizations, technology and data sharing is more critical to these models. Providers are asked to collaborate in a team-based approach to care, which means that they need to make informed decisions based on information about a patient’s health history, current treatment, prescriptions and diagnostic testing. In return for these efforts, providers may receive financial incentives from health plans, such as annual bonus payments or a share of savings based on their overall performance and the total cost of care.

ACOs also typically incorporate a strong emphasis on care management. Within these programs, care managers reach out to at-risk patients in between doctor’s office visits to ensure that they are following recommended treatment guidelines and to support them in health improvement. However, ACOs don’t focus solely on at-risk patients. Most ACOs also promote preventive measures, encouraging providers to ensure that individuals receive the appropriate screenings, immunizations and diagnostic testing.
Common Characteristics of Accountable Care Models

While ACOs, patient-centered medical homes and bundled payment models do vary in their structure and specific goals, there are many common foundational elements that improve care, lower costs and provide a better patient experience, supporting Triple Aim objectives. According to a recent report by research firm Deloitte, some of the desired characteristics of an ACO include data sharing across all partners, care coordination across the spectrum of care, and goals and metrics that define success, among others.6

Setting and tracking quality goals

Setting quality goals is a critical part of the early-stage development process for accountable care. Many models use nationally recognized metrics, such as measures from the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS measures set standardized goals for areas including preventive care, chronic condition management, proper diagnostic testing and other important care efforts.

FOR EXAMPLE

HEDIS measures related to diabetic patients ensure that these individuals receive appropriate follow-up and testing with regard to eye exams, blood glucose levels and cholesterol testing. Once these goals are established, plans and providers must work together to collect data to track performance against these metrics. Each provider typically receives reporting that shows their own performance as well as benchmarks scores across the model’s network.

Health plans may also incorporate utilization metrics as part of their goal setting.

FOR EXAMPLE

An ACO might strive to reduce hospital admissions, readmissions and/or emergency room utilization, given that much of this utilization is avoidable when the right care and support is provided to patients. Finally, patient satisfaction data may also be tracked and measured. This can be accomplished through the use of patient surveys.

Facilitating data sharing

As outlined in the Deloitte study, accountable care models must also enable data sharing across providers. This can take the form of retrospective reporting as well as health information exchange (i.e., pushing and pulling data from the electronic medical records of participating providers). It may also include software that shares real-time data across all providers—including care managers—about any changes to a patient’s treatment and health status. As part of these efforts, providers may be alerted that one of their patients has been admitted to the hospital or ER. Empowered with this insight, PCPs can better coordinate treatment and follow-up with patients after discharge to reconcile any new care plans or medications with existing treatment.

Care coordination efforts

Care coordination efforts are also a common characteristic across all types of accountable care models. Whether a physician or a care manager is responsible for this oversight, providers within these models must take steps to ensure they deliver efficient, appropriate and personalized care to patients across every clinical setting. Care coordination efforts also aim to provide timely follow-up care after a transition of care—from a hospital to home, for example. As such, care coordination can also address one of the most significant and potentially avoidable drivers of health care costs: hospital readmissions. Hospitals spent $41.3 billion between January and November 2011 to treat patients readmitted within 30 days of

Accountable care is positioned for growth. The department of Health and Human Services recently set a goal of tying 30 percent of Medicare payments to quality or value through accountable care arrangements by the end of 2016.5
discharge, according to the Agency for Healthcare Research and Quality (AHRQ). In 2011, the cost of hospital readmissions for 600,000 privately insured (non-Medicare/Medicaid members) totaled $8.1 billion. Improving care coordination by encouraging collaboration between doctors, hospitals and other providers may help prevent many of these readmissions.

Other Best Practices and Strategies for Success

While all health plans and providers are at different stages of readiness to take on the challenges of accountable care, the following elements are often considered “best practices” among successful collaborations. Employers will want to consider these factors as they work with their health insurance carrier to identify an appropriate accountable care-based health plan.

Date analysis and risk stratification to improve population health

Given that data is such a key element of accountable care, it makes sense that health plans should also be analyzing their own claims data to better understand population risks, gaps in treatment and opportunities to improve quality. Some plans integrate this claims data with clinical data from providers to create a comprehensive picture of population health. As a result, they can stratify members who are at risk and develop data-driven strategies for reaching out to these members through care management and other health improvement programs. Plans can also offer this reporting to providers to give them a true perspective on their own opportunities and challenges at the practice level.

FOR EXAMPLE

Providers might receive data that helps them understand whether their care efforts for diabetic patients are translating into better health outcomes. Or they can access information about how many of their patients are frequent utilizers of the emergency room. Practices can also compare their performance in specific quality and cost-control efforts against other similar providers, which allows for benchmarking and appropriate goal setting.

Practice transformation support

Innovative contracting and data sharing alone are not enough to truly transform care delivery. Providers must also change the way they operate. To do so, all professionals within the practice must receive extensive training about clinical best practices, new workflow processes, quality improvement efforts and onboarding support to ensure that they understand the ACO’s goals. At the same time, providers themselves must be culturally ready to make this shift, meaning that they are both ready and able to transition the way that their practices operate on a daily basis. Health plans can facilitate this transformation, however providers must first be willing to adopt the goals and practices of the ACO model.

Efforts to improve in-network steerage and optimize utilization

An accountable care model works best if members stay inside the network when they seek health care services, where care is more coordinated, consistent and high quality. As such, plans must incorporate measures to encourage in-network utilization (often referred to as “steerage” in these models) and referrals wherever possible. At the same time, they must discourage unnecessary utilization like avoidable ER visits. See Figure 1 for strategies that may incorporated by accountable care models.

According to a recent study, 55% of U.S. adults said that they would choose a coordinated care model over a self-directed approach. For those already experienced with elements of coordinated care networks, this number rose to 62%.

FOR EXAMPLE

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Promoting consistent, evidence-based care practices
Evidence-based medicine is also a core element of a successful accountable care model. This term refers to care and treatment that is based on the latest medical literature. Experts agree that evidence-based medicine can provide a roadmap to simultaneously achieve higher quality and more efficient care.12 Consistent, evidence-based care practices can also help accountable care organizations eliminate waste and inefficient use of health care resources.

Developing tools, strategies and information to engage members
Members themselves have an important role to play in accountable care models, as their decisions have an impact on cost of care as well as outcomes. As such, the value of member education and engagement cannot be underestimated. Accountable care organizations may use a variety of means to undertake these efforts. These include technology-based tools, such as transparency calculators (supplying cost/quality information), patient portals with access to each individual’s medical information and health history, and population health and wellness programs.

The Employer’s Role in These Efforts
While employers certainly play a role in selecting a health plan product that incorporates many of the characteristics outlined above, these organizations must also ensure that the model’s structure and design meet the needs of their population. Employers may want to partner with their health plan to ensure that a strategic benefit design addresses the challenges and opportunities presented in an employee population.

FOR EXAMPLE
Analysis of claims data may reveal a high incidence of diabetes in one workforce. Lowering the cost of diabetic supplies and medication may be important in encouraging greater treatment compliance and preventing disease progression in these individuals.

Employers must also ensure that the model’s network is appropriate for the geographic reach and concentration of their workforce. Many accountable care models are developed in partnership with local health systems in urban areas, while PCMH models may be employed within smaller medical practices in more rural settings. If an employer’s workforce is spread across the country,
Employers can also supplement accountable care efforts by integrating their own wellness and health improvement programs into the mix. Data from these programs—such as health risk assessments and biometric screening results—is also important to consider when analyzing population health as part of these models. In addition, employers can develop their own health improvement incentives, such as lowering premium costs for at-risk employees who enroll in a care management program.

The Advantaged of Accountable Care for Employers Today and Tomorrow

While accountable care is still in its infancy, many models have already shown incredible promise in moving the needle on quality and costs.

As these models expand and grow, employers of all sizes will be able to participate in plans that incorporate many of these value-driven strategies. For larger, self-funded employers, this can mean direct costs savings and a lower medical trend. It also means better support for at-risk employees, translating to a healthier, happier population. For other employers, cost savings will likely translate into lower premium increases over time, and lower out-of-pocket costs for employees who are able to make cost-conscious health care choices and improve their lifestyles. Employee satisfaction and productivity are also likely to rise as improved access to care—through convenient and extended office visits—becomes standard in these models.

As a result, employers who aren’t already in discussions with their health plan about the benefits of accountable care should be moving forward with this approach. Given the rapid shift away from traditional fee-for-service, it’s only a matter of time before accountable care becomes the new “normal” in the health care system.
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