PRESCRIPTIONS FOR EXCELLENCE IN
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TABLE OF CONTENTS

Prescriptions for Excellence in Health Care is brought to Population Health Matters readers by Jefferson School of Population Health in partnership with Lilly USA, LLC to provide essential information from the quality improvement and patient safety arenas.

EDITORIAL

ACOs Due for Their Annual Checkup

David B. Nash, MD, MBA
Editor-in-Chief

As 2013 drew to a close, Premier Healthcare Alliance predicted that participation in accountable care organizations (ACOs) would double in 2014 as a result of more providers developing core ACO capabilities.[1] Premier's forecast was made on the basis of its survey of 115 senior executives that revealed a growing trend in high-risk population management, coupled with reductions in cost and increases in health care quality and patient satisfaction. Of those who responded:

- More than 75% reported that they were integrating clinical and claims data to better manage population health respondents.
- 50% reported using predictive analytics to forecast individual patient and population needs.
- 46.3% reported using integrated data to bring about a reduction in silos.

So, as we barrel toward 2015, is the ACO movement gaining traction? By mid-2014, a leading health care data and research resource identified 537 ACOs nationwide (up from 320 the previous year), with more than 190,000 physicians and other health care professionals participating.[2] Although the number of Medicare ACOs has grown more rapidly than the number of non-Medicare ACOs, 46-52 million Americans (15%-18% of the total population) are patients in organizations with ACO arrangements with at least 1 payer.[2]

The next question is, are ACOs doing what they are designed to do (ie, improving quality and lowering costs)? Although it is far too early to draw conclusions, the Centers for Medicare & Medicaid Services (CMS) has begun to release financial and quality outcomes. Matthew Petersen and David Muhlestein provide a good synopsis in their article, *ACO Results: What We Know So Far*. For example:

- The Pioneer ACO program reported mixed results; of the $147 million in total savings, $76 million of which was returned to the program, only 12 of the 32 original ACOs shared in the savings. All Pioneer ACOs were successful in reporting quality metrics (related to patient experience,

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care coordination, patient safety, preventive health, and at-risk populations) and demonstrated improvement where comparable data were available.[3]

- The broader ranging, and less stringent, Medicare Shared Savings ACO program released preliminary results on 114 ACOs that were started in 2012. Of the 54 that held costs below established budget benchmarks, 29 received a portion of the $126 million in shared savings – in addition to generating $128 million in total CMS trust fund savings. Importantly, all but 5 of the ACOs successfully reported the required set of 33 ACO quality metrics.[3]

I couldn't agree more with Petersen and Muhlestein – these early results have real value that goes beyond answering the question of how we're doing. They can be enormously useful in helping ACOs develop winning strategies and avoid potential pitfalls.

In this issue, we wrap up our series on *Creating a Framework for Accountable Care* with articles from 3 different but complementary perspectives. The first article relates the "Biography of a New ACO," an ongoing exercise in transforming health care delivery and adjusting to payment reforms in a large urban/suburban health system. "Evolving Health Care Models and the Impact on Value and Quality," offers a glimpse into innovative payer initiatives; specifically, Humana's solutions for enhancing quality health outcomes at a lower cost. With the aid of a clever analogy, "Employers and Accountable Care Organizations: A Good Marriage?" sheds light on the pros and cons of this interesting "relationship."

As always, I welcome feedback from our readers at david.nash@jefferson.edu.

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A MESSAGE FROM LILLY

Opportunities, Uncertainty Loom in 2015 for the Health Exchange Marketplace

Ryan Urgo, MPP

With open enrollment for the 2015 Health Exchange Marketplace now under way, insurers are preparing for what they hope will be a promising start to the new plan year. After turning the corner on a challenging launch in 2014, state-run and federally-facilitated exchanges have enrolled just under 7 million beneficiaries, meeting the estimate set by the Congressional Budget Office in May 2013.[1] These enrollment numbers were reassuring to plans, leading many national and regional insurers to expand their presence in 2015.

A Health and Human Services (HHS) report released on September 23, 2014 stated that there will be a 25% increase in the number of issuers offering Marketplace coverage for 2015 compared to 2014.[2] Recently, HHS has tamped down expectations for total enrollment in 2015, predicting a range somewhere between 9 and 10 million.[3] However, staffing decisions made by many national plans suggest a decidedly more bullish position. According to a recent survey by Reuters, most large national managed care organizations expect a minimum 20% increase in their 2015 Exchange membership, and many have doubled or tripled their support staff in advance of open enrollment in a display of confidence.[4]

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In general, state-run and federally-facilitated Exchanges contain sufficiently balanced risk pools to avert extreme cases of adverse selection, wherein a disproportionately sicker membership leads to premiums increases that would be unaffordable to many enrollees. Recent studies show that 2015 Exchange premiums increases will average 8% – growth that is considered manageable by the historical standards of US health care inflation.[5]

Though all of this can be viewed positively by consumers and proponents of the Affordable Care Act (ACA), the devil continues to lurk in the details. A *New York Times* analysis revealed that many insurers with the largest market share in 2014 intend to raise premiums much higher than the "average."[6] Additionally, HHS will permit beneficiaries to autoenroll in their current plans – a decision that could reduce complexity, but also make it more likely that consumers will forgo a search for a more cost-effective plan in 2015. Moreover, beneficiaries who do not revisit healthcare.gov to update their annual income will receive the same subsidy awarded in 2014, increasing the likelihood that they could leave additional savings on the table.

At the same time, the prospect of lower reimbursement rates for hospitals and physicians compared to what they typically receive for traditional commercial coverage have compelled many providers to opt out of Exchange networks. Insurers tend to offer Exchange plans with narrow provider networks and benefit designs that place substantial out-of-pocket cost burdens on consumers in the form of large deductibles and higher coinsurance for various benefits. Federal regulators continue to examine whether Exchange plans are meeting prevailing "network adequacy" standards.

Despite these concerns, nothing casts a larger shadow over the future of the Exchange Marketplaces than yet another pending Supreme Court decision (estimated release in June 2015). On November 7, 2014, the Court agreed to review a challenge to the legality of the subsidies offered in federally-facilitated exchange states. If the Supreme Court rules to invalidate subsidies for the millions of beneficiaries enrolled in coverage through a federally-facilitated exchange (37 states), it would significantly disrupt the Marketplace. Barring a regulatory or legislative solution, premiums would become unaffordable for most enrollees, leading them to drop coverage and increasing the likelihood of what the insurance industry would term a marketplace "death spiral." There is growing concern about this case among proponents of the ACA because of the potentially devastating financial impact. In addition to the very real effects that would be felt by consumers, insurers, and other health care providers, the case poses a major threat to a key component of the ACA itself. Until a final decision is rendered, subsidies will continue to be available to all beneficiaries – and at the moment it is business as usual – with 2015 open enrollment under way.

Taken together, early signs suggest the Exchange Marketplaces are poised for success in 2015, though uncertainty also looms large. Like much of health reform thus far, another chapter is yet to be written, and the repercussions will surely be felt by payers, providers, and beneficiaries alike.

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Biography of a New ACO

Joel Port, FACHE

On March 23, 2010, the President of the United States signed the Affordable Care Act (ACA), supporting the concept of access to health care for everyone.[1] In addition to that supporting premise, the Act provided significant funding for health care innovations including 2 Medicare Accountable Care Organization (ACO) programs - Pioneer and the Medicare Shared Savings Programs (MSSP). Both of these programs provided novel incentives for health care providers to assume risk, meet or exceed quality benchmarks, and share in financial savings with the Centers for Medicare & Medicaid Services (CMS). Although the Pioneer program was created for advanced managed care health networks located in relatively efficient markets, the MSSP was designed to engage providers located in relatively inefficient markets in managing risks among their patients. This article focuses on Jefferson Health System's (JHS) newly developed ACO (accepted into the MSSP as of January 1, 2014) and how we are pursuing this strategic opportunity for the benefit of participating physicians, member health systems, and their patients.

Created in 1995 with the merger of the Thomas Jefferson University Hospital and the Main Line Health System, JHS is comprised of 8 hospitals with more than $3 billion in revenues. After the passage of the ACA, JHS thoughtfully considered how it would work with its member health systems to meet the needs of its communities in the context of the new law. In 2010, JHS formed a limited liability company called ACO-PA and, by 2011, an initial ACO business plan had been developed and the journey to value-based care had begun. A pay-for-performance program with a commercial payer was instituted; however, it was another 2 years before JHS and its members agreed to fully implement an ACO strategy.

In response to several market factors, JHS and its members revisited the ACO strategy in early 2013. At that time, the dynamics of health care reform and other Medicare reimbursement changes (eg, penalties for readmissions) were beginning to impact the member hospitals, and there was a new strategic focus on population health and value-based care. Thus, the original business plan was updated and approved in May 2013. Key among the plan's multiple components was applying for the MSSP. When JHS invited other health systems and hospitals to join this new ACO and to embrace the new business plan, Holy Redeemer Health System joined with ACO-PA in its 2014 MSSP application.

The other Medicare program - the Pioneer ACO Model - "is designed for health care organizations and providers with experience in coordinating care for patients across care settings. It allows these provider groups to move more rapidly from a shared savings payment model to a population-based payment model on a track consistent with, but separate from, the MSSP."[2] Because JHS was a relatively new ACO, the MSSP was more appealing in that it had an "upside only" option for the first 3 years, whereas the Pioneer program had "downside risk." Applying to the MSSP program would serve as a catalyst for our ACO development, and help move JHS and its members from volume to value.

Although the MSSP application is detailed and extensive, it serves as an excellent assessment of an ACO's readiness to take on any risk - upside only or downside. The CMS requirement of attributing a minimum of 5000 Medicare beneficiaries to an ACO demands a primary care network of significant size – a substantial hurdle for most ACOs. Fortunately, in a period of less than 8 weeks, 225 primary care physicians committed to ACO-PA, with an attribution of more than 30,000 beneficiaries. Following the July 2013 submission of the MSSP application, ACO-PA was formally accepted into the program for a January 2014 start date. Once the application was accepted by CMS, the real work began.

ACO-PA recognized that success under the MSSP would require patients and their physicians to be central; thus, patient data transparency would be paramount. Access to Medicare claims files enabled us to offer the participating physicians

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patient-specific data that previously were unavailable to them, and helped us understand how to better serve patients, especially those with significant chronic diseases (eg, chronic heart failure, chronic obstructive pulmonary disease, coronary artery disease).

To get a jump start in the first year of MSSP, we studied successful ACOs. Rather than purchasing a population health system, we contracted with the UPMC Health Plan (UPMC), an organization with extensive experience in Medicare Advantage products and effective chronic care coordination strategies that could be transferred or adapted to the MSSP. UPMC is able to provide aggregated and detailed data reports (ie, risk stratification, frequent emergency room and inpatient utilizers, ambulatory care-sensitive conditions, readmissions, physician and hospital benchmarking, member profiles) to our participating primary care physicians.

Another key area for MSSP is quality reporting. ACO-PA is assisting practices to collect quality metrics for 2014 and will report in January 2015 as one group. Because our physicians use multiple electronic medical records, and 8 different systems, reporting quality metrics likely will take significant time and effort. We are working with UPMC to collect and report these metrics.

With patient data in hand, care coordination support can be more focused and targeted. ACO-PA has begun to make care coordination investments to provide the appropriate resources to patients who require additional clinical support. Working with participating hospitals and post-acute care providers, we aim to reduce the likelihood of hospital readmissions within specified time frames.

To assist ACO-PA in focusing its investments and care coordination efforts, a Quality/Care Coordination Committee was instituted and staffed with physician leaders representing the participating practices. Three divisions were established representing the 3 principal members of ACO-PA (Jefferson, Main Line Health, and Holy Redeemer associated physicians), and each division is overseen by a medical director. To support medical management efforts, Quality Summits are held for participating physicians and office staff to review specific topics related to MSSP. In the coming year, resources will be offered to practices interested in advancing to patient-centered medical home recognition.

Recently, ACO-PA changed its name to the Delaware Valley ACO (DVACO) to more closely reflect the geographic location of participating physicians and hospitals. With the recent addition of Doylestown Hospital, DVACO increased its primary care physician base to more than 430 physicians as we approach the second year of MSSP.

Moving a health system and community physicians from volume to value is a long journey with many successes and failures along the way. For the members of DVACO, that journey is under way, with a distinct focus and a clear investment strategy that hold great promise for the long-term success of the organization.

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Evolving Health Care Models and the Impact on Value and Quality

Bruce Perkins

From Australia to Sweden, developed countries are struggling to manage the cost of health care as spending continues to consume greater percentages of gross domestic product and approaches unsustainable levels, while the value attained for this large health care spend is being questioned.

As a result, many organizations are piloting alternative solutions to drive enhanced outcomes at lower costs. These solutions take many forms and differ from traditional unmanaged fee-for-service (FFS) medicine on several dimensions, including:

- More efficient, narrower networks of physicians.
- Better coordinated and managed patient care delivered by providers.
- Redesigned financial incentives payments that align with desired outcomes.

Although it is widely accepted that these aligned, coordinated plans can provide care at lower cost than traditional FFS medicine, the fact that patients enrolled in these plans enjoy better health outcomes merits equal attention. At Humana, we have found that more aligned, coordinated care models not only lower the cost of care but also deliver far better outcomes than traditional FFS models. Although patients in managed programs are typically older with more chronic conditions and fewer financial resources, the data show that mortality rates are lower, recovery from acute conditions is faster, and long-term health is better than in FFS models. Within Humana's managed populations, improved outcomes continue as the organization leverages models that better align payer and physician incentives.

As policy makers and medical experts continue to seek new models for financing and delivering quality care at affordable prices, they should take note of, and perhaps seek to replicate, a real-world success story.

Aligned, Coordinated Care Produces Better Patient Outcomes

In the past, there were widespread concerns - especially on the part of the general public - that health care cost savings would come at the expense of quality of care. The misperception that higher cost is synonymous with better quality remains widespread.

Humana's experience with a substantial Medicare population challenges that assumption. Claims data were collected for 3 million patients; approximately 1.3 million of the patients in the sample used providers on a traditional FFS basis ("unmanaged FFS") while the remaining 1.7 million patients were enrolled in private Medicare Advantage (MA) plans. Of those in private MA plans, 1.4 million patients were either in noncapitated, "managed FFS" plans (ie, preferred provider organizations) or health care maintenance organizations (HMOs). Approximately 300,000 patients were enrolled in an HMO plan that included global capitation (ie, risk sharing). In the risk-sharing models, participating primary care physicians were paid a contracted rate (adjusted for age, sex, illness, and regional differences) for each member regardless of the number or nature of services provided.

Each of these groups was compared against internationally accepted dimensions of health care quality: (1) single-year mortality, (2) recovery from acute episodes of care requiring hospitalization, and (3) sustainability of health over time. Regressions were used to risk adjust the data for 2 key factors that shape an individual's health status (age and number of comorbidities) to deal with the nonidentical demographic composition of our 3 samples.

Patients enrolled in more aligned, coordinated models had lower mortality rates and enjoyed better health with fewer complications than those in traditional FFS models. Although large improvements in outcomes occurred in managed and unmanaged FFS models, the risk-sharing models demonstrated better outcomes than the managed FFS models. Specifically, single-year mortality rates were

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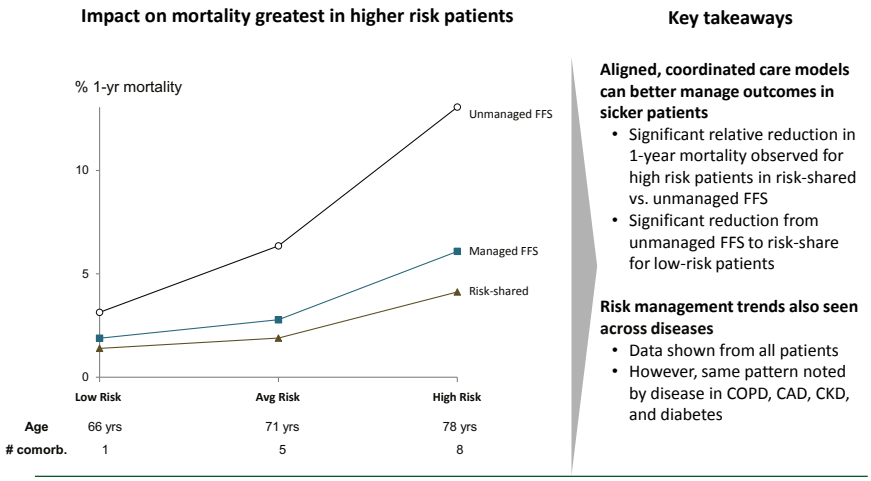
2.7% for managed FFS plans and 1.9% for risk-shared plans—less than half of the 6.8% mortality rate in unmanaged FFS. Moreover, this mortality gap widens with higher risk patients, as shown in Table 1.

Moreover, managed FFS and risk-sharing models had shorter average hospital stays and fewer readmissions than patients enrolled in non-MA models. The average length of stay in risk-shared models was 4.8 days, a full day shorter than in non-MA models. Risk-shared plans also fared better in terms of readmission rates. Taken together, this suggests that shorter stays are associated with improvements in the management of acute episodes of care.

Table 1. Management of sicker patients improves with shift in models



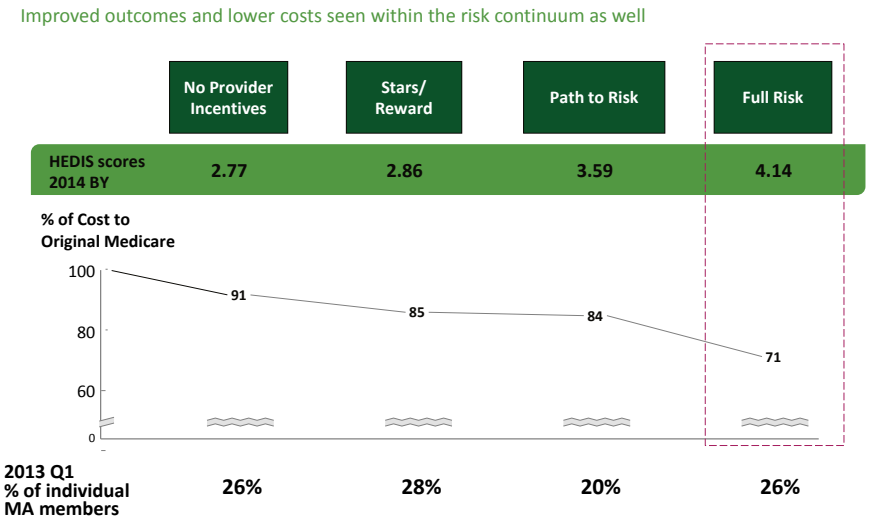
Humana

Source: CMS Carrier Claims and Enrollment 2011; Humana claims 2011

Key

FFS (Fee for Service)
COPD (chronic obstructive pulmonary disease)
CAD (coronary artery disease)
CKD (chronic kidney disease)

Table 2. Integrated care delivery continuum.



Humana

Key

MA (Medicare Advantage)
Q (quarter)

The benefits of more aligned, coordinated models are immediate and long lasting. In the first year patients opted to switch to a managed FFS plan, mortality rates, average lengths of stay, and frequency of readmission dropped substantially, and have continued to decrease with each additional year of enrollment.

One of the greatest advantages of aligned, coordinated models is the emphasis on healthier living and preventive care, especially in managing chronic conditions. For example, patients with diabetes who are enrolled in aligned, coordinated MA plans received more hemoglobin A1c tests and nephropathy screenings than patients in FFS plans. This translates into startling outcomes; for example, 3 amputations per 10,000 patients in risk-shared plans compared to 111 per 10,000 patients in FFS plans. Similar results have been observed in other chronic conditions.

Within Humana's MA plan population, increased risk sharing between providers and payers was correlated across the spectrum with improved health care quality, as measured by HEDIS (Healthcare Effectiveness Data and Information Set), which tracks 75 broadly accepted measures of high-quality health care. As indicated in Table 2,

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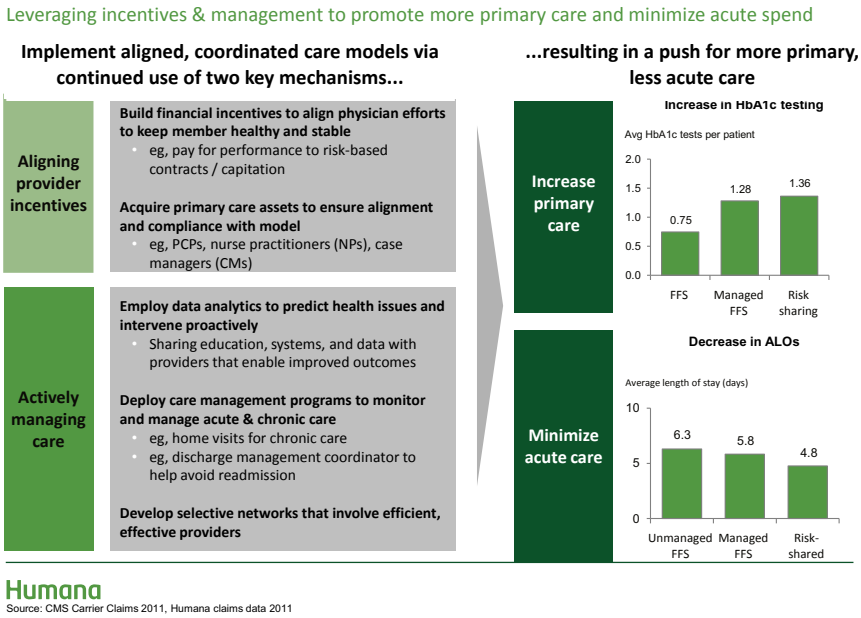
Table 3. Payers continue to promote aligned models



Humana

Source: CMS Carrier Claims 2011, Humana claims data 2011

Key

HbA1c (glycosylated hemoglobin test)
FFS (fee for service)
ALOs (average length of stay)

this increase in health care quality also is correlated with a decrease in costs at each step along the risk-sharing and incentives spectrum.

Health Care Stakeholders Are Adapting Aligned and Coordinated Models

Experience indicates that aligned, coordinated models result in a "win-win" for patients by controlling costs and saving lives. As policy makers take note of these results, Humana is investing more resources into managed care models, and other health plans are expected to follow suit. Although these new models may not be adopted immediately, managed care plan membership likely will grow both in the public and private payer spaces. In particular, Medicaid and commercial exchanges stand to gain many more managed care members in the coming years because of cost pressures facing those subscribers.

With this in mind, Humana is focused on building capacity and capabilities to further improve outcomes through increased primary care and decreased acute care. As shown in Table 3, this will be achieved by several coordinated means:

- Building robust, patient-aligned financial incentives with providers.
- Deploying care management programs to monitor acute and chronic care.
- Using data analytics to intervene proactively.

In this way, the organization seeks to transform the roles of payers and providers from transactional agents to health "coaches" and "quarterbacks."

Health care is a huge and contentious issue and likely will become more so as additional elements of the Affordable Care Act are rolled out. To prepare for these shifts in the health care landscape, policy makers and medical experts must continue to seek new models for the delivery of quality care at affordable prices. The foregoing model is generalizable and one that might be replicated.

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Employers and Accountable Care Organizations: A Good Marriage?

Laurel Pickering, MPH

Employers foot the health care bill for the nearly 60% of Americans enrolled in employer-sponsored insurance, representing approximately 21% of the nation's overall health care spending. For decades, employers have been the first to test new health care designs and delivery models, with the hope of achieving better health outcomes and reduced costs.

Health reform popularized a model that was first implemented in public insurance programs - the accountable care organization (ACO). Although the structure is relatively new, employers have focused on accountability for quite some time. As payers for their employees' health care, they seek accountability, not only from the plans that provide it but also from their employees who receive it. To increase employees' engagement in their own health and related expenditures, employers support initiatives focused on accountability at different levels; for instance, demanding cost and quality transparency, offering consumer-directed health plans, and testing private health insurance exchanges.

Although the concept of accountability strikes a familiar chord with employers, ACOs do not. Employers are not used to working with providers, or considering how provider groups are structured and paid. But that is changing and, for employers, there is both plenty to love about ACOs, and plenty *not* to love.

What's to Love?

1. **Providers are engaged in the overall health of their patients.** Integration and coordination among hospitals, physicians, other providers, and patients are critical elements of an accountable care model. Traditionally, a physician only thinks about a patient once he or she arrives in the office. ACO physicians proactively manage the health of patients and consider their needs even when they aren't in the office. Accountable care moves toward population health management – the "holy grail" for which employers have been searching.

2. **Providers must care about cost.** Historically, providers deliver care with little thought to what their treatment plans will cost the insurer, employer, or patient. In a fee-for-service world, more is better. In accountable care scenarios, providers often share in savings that result from more efficient, appropriate care. So there's an incentive for physicians to think about the cost of services they prescribe – including where they refer patients for these services.

3. **The promise of better outcomes.** In ACOs, providers are paid based on outcomes rather than services. An ACO often takes on risk for the overall health of a defined population, supported by teams of physicians, hospitals and other health care providers and suppliers that work together to coordinate and improve care.

4. **The promise of reduced costs.** ACOs reduce costs by cutting down on waste and inefficiencies, and by promoting the idea of paying for value and not volume. If providers know they'll share in savings achieved by more efficient care, they're more likely to consider cost when making decisions.

Sounds Good. What's *Not* to Love?

1. **Employers May Be Asked to Pay More.** Reminder to readers: self-insured employers take on all the risk of health care costs and pay for every employee (and often dependent) medical expense as it occurs. That's a real incentive for employers to care about the health of their employees and the subsequent impact on health care costs – making ACOs an attractive option. But in some instances, the implementation of ACOs and other new delivery models (eg, patient-centered medical

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homes) require self-insured employers to pay more up front, at least initially.

2. **Return on Investment (ROI) is Uncertain.** Human resource and benefits professionals are stewards of company resources and must be accountable to the leadership for how money is spent. They are often expected to explain the benefits of new programs to senior finance staff. Important metrics include impact on clinical outcomes, cost, and utilization. Employers also care about reductions in both absenteeism and presenteeism, and increases in productivity. Because measures like these are not readily available, especially for ACOs, the ROI of new delivery models is unclear to employers. As these new models accrue data over time, it is reasonable to assume that more information will become available. Recent evaluative results of the Pioneer ACOs showed small savings, and indicated that further refinement of the model is needed.

3. **Narrower Networks.** For ACOs to be effective in coordinating care and managing population health, a finite group of providers is included in the organization. There is increasing recognition that working with a smaller or "narrow" network of providers can deliver cost savings and improved outcomes. But employees want access to any provider they choose, and employers must effectively communicate the advantages of narrower networks to deliver on the promise of ACOs.

4. **Market Power and Consolidation.** In order to successfully coordinate care and integrate services, providers must be aligned and maintain patient health records on the same electronic system. This has driven consolidation and merger and acquisition activity among hospitals and physician practices. Elimination of duplicative services and personnel can result from such consolidation, as can the benefit of economies of scale. But historically, such activity has instead resulted in higher prices and revenues, as well as payment variations across markets. Employers fear this trend will increase costs and cancel out the benefits of care coordination, integration, and population health management that ACOs promise to deliver.

No Better Time than Now for Employers to Engage with ACOs

Now is the time for employers to connect with ACOs and take an active role in shaping these products to fit their needs. Important considerations include:

- Ensure alignment of the ACO's goals and services with the employer's.
- Match actual employee utilization of health care services with services the ACO provides.
- Actively discuss shared savings to make sure the employer saves too.
- Gather information on improved quality and reduced costs.

Intel is one employer currently working directly with an ACO. In New Mexico, for example, Intel employees use the Presbyterian Health Services network, which receives a bonus if quality goals are met and health care costs do not exceed a certain amount. If costs exceed the specified amount, the network will pay a penalty.

Rushing Toward the Future

In a post-reform world, employers must make important strategy decisions about health care benefits. The excise tax, for example, puts pressure on employers to deliver more cost-effective benefits. Some employers will rush away from providing benefits and take a hands-off approach by using private exchanges. Others will rush toward actively participating in solutions like ACOs that promise more efficient health care delivery and a healthier employee population.

Do "only fools rush in"? Not in this case.

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