Accountable Care Organizations—An Employer POV Primer

The accountable care organization (ACO) has emerged as the centerpiece of postreform initiatives to improve the delivery of quality, cost-efficient care. As the primary partners in delivering ACOs, payers and providers have begun to collaborate on the opportunities presented by the legislation. For employers, however, this new approach to managed health care delivery models will present challenges in adoption different from its predecessors: preferred provider organizations, health maintenance organizations and consumer-driven models. This article identifies these challenges and helps employers understand how they can respond in ways that make them active participants in the emergence of ACOs and secure the potential value of ACOs for their own organizations. For employers, the method to capturing the value of these emerging delivery models is to have a broad understanding of the evolving payer and provider marketplace, how to access or develop ACOs, and how smart decisions today can improve the future landscape of health care.

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Health industry professionals frequently caution employers that there are no silver bullets to the problem of rising health costs—and then proceed to try to identify a silver-bullet solution. Spawned by the Affordable Care Act, accountable care organizations (ACOs) have taken their place as the next evolution of health care delivery models that will lead the industry toward high-quality and cost-efficient care.

For some providers, it’s a move of necessity to overcome longstanding inefficiencies and lagging infrastructure; for others, it’s a way to capitalize on performance already achieved and take advantage of a competitive distinction. For many providers, it is an attempt to position themselves to attract and maintain patients, particularly as an influx of new members come into the health care system through private exchanges. Whether ACOs evolve as the successor to preferred provider organizations (PPOs), health maintenance organizations (HMOs) and account-savings (consumer-directed) products, or as an embedded feature of a health plan with little employer involvement or decision making, will likely be driven in part by employer priorities and business decisions.

While the Centers for Medicare and Medicaid Services (CMS) has very distinct rules and definitions for what comprises an ACO for the Medicare market, the concept of an ACO is far more ambiguous in the commercial market that applies to employers. At its core, an ACO is a health care delivery
system that has partnered with a payer or purchaser of health care to develop arrangements that align financial interests with the delivery of effective and quality care for a specific population. However, with the definition open to interpretation, an ACO can be anything from a fully transformative change in the delivery of health care, to a rebranding of marginal managed care techniques that have been in place for years.

How can an employer distinguish among the different offerings and, when done effectively, what does the development of ACOs mean to the employer and its bottom line? Specifically, what does an employer need to understand to enhance the potential upside to delivering health care to its employees through these new organizations?

For the majority of employers, exposure to ACOs will be through relationships with their health plan partners. As health plans form ACOs with health systems, ACOs will increasingly become a more integral part of the HMOs, PPOs and other traditional care-management plans that insurance companies will sell to their employer clients.

ACO Breadth and Depth in Today’s Market

The first step to understanding the implications and potential benefits of these ACO developments is to gain a clear picture of what is available in today’s marketplace. As ACOs have garnered attention, the label has gained value as a branding and marketing tool. However, the definition of accountable care varies widely across health plans and provider groups, and the label may be attached to anything from a few cursory efficiency incentives to a genuinely transformative delivery model.

Furthermore, while many organizations have an aggressive agenda for forming and developing ACOs, true ACO development is often a custom and labor-intensive process that requires time and high-level resources, which has a limiting effect on the speed of rollout. This often creates the circumstance where depth is the enemy of breadth in ACO development from a health plan.

ACO Breadth—Reach Across Products and Geographies

ACO development is in its earliest stages; while expanding, ACOs still have limited reach in today’s marketplace. Because these are generally single agreements between a health plan and an individual health care delivery system, the employer should consider how broadly ACOs could actually fit with the employer’s specific circumstances—its geography, mix of health plan vendors, mix of plan types and the provider selections of its employees. Various insurers have indicated that ACOs may apply only to certain plan types. For example, some may apply the concept only to their PPO plan offerings, on the basis that it is fee-for-service-based contracts in need of change, while others may apply it only to their HMOs, on the basis that these products have the required infrastructure on which effective ACO development will rely. A health plan vendor may have a well-advanced ACO model which closely fits the employer’s interests and values, but the employer may have its focus on an entirely different product line.

Where the ACO aligns with the employer’s preferred products, there is still the need to have a meaningful match of geographies and provider groups. Operational ACOs are still few and far between in many regions. Employers with a concentrated share of employees in geographies that match a health plan’s ACO market may find the most opportunity for significant change—if there are ACO developments within that specific region. Conversely, employers whose people are dispersed over wide regional or national geographies will likely have difficulty matching available ACOs to a critical mass of their population.

ACO Depth—Distinguishing Criteria

In some cases, an ACO is little more than an in-place capitated health plan with some quality and outcome metrics integrated into the payment mechanisms—basically, a traditional capitated HMO model. In others, an ACO is an evolved partnership between the health care delivery system, involving the physicians, hospital and health plan in ways that align all parties’ financial interests, clinical processes and operations to deliver cost-effective, quality care around a commonly accepted set of goals for improved results. Reasonably, some ACOs operate on the "nudge" principle—improve things gradually in achievable ways to avoid ending up with nothing by holding out for the unattainable. This is fine where that is the best that can be done given the circumstances, but employers treating ACOs as a purchasing or de-
Desired Characters of an ACO

- Strong joint governance
- Executive leadership from all partners
- Trust and transparency across all partners
- Material investment by all parties
- Global budget approach that aligns financial interests and shares risk
- Long-term commitments
- Data infrastructure that enables fluid clinical data capture and use in treatment and management settings
- Data sharing across all partners
- Aligned clinical and operational processes
- Care coordination across entire spectrum of care
- Goals and metrics that will define and measure success

sign criterion need to be well aware of which ACO definition is in play, so that they proceed with correspondingly high or low expectations. An employer looking for a meaningful, near-term way to stem cost inflation without cost shifting will need the deeper, transformative ACO model. The sidebar provides a checklist of characteristics to be found in the more advanced, higher potential ACO arrangements. In seeking to distinguish advanced vs. modest ACOs, perhaps the key area of focus is to separate process goals from financial and clinical results goals, and to identify the presence of actual risk for whether or not goals are met.

What Could an ACO Deliver? Two Examples

The more effective ACOs appear to be when the payer, provider and employer all have incentives and risks and a compelling business interest for making the investment. Two particular published examples demonstrate some common themes to success in two very different markets.

In the Sacramento area, the California Public Employees’ Retirement System (CalPERS), one of the largest health care purchasers in the country, collaborated with one of its health plan vendors, Blue Shield of California (BSC); a medical group, Hill Physicians Medical Group (Hill Physicians); and a hospital system, Dignity Health (Dignity), to form an accountable care arrangement that aligned incentives among all parties involved.

In Louisville, Kentucky, Norton Healthcare, an integrated delivery system based in Louisville, collaborated with its payer partner, Humana, to form an ACO pilot that managed approximately 7,000 Humana and Norton employees.

One critical element that aided in the achievements of these arrangements was that all parties involved were properly invested and had incentive and motivation for the arrangements to succeed.

In the Sacramento example, BSC, Dignity and Hill Physicians had a common motivation—a compelling interest in addressing competition for membership from the Kaiser Health Plan of California—that called for an improved ability to deliver more cost-effective care. This prompted those three parties to invest in an upfront premium credit of $15.5 million\(^1\) to CalPERS, bringing the employer into the equation as another powerful party with a keen interest in the success of the venture. As such, payer and provider were at risk to deliver the savings promised through the greater efficiency, while the purchaser had a strong interest in seeing this succeed over the long term.

In the Louisville case, Norton, the health care provider, and Humana, the health plan payer, also served as the employers in this situation. They were motivated to succeed from an expense management perspective in their role as employers, as well as from a business interest perspective in bringing a viable product to market. Applying this ACO to their own employee populations was both a visible representation of partnership between entities (payer and provider) more often perceived to be at odds over reimbursements, and a message to the employer community that the management of care was not to be at the expense of appropriate coverage, access or quality of care.

Regardless of how these collaborations formed, they both involved a realignment of incentives. In the Sacramento case, all partners involved in the arrangement had a strong incentive to work together and achieve the cost targets since all parties had upside and downside risk. Because the medical group, hospital system and health plan all share in the burden of meeting or failing the established cost targets, incentives to reduce cost are aligned across the system and there is no benefit to any individual party to shift cost within the system. Because goals were aligned and all parties were motivated to help one another achieve the overall target, there was a much freer flow of data throughout the system that allowed for identification of several problem areas that were potential opportunities for greater efficiency and quality of care. For this system,
overutilization, preventable readmissions and out-of-network services were identified as opportunities for increased efficiencies and ultimately lower costs. In its first year, this particular ACO experienced a 12.1% reduction in overall inpatient days despite seeing an actual growth in membership. In addition, hospital readmissions dropped 15%, and extended hospital stays of 20 days or more dropped 50%.2

In Norton’s case, the employers and providers developed a shared savings model that was linked to achieving specifically defined quality metrics.3 As an integrated delivery system, Norton already had much of the infrastructure in place to form an effective ACO; however, Norton still had to realign incentives in its payment system to focus more on performance measurement and reporting and had to expand on its health information technology system. Some of the savings the Norton system observed was in the joint-replacement accountability study, where a 7.3% decrease in direct variable cost, a 6.7% reduction in length of stay and a 13% reduction in 30-day readmissions were observed.4

It is worth noting that both of these cases represent employers that are significant presences in their communities and concentrated geographies. While CalPERS is a statewide entity, and Humana a health plan covering a wide section of the country, each was situated to take advantage of a single location with a single health plan and provider system. Meaningful, tangible savings and utilization reductions were observed in each case, and the primary source of achievements was that there was substantial depth to each ACO that properly aligned incentives to reduce costs and increase efficiencies.

**What Can an Employer Do Today?**

When presented with the opportunity to engage with a health plan partner that can offer access to effective ACOs that are delivering savings, what are some things an employer can contemplate? Few employers can replicate the circumstances outlined in the case studies above, so we need to consider how ACOs may affect the average, rather than only the exceptional, employer.

The dynamic that will perpetuate the environment for ACOs to continue to form and improve on their results will be created by employers driving membership to these more cost-effective and efficient provider systems, and distinguishing between the “in name only” version and those truly able to deliver on the promise of savings through quality and efficiency. While many employers will likely not be able to buy a readily available ACO product, employers can still make conscious decisions that influence how these ACOs are developed and their success.

The most basic and perhaps easiest decision may be for an employer to simply align itself with a health plan partner that is clearly making efforts in this area (Figure 1). An employer can choose a
delivery method changes

The next step is slightly more involved and requires a more visible commitment to ACOs. When available, employers can adopt plan selections or benefit designs that channel members toward ACOs (Figure 2). It is the next evolution of limiting access through narrow networks or driving care toward specific providers by tiered benefit designs; both are approaches that have become increasingly popular in recent years with the goal of driving consumers to access health care services in the most efficient manner possible.

Lastly, certain employers that have a significant influence in a market—such as those in the case study examples—could become catalysts and full partners in the development of an ACO (Figure 3). One might envision this opportunity in markets where the providers have coalesced into a very few health systems that are “must-haves” in their market. An employer or a coalition of employers that possess enough leverage and can provide a desired level of membership for a provider within that geographical region could change the dynamic by putting the choice directly to providers of a meaningful risk-bearing ACO, or more cost shifting to their patients. They can engage in the definitional stage, bring vendor partners and providers together, and push for specific programs, goals and financial commitments.

**Securing Value**

Directing members to more efficient providers is a dynamic that will benefit both these new ACOs and the employer’s bottom line. Employers may be able to curb the rising cost of their health care spending, and ACOs are betting on being able to deliver better care at a lower cost while increasing their share of the market. One of the top priorities of an ACO is to attract an increasing number of patients into a more efficient system—just as with the onset of PPOs and HMOs, the objective is to gain in net revenues by making up in new patients and better managed resources what they lose in lower unit price or fewer procedures. At
delivery method changes

By employers, health plans and provider systems fulfilling both sides of the equation—more members and more efficient delivery—faster proliferation and development of ACOs will occur in the market. On a practical level, until ACOs become a more penetrating presence in the market and a prominent part of the provider networks offered by insurance companies, it is mostly larger and geographically concentrated employers that will be able to actively capitalize and push forward the ACO development and derive near-term value. Widely dispersed or smaller employers will likely be limited to securing value from the ACO movement as in Figure 1, waiting for the rising tide to lift all boats.

Health plans are developing funding models that allow different types of employers to participate, but the options open to specific employers will depend on their circumstances. For example, self-insured employers can participate in the upside or downside savings or costs on a pooled basis with other self-insured employers, and large employers with greater market influence may be able to demand an upfront premium credit, similar to the CalPERS experience.

Figure 4 illustrates how payments may flow to and from the employer from the ACO.

Even as the health care marketplace continues to evolve, employers will remain the primary avenue through which the majority of working-age people will receive their health insurance. There is some irony that possibly the most prominent emerging structural change in health care delivery is mostly having only a tangential effect on employers at this point.

However, while ACOs currently touch relatively few consumers, the changes that are occurring will impact the long-term trajectory of the health care cost curve and the perceived value of employee health benefits. As one of the key players of the commercial health care marketplace, employers should engage in whatever way their size and circumstances permit. The employer's role in the discourse and progression of health care delivery models will help guide the pace, direction and priority of change that payers and providers deliver, and how that change meets the needs of the employer community.

Endnotes

2. Ibid.