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5 questions to ask when considering an accountable care strategy

An employer checklist to understand, navigate and build a plan for value-based care.

By **Eric Parmenter** | May 16, 2018

With an annual employee health care spend that's approaching $1 trillion, self-funded employers

(https://www.benefitspro.com/2018/03/20/self-insured-plans-gaining-among-small-businesses/) are essentially operating mini insurance companies. Innovative companies are embracing their role as leaders in this employer-driven health care economy, and they are increasingly taking advantage of new approaches to managing their

employees' health. For instance, today, 96 percent of large employers offer telemedicine services, 54 percent offer onsite or near site health centers, and 21 percent have incorporated accountable care organizations (https://www.benefitspro.com/2017/02/14/studies-reflect-well-on-acos/) (ACOs) into their strategies—a figure that is projected to double by 2020, according to a recent survey by NBGH. These new approaches allow employers to break the traditional care model, improve health outcomes and the patient experience, and better control costs.

ACOs are organizations that empower health care provider groups, such as health systems and/or multi-specialty physician groups, to take accountability for the total cost and outcome of care for a population. While ACOs have been mostly promoted via the Affordable Care Act as a "value based" Medicare plan variant, the general concept has expanded to employer-sponsored health benefit plans.

ACOs represent an intriguing strategy where the buyers of health care, employers and their people who pay the bills, have aligned incentives with providers so that patients receive the right care, at the right time, at the right place, at the right cost, with the right outcome. This is what I see as the new *patient's bill of rights* in this employer-driven health care economy. The sellers of health care, after all, are the providers of care itself — hospitals and physicians. It seems obvious that buyers and sellers should negotiate the terms of their agreement so that the patient's rights are satisfied.

As more and more employers engage in accountable relationships with the providers through employer ACO (eACO) arrangements, a paradigm shift will emerge. Health care expenses will be managed as a long-term risk-based investment, rather than an annual cost-shifting exercise. When providers have skin in the game, employers can take a more strategic view of health care benefits and leverage the partnerships with the seller to effectively manage the population, reduce cost, and improve the health of your workforce.

In order to evaluate an eACO strategy, employers and consultants can use the following checklist to answer five basic questions:

1. **How do I know if my particular organization would benefit from an eACO?**

Consider the unique needs of your particular population. Maybe run a survey to gauge satisfaction in your existing health program, uncover gaps, and identify cost savings areas. Understand health trends in the area of the country you live in — research increasingly shows (https://www.washingtonpost.com/?utm_term=.96a07056c887)that where people live (or in this case, where your workforce is mostly located) can have a huge influence on their health. To that end, eACOs are not ideal for a highly distributed population but may make sense if you have at least 1,000 employees in a given market with a provider system capable of managing the health of a population. Once you've taken the time to assess these factors, you can more clearly understand how an eACO might benefit your organization.

2. **What should be our criteria when determining provider capabilities?**

First, it's imperative in face-to-face interactions that you can assess the willingness of a provider set to enter a risk-based partnership to contractually improve health outcomes and cost of the employee population (more on that in question five). CIN, which stands for Clinically Integrated Network, is an acronym to pay close attention to. In short, it's a group of physicians working together to harmonize the efficiency and quality of the care they provide. It's essentially the foundation that enables providers to build an ACO. Criteria to hone in on, which a consultant can help vet, include:

- An infrastructure in place to manage population health guided by value-based care principles;
- Unit costs that are more favorable than traditional carrier network rates for broad PPO networks; and
- Compensation models that reward providers for coordinated care, cost management, and reducing waste.

3. **Should we contract with ACOs directly?**

Contracting with providers directly may prove challenging for all but the largest employers. ACOs may not provide an administrative solution; if they do, integrating it into your larger health benefits back office can be a manual, time-consuming nightmare.

Companies should consider contracting with an administrative partner that can help you evaluate the components listed above, facilitate a relationship with your eACO provider partner, and easily plug that eACO into your company's broader benefits operations.

4. **How do we ensure our employees understand the arrangement and take advantage of it?**

An eACO won't provide much value if your employees don't use it.

First and foremost, you need a clear communications strategy when rolling out the eACO, which will most likely happen during open enrollment. Seize the opportunity to outline the eACO, explain the difference between it and other plan options, and the criteria that would make the eACO a good choice for care.

From there, you want technology solutions that makes it as effortless as possible for employees; companies that aren't utilizing new solutions that help their people engage with the right health benefits are behind the curve. In this case, a smart solution can:

- Help ensure that your employees understand the eACO on an ongoing basis—which providers are in that eACO network, how the costs compare to other options, and their choices if they can't have a specific care need met by the eACO.
- Drive employees to the eACO when they're seeking care, listing the eACO first in any search results, and helping them course correct when they aren't using the eACO. For example, flagging the eACO if they're making an appointment with an out-of-network provider, or pointing out an eACO would have been a more cost effective option on a post-appointment EOB.
- Make it as easy as possible for employees to access the eACO, from making appointments to paying for services.

5. **Are there standards for reporting from ACOs so we can determine effectiveness?**

The reality is that it's going to take time to establish standards for measurement. That doesn't mean you can't proactively take steps to ensure there's a return on this investment. For starters, going back to the first step in the checklist, it's imperative that you and your eACO partners determine and agree upon what you'll measure when entering the partnership. Some options to consider:

- Establishment of population-based clinical targets, such as reductions in admission and closing gaps in care;
- Service and care coordination standards that ensure ease of navigation and access;
- Member engagement in care management; and
- Member satisfaction, which can be assessed through a Net Promoter Score (NPS), a standard measure of satisfaction that looks at how likely employees are to recommend their respective eACO.

From there, your eACO partners should meet with your team quarterly to review results, monitor performance, and make adjustments. To help guide and refine this process, employers and consultants can follow developments from organizations that are tracking trends in this space and developing their own standard performance measures as they evolve.

In summation, adoption of widespread eACO strategies will drive employer-sponsored health benefits from high-cost, fee-for health care service reimbursement to accountable, quality health care at an affordable cost. This is the shift from volume to value, which is in essence, high quality health care at a lower cost and high customer satisfaction. By reducing the number of middle-men, creating accountable clinically-integrated networks of providers, and making health care easy for the end-user, employers will be able to save money that can be reinvested into other areas of their business.

Eric currently serves as National Leader of Value-Based Care at Collective Health (https://collectivehealth.com/). He is a 30 year veteran of the healthcare industry as an executive and consultant. As a Principal at Willis Towers Watson, Eric developed and grew the national Hospital Industry focus. He's a passionate advocate for change in our healthcare system, and his work has been featured in Reuters, Fox News, Inc Magazine and more.

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