Volume 6, Number 3 March, 2015

Accountable Care NEWS

ACO "Direct-to-Employer" Health Plans – WHY NOT?

By Jack Hill and Bret Petrick, CLU, ChFC, CSFS

There has never been a better time in this nation's history for medical providers to take control of the health care system than now. Health Care Reform has produced a number of challenges to the way that medical providers are paid, and the number one question is how you adapt while still remaining profitable.

One of the key opportunities available today is through the development of a health plan strategy with self-funded employers in your community. In the context of this article I will refer to medical providers as Accountable Care Organizations (ACO) but any type of provider organization can avail themselves of the strategies provided.

An ACO's payer mix and negotiated contracts with third party payers directly impact its financial stability. In most instances, commercial payments represent the greatest contribution to margin. The majority of an ACO's commercial payments are secured through managed care organizations and PPO networks where the ACO is a passive participant in the transaction.

When the PPO network or managed care organization is the intermediary in securing commercial business the ACO has little leverage in defining its relationship to the individual or employer purchasing health care coverage. In this system the ACO is nothing more than a discounted medical delivery system.

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In This Issue

Compatibility between Accountable Care and Workers Compensation

By Jacob Lazarovic, MD, FAAFP

First let's review the acronym glossary. Accountable Care Organizations (ACOs) were stimulated by the Patient Protection and Affordable Care Act (PPACA). A cousin of the ACO model is the patient-centered medical home (PCMH) model. And these, and similar delivery systems, are often described as value-based healthcare (VBH) models.

While similar to managed care models of yesteryear, VBH models comprise three critical elements:

- The medical entity bears financial responsibility for the health care needs of a defined population, employing shared savings and risk arrangements that "align the incentives" among all stakeholders.
- The entity coordinates and oversees the clinical provision of care across the continuum of all services required for the population being served.
- The entity provides measured outcomes relating to both cost and health, ideally achieving both medical expense reductions and superior clinical results.

It is recognized that successful ACOs require both a sophisticated administrative infrastructure to manage care effectively, as well as robust information technology systems that collect data seamlessly across the system and deliver meaningful reporting and analytics. ACOs have proliferated rapidly since their inception in 2010. As of June 2014, there were said to be approximately 626 ACOs across the country, although there is considerable variation in industry statistics as reported by multiple sources.

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Innovation Drives Unique Care Model for Active and Frail Older Adults

By Balu Gadhe, MD

Wellness can be a tricky thing. Even when you're feeling well, there may be complications just under surface, waiting to appear. What if there were a way to identify these potential issues before they flared up into something more serious? The benefits would be extraordinary, not just in how you feel right now, but also in the ways you are able to maintain your ideal level of health for years to come.

It could stop injury, hold off chronic illness -- even save your life. If it sounds like a fantasy, it isn't. In fact, it's the cornerstone of CareMore's prevention-driven approach to healthcare, and it works. At the root of CareMore's success is a proven model of care that brings each member into hyper focus. To illustrate how it works, imagine yourself at the center of a wheel.

The truth is, people really can have more energy, more strength, and more confidence at any age when they work out. … We bring together proven science, state-of-the-art equipment and a fun, clinically supervised atmosphere to help you turn back the clock. And once you get started, it's a habit you won't want to break.

CareMore provides the support that constantly surrounds you: our network of trusted primary care physicians, a care team of skilled Nurse Practitioners, and exclusive settings for your care and fitness needs. We seamlessly coordinate all of these efforts to ensure that the wheel is always turning in the right direction and toward your best possible health.

Health care isn't just a matter of going to your doctor twice a year or taking your medicine as directed. CareMore believes that it's a journey, and every journey needs a destination -- a place where seniors can meet along the path to lifelong wellness, a brick-and mortar setting where they can receive comprehensive care, but also a springboard for something more. Like forging new friendships, learning the latest in healthy living and understanding how the daily decisions you make can affect your long-term wellbeing. At CareMore, we have created that destination.

Rolling back some of the effects of time isn't easy, but what if we told you it was? The truth is, people really can have more energy, more strength, and more confidence at any age when they work out. You can improve mobility and rebuild the balance that prevents injury from falls. You can sharpen your memory and stimulate your mind. You just need the right resources and the desire to be your best possible self. We bring together proven science, state-of-the-art equipment and a fun, clinically supervised atmosphere to help you turn back the clock. And once you get started, it's a habit you won't want to break.

CareMore, a subsidiary of Anthem , has developed a model of care that is known for identifying the physical, mental, and social needs of older adults and other populations, and then developing innovative programs to address them successfully. The company serves more than 80,000 Medicare members throughout Southern California, Northern California, Las Vegas, Phoenix and Tucson, Ariz., and Richmond, Va. under three federally-approved Medicare Advantage contracts.

CareMore also is participating in a dual demonstration project in parts of Los Angeles County, in conjunction with state and federal regulators, to coordinate care for people eligible for both Medicare and Medicaid. Additionally, CareMore operates a medical group and offers its proven clinical and health technology models to third parties through various subsidiaries.

The CareMore Care Centers are a new type of medical facility for older adults, from the chronically ill to the healthy-aged, that will serve as the hub for medical care as modern as digital remote monitoring patient technology to good-old fashioned regular check-ups. Instead of having patients travel all over the area to see different doctors and specialists for medical care, the Care Center medical teams revolve around the patient in a one-stop facility.

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The Care Centers feature primary care medical services as well as podiatry, mental health services, diabetes management, wound management, a hypertension program, prevention services, and many others. The Care Center serves as the centerpiece for our smart patient technology that allows our doctors and team members to monitor patients' health from their home each day.

A patient with hypertension, for example, will be fitted with a blood pressure device that they will use at home, and it will send the patient's blood pressure each day to our doctors via remote technology. If the patient's blood pressure is high, we will call the patient and make adjustments in their medications immediately or have them see a doctor right away.

This technology is reshaping patient care for the older adult." Through these services, CareMore seeks to preserve costs and help seniors live longer, more independent lives.

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Innovation Drives Unique Care Model

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With delivered proven results in managing high risk populations, including people with kidney disease, heart disease and diabetes, there is an increasing demand for quality solutions like those that CareMore provides. Over the years organizations nation-wide have expressed interest in learning how CareMore works to improve the health of people with chronic conditions while also containing costs. To answer this, CareMore plans to roll out two new products that will teach providers, payers, and other health care organizations how to implement the most impactful, economical portions of the CareMore model. CareMore will oversee these programs which will provide the knowledge, operating model, and technology necessary to help organizations effectively manage their high-risk Medicare and Medicaid members.

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One new product will allow CareMore clinical team members access to high-risk patients of other organizations to provide coordinated and specialized care. Through these new products, CareMore will be able to help patients outside of their Medicare plans benefit from a quality care model and lower costs.

With seniors becoming the largest growing demographic in the United States, CareMore has also been hard at work expanding its network to accommodate new patients who qualify for the Medicare and Medi-Cal programs. The Cal-Medi Connect program is a recently launched state initiative designed to coordinate medical care for those who are eligible for both Medicare and Medi-Cal (also called “dual eligibles). CareMore is one of five plans in Los Angeles that was selected to provide care for Cal MediConnect members.

As part of its growing footprint to improve access to these patients, CareMore will provide members with greater access to its network of Care Centers, where members can manage their health. The Care Centers offer medical evaluations by licensed clinicians and access to programs that help members better manage chronic diseases such as diabetes and heart disease. CareMore’s Cal MediConnect plan includes a “healthy start” introductory visit, a 24-hour nurse hotline, and transportation to health care resources.

In 2014 CareMore’s Medicare Advantage Plans were recognized as one of the top two plans in California by *U.S. News & World Report*, creator of the highly-recognized "Best" series of consumer guides.

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ACO “Direct-to-Employer” Health Plans

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Employer-sponsored health insurance covers about 149 million nonelderly people in the US according to the 2013 Employer Health Benefit Survey conducted by Kaiser Family Foundation (Kaiser) and the Health Research & Educational Trust (HRET). For the ACO, the employer-sponsored segment of its commercial business is substantial. With the advent of the Accountable Care Act (ACA) there are increased uncertainties and escalating costs for employers that continue to offer a group health plan. Other key market forces indicate that:

- Employers are looking to establish direct relationships with medical providers to improve quality and reduce costs
- Employers are becoming more frustrated with the lack of information when rate increases are being presented
- Refugees from the fully-insured marketplace are looking at self-funding alternatives
- Employees are increasingly becoming less satisfied with their health benefit plans
- 57% of health plans are self-funded today, an increase of nearly 30% in the past ten years
- There is very little risk management in the marketplace to manage and understand the key elements affecting healthcare quality and cost

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An ACO can take advantage of current market conditions by developing a direct-to-employer contracting strategy. Key benefits to this strategy may include:

- Securing direct reimbursement terms through gain sharing, plan management revenues, increased revenues through payment of certain disease management regimens of care, and reduction in outmigration of services through plan design and plan steerage
- Directly having a voice in the development of protocols and procedures with regard to case management, regimens of care, referral authorizations, plan design parameters and use of nurse managers to effectively engage in population health management in order to positively impact employers’ healthcare budget.
- Disintermediate commercial payers in order to better negotiate current reimbursement contracts

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