A Path to Accountable Care

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With all the attention being paid to emerging accountable care organizations throughout the country, a California model is delivering measurable results. Catholic Healthcare West (CHW) (now Dignity Health), Hill Physicians Medical Group, and Blue Shield of California had preliminary conversations in early 2007 to find ways to work together that could lead to material improvements in the delivery system. They envisioned a delivery model that realigned incentives between the hospital, medical group, and health plan to promote cooperation and integration in a financially viable way for all parties. This model also incorporated aggressive cost-saving initiatives to reduce waste and duplication, not just shift cost within the system.

The parties would accomplish this vision through:

- **In-depth population assessment**: Identify cost drivers and develop interventions based on clinical best practices to address those costs.
- **Data sharing**: Share clinical and case-management information in order to remove redundancies.
- **Cross-organizational collaboration**: Assemble a multi-organizational and multi-disciplinary team to establish a baseline of current processes and develop new, integrated, innovative care processes tailored to the care needs of the population and to the individual patient.

CHW, Hill, and Blue Shield launched the pilot with the California Public Employees’ Retirement System (CalPERS) in January 2010. The pilot covered more than 40,000 Blue Shield members assigned to Hill in the greater Sacramento region. This represented about 75 percent of the CalPERS member population and accounted for about 75 percent of all dollars being spent for hospital services in the Sacramento area.

By the end of the year, the collaboration achieved $15.5 million in savings, which translated to no premium increase for CalPERS members in 2010. The savings largely resulted from a 15 percent reduction in inpatient readmissions and a 15 percent reduction in inpatient days utilized. Further, inpatient stays of 20 or more days were reduced by 50 percent. These, of course, tended to be catastrophic cases and often the most expensive hospital costs per day.

The foundation for these results is a three-way risk arrangement that plays a key role in keeping the parties aligned. The arrangement puts each party at financial risk for meeting per-member, per-month (PMPM) cost targets spanning institutional, professional, pharmacy, and ancillary services. Since each party has both upside and downside potential for health care ex-
penditures, each is incentivized to cooperate rather than compete for revenue.

It is encouraging to see such outcomes achieved in a network-model environment. Since most insured people in the United States have coverage in network-model health plans, it is critical that solutions evolve in network plans if there is to be any hope of achieving affordable access to quality care for all Americans.

As the parties continue to introduce new initiatives to improve quality and reduce cost, this approach promotes continuous learning and system improvement. This model can be replicated as long as the partners are willing to build trust and share data in order to achieve mutual goals that integrate care, improve quality, and reduce cost.

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Note: Authored commentaries in this IOM Series draw on the experience and expertise of field leaders to highlight health and health care innovations they feel have the potential, if engaged at scale, to foster transformative progress toward the continuously improving and learning health system envisioned by the IOM. Statements are personal, and are not those of the IOM or the National Academies.

In the context of a growing focus on Accountable Care Organizations, Bruce Bodaken describes economic savings and performance improvement through delivery model reforms that realigned activities and incentives among inpatient, outpatient, and payer stakeholders. His discussion touches on several issues and lessons central to delivery of care that is effective, efficient, and continuously improving, including the importance of:

- Taking advantage of network-model care to shift incentives toward continuous improvement.
- Ongoing, cooperative assessment of the use patterns and cost drivers for the population served.
- Transparency and data sharing among stakeholders.

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