

# A Pathway for Coordinated, Affordable Employer-Sponsored Health Care

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### KEY TAKEAWAYS

- Advancing employee health and well-being is more important than ever, and employer-sponsored health care is falling short. Barriers remain to getting the care employees need to stay well, persistent inequities in health care and health, and rising costs. A key reason is that care depends on “fee-for-service” payment, leading to poor coordination, insufficient support for staying well, inconvenient access, and lack of transparency about quality and cost. But evidence on emerging reforms shows how to overcome these challenges and deliver high-quality, coordinated and affordable care for employees and their families.
- Employers have invested in numerous initiatives to lower costs and improve care, but the majority have focused on partial reforms. Now, employers are seeking more comprehensive partnerships with health care providers to deliver better care, on a foundation of per-member per-month payments that promote greater flexibility and coordination, accountability for achieving key quality goals, avoidance of costly complications, and improving patients’ care experience.
- Public health care programs, such as Medicare and Medicaid, face similar challenges and have seen similar modest impacts from incremental payment reforms. However, some promising models, including Medicare advanced accountable care organizations (ACOs) and Medicare Advantage accountable contracts with advanced primary care providers, can help show how to succeed in transforming care and create new opportunities for the public and private alignment on health care reform.
- Building on lessons from prior reform efforts, more rapid transformation is possible to provide comprehensive, coordinated care with advanced primary care. The Morgan Health-Vera Whole Health partnership shows how employers can collaborate with leading primary care organizations to build needed capabilities, supported by person-centered, accountable payment reforms, to deliver high-quality care to employees at a lower cost.

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## OVERVIEW The Urgent Need for Employer Leadership to Improve Health Care

Employer-sponsored health coverage remains the main source of health care support for America's working families, but it faces increasingly difficult challenges: barriers to many employees in getting the care they need to stay well, persistent inequities in health care and health, and rising costs. A key reason is that care depends on "fee-for-service" payment, leading to poor coordination, insufficient support for staying well, inconvenient access, and lack of transparency about quality and cost. But evidence on emerging reforms shows how to overcome these challenges and deliver high-quality, coordinated and affordable care for employees and their families.

Advancing employee health and well-being is more important than ever, and employer-sponsored health care is falling short. Costs continue to rise; [in 2020](#), the average annual premium for employer-sponsored insurance was \$7,470 for single households and \$21,342 for families – a 55 percent increase since 2010 and 22 percent since 2015. Employers pay hospitals [an average of 247 percent of Medicare prices](#) and over 300 percent in some markets. Large employers typically [lack the market power](#) to manage these costs by seeking to negotiate lower fee-for-service (FFS) rates. Instead, many have tried shifting costs to employees through higher deductibles and copays. However, these blunt approaches have caused employees to cut back on both [necessary and unnecessary care](#).

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Adding to the challenge of affordability, employees also face obstacles to receiving care that is personalized, convenient, and effective in helping them stay well and manage risk factors or chronic diseases. Effective primary care is the foundation of well-coordinated, prevention-oriented care. But less than two thirds of adults under 60 [have a regular relationship](#) with a primary care clinician, with even lower rates for Latino, Black, and Asian Americans, and these rates have continued to fall over the past decade. Medical Expenditure Panel Survey data indicates that only 55 percent of privately insured individuals report a regular, office-based source of care, with the remainder either lacking any source of care or receiving it from a hospital.

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Examples exist around the country of better care models, specifically primary care integrated with easy access to more comprehensive care that includes the availability of telehealth, home-based care, and behavioral health care. The COVID-19 pandemic has further highlighted the importance of comprehensive, coordinated care. Throughout the pandemic, people receiving care from integrated care systems had [access to more advanced virtual and community-based care](#). However, most Americans [still receive "fee for service" care](#), which offers limited resources to coordinate care

and support patients outside of health care facilities. As a result—alongside the hospitalizations, deaths, and long-term consequences of COVID-19—[cancer screening has declined](#); [rates of chronic disease risk factor control have worsened](#); more people are experiencing depression, [anxiety, and other unmet mental health needs](#); and [disparities in health outcomes widened](#) for ethnic minority and low-income populations.

Overall, too few employees have access to health care that:

- Is affordable and sustainable;
- Focuses on paying for and supporting better health rather than poorly coordinated medical services;
- Keeps individuals and families healthy by supporting prevention and addressing risk factors;
- Provides ongoing access to high-quality primary care at home and virtually;
- Ensures timely, well-coordinated, expert care for specialized needs; and
- Reduces racial and ethnic disparities in health by ensuring all employees can benefit.

Changing this status quo requires advanced primary care practices that bring together a range of capabilities, including:

- Using advanced data analytics to track and anticipate individual health needs and addressing those needs with minimal duplication and delays;
- Providing home-based, virtual care, augmented by digital applications and tools to promote personal health and wellness;
- Care coordination that allows for timely and rapid referrals for high-quality specialty care when needed;
- Delivering culturally competent, team-based care that focus on what matters most to employees and their families; and
- Building relationships with community organizations to improve access to social supports and other interventions that address broader social drivers of health.

A growing number of successful examples show that advancing robust, [well-financed and comprehensive](#) primary care could better address employee needs. Such models use person-level per-member per-month payments or direct contracting, both of which include provider accountability for achieving key quality goals, avoiding costly complications, and improving patients' care experience. With payments no longer attached to specific services or the volume of care provided, primary care organizations can realize transformative care models that improve health at lower costs.

Building and scaling these models, however, requires employer leadership to adopt innovative programs that drive change away from status quo, fee-for-service, uncoordinated, costly, and inconvenient care and deliver the coordinated, person-centered, affordable, high-quality care employees need.

In this report, we describe how employers can implement a strategy to transform care. We explain why some previous reforms aiming to improve employee health care have fallen short, achieving only incremental progress at best, and how a more comprehensive approach can build on lessons learned from previous reform efforts. We connect these challenges to the similar ones faced by Federal and state governments in implementing health care improvement initiatives. With this context, we highlight efforts by Morgan Health and Vera Whole Health, along with other leading employer reform initiatives, and describe the potential of these efforts to succeed in delivering high-value coordinated care, and to help drive system-wide progress to make coordinated, affordable, high-quality care more widely available for employees and their families.

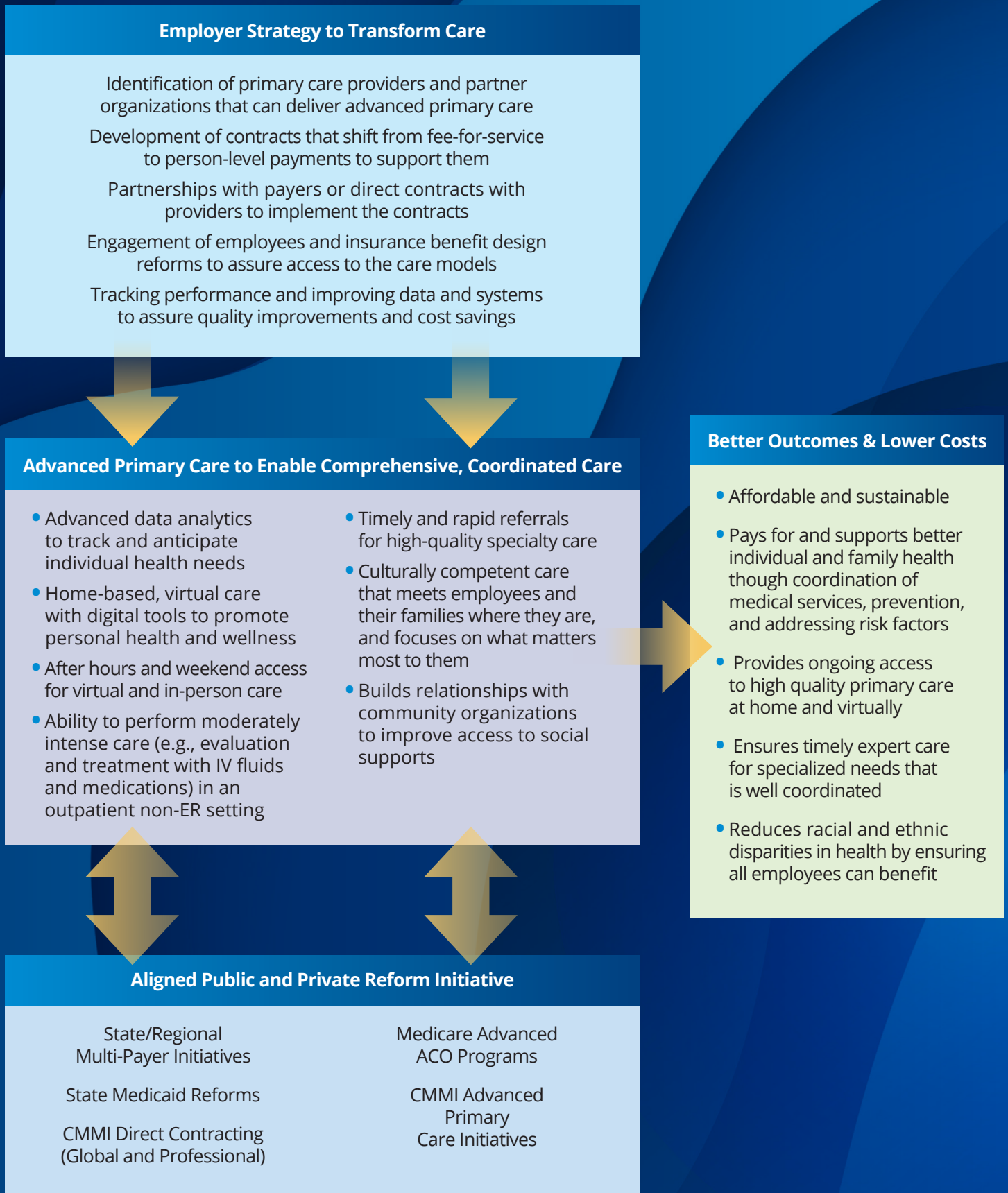
## OVERVIEW **Advanced Primary Care Delivers Coordinated, Affordable, Equitable Health Care for Employees and Families**

Employers can improve health care access and outcomes, increase equity, and reduce total costs by implementing a strategy that uses advanced primary care to enable comprehensive, coordinated care for employees and their families.

Both small and large primary care practices and established health systems have implemented comprehensive care models with supportive infrastructure and financing. Figure 1 summarizes how employers can take steps to make comprehensive care more widely available to their employees. While most primary care providers and health systems do not yet have the capabilities described, employers can partner and engage established comprehensive care providers or third-party organizations that work with them to build these capabilities. Changes in payment from fee-for-service to accountability for total costs and outcomes will advance providers ability to adopt comprehensive care capabilities. These new partnerships can be implemented through contracts administered by private insurers that are willing to shift their focus from traditional claims processing to payment models that create support and accountability for better person-level care and lower total costs. Alternatively, employers can contract directly with the health care providers. Achieving “critical mass” of participating employers and providers to drive change is difficult, even for large employers, but timely opportunities exist for alignment across employers and with Federal and state initiatives that have similar goals.



Figure 1.



## Previous Efforts to Provide High-Quality Coordinated Care for Employees: Promising Reforms, Limited Scope

Employers have invested in numerous initiatives to lower costs and improve care, but the majority have focused on partial reforms. Employers now are seeking more comprehensive partnerships with health care providers to deliver better care, with a foundation of advanced primary care capabilities, accountability for results, and a greater shift from fee-for-service payment.

Employer efforts to improve care are not new, with employers across the country [investing in a wide range of steps](#) designed to improve the quality and coordination of care and help reduce costs. **Table 1** compiles these approaches, with examples and the evidence of their impact.

Many employers have established on-site or near-site clinics, often coupled with telehealth initiatives, to improve access to preventive care, primary care, and wellness supports. Some employers have implemented these clinics on their own, while others have contracted with organizations like [Premise Health](#) and [Crossover](#). So far, the limited published evidence suggests that such clinics are associated with [small](#) cost savings, although some case studies have reported more substantial results. The key challenge for these clinics is that their services are typically more effective and practical for lower-risk patients and acute needs, and the clinics are often not well coordinated with longitudinal advanced primary care models or with an employee's specialized care needs.



**Table 1. Employer-Driven Efforts to Improve Care and Lower Costs**

Program Type	Features and Goals	Example Results and Challenges for Scaling	Uptake and Example Implementers
Employee Wellness Programs	Interventions and supports outside of traditional medical settings designed to help employees adopt and sustain behaviors that reduce health risk factors and improve quality of life.	<p><b>Results:</b> Greater engagement and improved health behaviors, but variable evidence on whether wellness programs impact cost and health outcomes.</p> <p><b>Challenges:</b> Many participants are already low-risk, and those facing greater health barriers may need more comprehensive support than a wellness program provides.</p>	<p>In 2019, 58 percent of employers offered wellness programs, and <a href="#">84 percent</a> of large employers offered workplace wellness programs.</p> <p><b>Example Implementers:</b> <a href="#">Google</a>, <a href="#">Microsoft</a>, <a href="#">Optum</a></p>
Onsite/Near Site Clinics	Preventive screenings, immunizations, chronic condition management, and employee health and wellness coaching delivered by clinicians at or near the employer location.	<p><b>Results:</b> Some employers have reported positive results in using onsite or near-site clinics (such as reductions in overall costs or ED usage).</p> <p><b>Challenges:</b> Improved access and savings often involve lower-risk patients, and challenges exist in scaling to medical care beyond core primary care.</p>	<p>In <a href="#">2019</a>, 20 percent of employers offered an onsite health clinic while 7 percent offered near-site or multi-employer health clinics.</p> <p><b>Example Implementers:</b> <a href="#">Premise Health</a>, <a href="#">Crossover</a>, <a href="#">Marathon Health</a>, <a href="#">Vigilant Health</a>, <a href="#">USAA</a>, <a href="#">Goldman Sachs</a>, <a href="#">Capital One</a></p>
Virtual Care Platforms	Virtual care allows care to be received at an individual's home through video visits, audio-only visits, remote monitoring, and digital technologies.	<p><b>Results:</b> Limited evidence so far.</p> <p><b>Challenges:</b> Identifying the right mix of virtual and in-person services to impact cost and quality, and effective coordination with other components of an employee's care.</p>	<p>In <a href="#">2020</a>, 76 percent employers offered telephonic and 72 percent offer video-based virtual care visits.</p> <p><b>Example Implementers:</b> <a href="#">Amazon Care</a>, <a href="#">CVS Health-Aetna</a></p>
Centers of Excellence (COE)	Specific provider organizations deliver certain interventions or care for certain conditions or procedures (e.g., spine pain, nonurgent cardiac procedures, cancer treatment). Often accompanied by consumer-facing financial incentives (e.g., lower co-pays, travel support) and prospective bundled payments to providers.	<p><b>Results:</b> Several employers report lower surgery rates under COE programs, as the expert clinician in the COE finds the surgery was not appropriate for the referred person. Other COEs report fewer complications and lower post-acute care costs (e.g., SNF, readmissions) due to greater expertise in the given procedure.</p> <p><b>Challenges:</b> COEs involve important areas of specialized care but these only account for a minority of patient health needs and medical costs.</p>	<p>In 2019, <a href="#">45 percent</a> of employers offered COEs within their health plans.</p> <p><b>Example Implementers:</b> <a href="#">Walmart</a>, <a href="#">Lowe's</a>, <a href="#">Boeing</a>, <a href="#">General Electric</a>, <a href="#">Employers Centers of Excellence Network (ECEN)</a></p>
Care Navigation	Services that help patients access and coordinate health care.	<p><b>Results:</b> Some care navigation services have been shown to reduce costs for employers.</p> <p><b>Challenges:</b> Access to sufficient data to identify relevant providers and ensure those providers have capacity for new patients.</p>	<p>In 2020, <a href="#">60 percent of employers</a> offered programs to help navigate the health care system.</p> <p><b>Example Implementers:</b> <a href="#">Grand Rounds</a>, <a href="#">Costco</a>, <a href="#">Walmart</a></p>
High Performance Networks (HPNs)	Identifies specific providers, based on quality and cost metrics, to create a more targeted, high-quality care network designed to lower costs. Can also link provider reimbursement to network's financial results.	<p><b>Results:</b> Limited published evidence so far.</p> <p><b>Challenges:</b> Tighter networks can increase employee use of higher-quality or higher-value clinicians, but it can be challenging to measure performance reliably and coordinate care well across the network and to scale for sufficient employee access.</p>	<p>In 2019, HPN usage was at <a href="#">16 percent</a>.</p> <p><b>Example Implementers:</b> <a href="#">BCBS Association</a>, <a href="#">Walmart</a></p>
Direct Contracting with Accountable Health Systems	Direct contracting or "direct-to-employer" arrangements with provider systems based on alternative payment models with accountability for outcomes and total costs can help employers achieve better outcomes and lower costs.	<p><b>Results:</b> General Motors reported savings of 17 percent per-member, per-month in its direct contracting program and saved 14 percent over its 2020 goal.</p> <p><b>Challenges:</b> Difficult to establish "critical mass" and administer for all but the largest employers.</p>	<p>In 2018, <a href="#">7 percent</a> of employers reported using direct contracting.</p> <p><b>Example Implementers:</b> <a href="#">General Motors</a>, <a href="#">ConnectedCare</a></p>



Employers also have seen promising results from specific reforms that target common high-cost services and conditions. Centers of Excellence identify high-value providers for procedures such as joint replacement, spinal surgery or cancer treatment, and use alternative payment models for providers and financial incentives for employees to encourage their use. As an example, Walmart's [Centers of Excellence](#) program, which covers 100 percent of employee costs for using a preferred provider, saw 15 percent lower costs for joint replacement among participating members, better outcomes, and less time spent in the hospital. [One in five](#) employers overall reported using similar Centers of Excellence models. Many employers have changed how they pay providers participating in Centers of Excellence or similar specialty care models, with third parties like [Carrum Health](#) and [Signify Health](#) assisting employers in implementing bundled payments with accountability for outcomes and costs across the entire specialized care episode. While these models have impacted specific high-cost, high-variation areas of care, they are limited in scope to particular procedures or conditions, and do not necessarily coordinate well with primary care or include steps to prevent underlying conditions from progressing to the point where patients need specialized services in the first place.

To address these coordination issues, employers also are taking steps to improve convenience and help employees navigate the health care system. About [three-quarters of employers](#) are now offering medical decision support tools and second opinion services. Third parties like [Grand Rounds help connect](#) patients to experts for second opinions in areas such as oncology and musculoskeletal care. Costco, a Grand Rounds client, [found that 60 percent of employees](#) using Grand Rounds for a second opinion saw a change in their diagnoses.

A similar strategy is identifying a strong network of providers, which can make it easier for employees to find high-quality or high-value clinicians. A Blue Cross Blue Shield [report](#) found that 16 percent of employers use these types of tools. However, these tools are often focused on specific costly care decisions (like COEs) not on a patient's comprehensive experience with care, and are not integrated with a patient's primary care provider who should be a trusted and critical source of support for care coordination.

Given the potentially important but limited impact of each of these approaches, some employers now are seeking to develop more integrated provider support for their efforts to improve employee health. [Direct contracting](#) with health care providers using alternative payment models can provide the aligned financial support needed to sustain efforts to improve quality and lower costs. For example, General Motors' [ConnectedCare](#) has results-based contracts with Henry Ford Health System, with administrative support from Blue Cross Blue Shield Michigan. Under this approach, Henry Ford Health System has contracted to provide hospital, outpatient, behavioral health, pharmacy and physician services, as well as an employee help line, all linked to financial accountability for improvements on 19 quality and cost measures. The measures include timely access — same day appointments, specialist appointments within 10 days, and telehealth options — as well as a 24/7 “concierge” line to help employees navigate and obtain the support they need, and metrics related to health risk factors and outcomes for common health problems. The health plan option using ConnectedCare is also the least costly benefit choice for employees, encouraging participation. The company [reported](#) a 17 percent per-member, per-month savings compared to its initial target in 2020 and a 14% saving above its goal.

While direct contracting that moves away from fee-for-service payment represents a more comprehensive approach to addressing employee health needs while reducing costs, the reality is that most employers today do not have the operational supports they need to contract with health care providers using such models. The contracting process and development of capabilities needed for success, like agreement on key metrics and timely data sharing and care reforms to support improvement, can be costly and challenging to implement. While strong primary care is the foundation for such comprehensive care models to succeed, employers may face a range of barriers in implementing these models, as we describe below.

Despite these obstacles, employers are increasingly concluding that, while each of these individual strategies can be helpful, success requires a more comprehensive approach to deliver optimal health care that builds on a foundation of advanced primary care. About

51 percent of [large employers](#) have said they are planning to implement at least one [advanced primary care strategy](#) in the next year. This effort will likely coincide with a [focus on virtual care](#) and identifying cost-effective and high-quality ways to supplement in-person care. The [Purchaser Business Group on Health](#) is supporting these efforts by [defining attributes](#) of advanced primary care and creating an aligned set of accountability measures to use in future employer contracts with health plans and providers. With an

effective strategy behind these efforts, and through related efforts, such as taking steps to achieve “critical mass” through alignment with similar reforms across employers and public payers, employers may be able to help primary care practices and other providers move further and faster away from fee-for-service, enabling high-value, coordinated care models to succeed.

## Overcoming Key Challenges in Implementing High-Value Coordinated Care Reform: Implications from Medicare Experience

Public health care programs, such as Medicare and Medicaid, face similar challenges and have seen similar modest impacts from incremental payment reforms. However, some promising models, including Medicare advanced ACOS and Medicare Advantage accountable contracts with advanced primary care help show how to succeed in transforming care, and create new opportunities for public-private alignment.

The trajectory of employer-sponsored initiatives to transform payment and delivery toward more comprehensive approaches that rely on advanced primary care aligns with the experience of other parts of the health care system. In particular, the traditional Medicare program, and especially the Medicare Advantage program, have seen considerably more movement away from fee-for-service payments to support adoption of advanced primary care and accountable coordinated care models. But progress and expanded access to date has been slow; most Americans still do not have access to such models.

Across the public and private sectors, a [recent Duke-Margolis Center review](#) found that reforms in payment and care have been limited:

- Payment reforms to date have been relatively modest moves away from the traditional fee-for-service payment approach, only producing incremental shifts in health care delivery;
- As a result, most programs have seen small cost savings and small quality increases;

- Most primary care groups still lack the infrastructure and capabilities to support high-quality, advanced coordinated care models; and
- Efforts by the Federal government, largely through Medicare, to work with interested employers and health plans have been limited and, with the exception of a few state-led efforts, have mostly failed so far to reach a critical mass of advanced payment reforms in particular markets.

Medicare’s ACOs programs (especially the Medicare Shared Savings Program) illustrate the promise of payment reform but also the challenges. [One review](#) found most ACOs outperformed in areas like depression screening and hospital readmissions, and another [review](#) of high-performing Medicare ACOs found they spend more money on primary care to help coordinate patient care and keep them out of the hospital. Further, [more ACO patients report](#) timely access to care and higher patient satisfaction with

clinician communication. Some of the most advanced ACO models, such as the NextGen program, [have demonstrated](#) greater savings than those that have not moved as far from FFS payment. However, implementing these models [takes time](#), especially if organizations lack upfront resources to invest in the essential competencies for success or partners that can provide the needed capabilities. Medicare ACOs [typically need around three years](#) to start showing savings, with quality metrics also [generally improving over time](#).

These examples also highlight the technical challenges in designing an arrangement around financial risk that can be mutually beneficial; how much money an organization saves depends on the financial benchmarks the organization is compared against and the amount of shared savings distributed to health care delivery organizations. The structure of a model can cause organizations to change their care patterns and reduce financial expenditures, but not lead to net savings for the payer if the incentive payments are higher than the generated savings.

Medicare Advantage health plans and their contracted primary care groups and health systems have a higher rate of use of comprehensive care models, allowing for greater flexibility to sustain integrated, comprehensive care models. Plans are paid on a capitated, risk-adjusted basis with significant additional payments and incentives linked to performance metrics related to quality and patient experience, providing substantial incentives to work with health care providers to improve quality while reducing costs. ChenMed and Oak Street Health are examples of two advanced primary care groups that now provide care to millions of Medicare Advantage patients across the country under these person-level accountable payment arrangements. In 2017, ChenMed [reported](#) 30% fewer ER visits and 28% fewer hospital admissions, while Oak Street Health [reported](#) lowering admissions by 50 percent and ED visits by 52 percent. Both organizations support primary care providers that serve smaller panels of patients than average practices, giving clinicians more time with patients, and offering virtual and after-hours opportunities to facilitate conversations when patients need them. Notably, these organizations required [substantial private capital](#) to build the capabilities needed for their care models to succeed.



Recently, the Centers for Medicare & Medicaid Services (CMS) [affirmed a conclusion](#) similar to that of many employers from the experience with payment and care reform to date: Coordinated and integrated care built on advanced primary care should be the goal of health care innovation to improve outcomes, including greater health equity, and that achieving this goal requires more comprehensive shifts away from fee-for-service into accountable payment models supported by the robust infrastructure needed to deliver high-quality, comprehensive care. This goal also requires broader coordination across stakeholders to move in the same direction. New initiatives like CMMI's [Global and Professional Direct Contracting model](#), along with state initiatives like North Carolina's [Healthy Opportunities Pilots](#) or Maryland's [Primary Care Program](#), can help build a critical mass of participants in comprehensive care models working to improve health across patient populations.

## New Morgan Health-Vera Whole Health Partnership

By building on lessons from prior reform efforts, more rapid transformation to deliver comprehensive, coordinated care with advanced primary care is possible. The Morgan Health-Vera Whole Health partnership shows how employers can collaborate with leading primary care organizations to build needed capabilities, supported by payment reforms and accountability, to deliver high-quality care to employees at a lower cost.

In partnership with [Vera Whole Health](#), Morgan Health aims to address payment reform challenges in ways that can improve care experiences, outcomes, and affordability, using a foundation of advanced, coordinated, comprehensive primary care. The Vera model aims to help organizations build diverse provider teams and offer a comprehensive range of services, with person-centered payments offering greater flexibility to deliver the care providers feel patients need. The Morgan Health-Vera partnership will help organizations specifically build the infrastructure needed to support comprehensive care models, create meaningful accountability based on total cost of care, pay providers in more flexible and sustainable ways, and focus on reducing disparities and barriers that will allow greater health gains for all. The model includes the following elements:

***The Morgan Health-Vera partnership will help organizations specifically build the infrastructure needed to support comprehensive care models, create meaningful accountability based on total cost of care, pay providers in more flexible and sustainable ways, and focus on reducing disparities and barriers that will allow greater health gains for all.***

- Direct employer partnership with independent primary care practices:** Morgan Health aims to add to the Vera model and work directly with local, independent primary care practices, such as Central Ohio Primary Care, to design and implement the integrated, broad-based infrastructure (e.g., behavioral health specialists, care coordinators, health coaches, ED alternatives/hospital coordination, population health analytics) required for primary care practices to manage holistically the health of an attributed plan member population. Vera reports its direct-to-employer primary care model has driven 10-15 percent in actual per member per month claims improvement, and improved quality in areas that include cholesterol, triglyceride and LDL control improvements.
- Enhanced and Accountable Primary Care Provider Reimbursement:** Under this primary care-led population health model, care teams will be responsible for the management of the total cost of care for an assigned population. Moving away from FFS reimbursement towards a person-level, capitated model aligns incentives between self-funded employers and providers, but also enables reimbursement for enhanced primary care services (e.g., team-based care, better support at home, care coordination, referral management) that are not typically captured in current FFS payment models. The additional resources, long-term planning and collaboration, and infrastructure investments enable primary care providers to succeed in shifting towards “upstream” and comprehensive care. In one market, Vera reported over \$3M in savings compared to a competitive product in the market—all while driving stronger engagement and member satisfaction.

- **Focus on health equity:** The Morgan-Vera partnership includes a deep commitment to measure and support providers in reducing health disparities. This effort requires developing new provider capabilities including (a) care delivery models that adapt to meet unique needs of all individuals in a local community and (b) performance guarantees structured on their ability to deliver on improving metrics related to health equity.

Moreover, it requires new employer capabilities to support the secure and trusted exchange of key data among health care providers to identify and understand the needs of their plan members, and to assure that those needs are effectively addressed.

## Overcoming Additional Challenges Facing Employer High Value-Coordinated Care Reforms

Employers need to address a set of challenges in implementing these reforms: engaging employees; developing new capabilities, including use of reliable and timely data to drive improvements; overcoming barriers to the new contracts with providers; and achieving critical mass for changing health care in a market.

As more employers aim to move towards high-value, coordinated care, they must overcome some important challenges in implementation. For example, employee turnover may limit the ability of employers to benefit from investments in moving care upstream and supporting strong care coordination. However, investments can still be valuable, especially if the programs these investments support have benefits that employees recognize or if they increase confidence that employers are committed to help them and their families stay healthier, not just keep health care costs down. Prevention and wellness initiatives [ranked in the top three](#) of employees' most desired benefits, and advanced primary care can improve upon these programs and further approaches and reduce the chance of disease progression.

Employers will need to create aligned benefit reforms and other incentives to encourage employees to engage with comprehensive care providers. While employees clearly value their health, they may not be confident in the value of a new or augmented source of primary care, and may be skeptical that their care will be better and lead to lower out-of-pocket costs. Employers can offer incentives as well, such as eliminating co-pays

for using providers who participate in delivering advanced primary care and coordinated-care networks, and enhancing the impact of such benefit reforms by providing reliable evidence of better care on the actual experience of care of employees.

However, many employers face challenges in generating the kind of reliable, complete, and timely data necessary to identify where health care performance can improve, implement needed reforms to make those improvements, and work with providers to take effective steps to improve results. [Providence St. Joseph Health](#) had to end direct contracting with Boeing in 2017 even after spending millions on electronic health records because they were not able to obtain timely data across different care settings to identify opportunities to improve coordination and care. New federal steps and private-sector innovations on data interoperability (such as [adoption of bulk FHIR API standards](#)) and improved analytic tools with privacy protections may enable more progress. Empowering organizations like Vera can help advance integration across platforms, support analyses to identify opportunities for care improvement, and foster partnerships with providers to help them succeed. For example, platforms can combine claims

and other shared data to create an up-to-date health profile pushed into providers' EMRs to show critical information, such as a member's prospective risk score, preventative and disease care opportunities, previous ER and inpatient admissions, filled prescriptions, and more. Leveraging improvements in secure patient data allows providers to take more informed steps to close care gaps and to work with their members effectively during and between visits.

Finally, these models are most likely to work where the reforms can reach critical mass. Employer-led reforms will have greater impact on health care markets where they have relatively high concentrations of employees. Organizations like Walmart, GM, and Boeing have led health care reforms in markets where the bulk of their employees work. For employers without concentrated workforces, and for smaller employers, steps to help employers jointly participate in aligned reform efforts at the state and federal level can make it easier for

***Employer-led reforms will have greater impact on health care markets where they have relatively high concentrations of employees.***

interested employers to succeed. For example, the Purchaser Business Group on Health and its members with California-based employees are helping to drive a state reform effort to improve access to advanced primary care in collaboration with health plans and the state. In addition, the CMS-supported Health Care Payment Learning and Action Network is developing tools and resources to [improve primary care](#) and [advance equity](#), including through multipayer, state-level initiatives bringing together employers, private insurers, Medicare, and state programs.

## KEY TAKEAWAYS

Through collaborations to learn from and scale reforms, employers can overcome barriers to progress and accelerate the implementation and impact of accountable, coordinated care with a strong foundation of advanced primary care.

Advancing innovation in the employer sector will require employers to change how they are operating today and introduce quality-based risk models that enable provider accountability. Innovation will be facilitated through honest sharing of information on what works and what doesn't, as well as through venues where information can be shared. Because many of the lessons of public programs are relevant here, collaboration across the public and the private sectors in providing high-quality coordinated care and addressing health equity are particularly important.

While interest among employers and providers is currently strong, there is not yet a clear and straightforward path for success and scaling. Reaching critical mass requires aligned steps to help employers of all sizes develop and

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implement new ways of contracting with innovative health care providers that pay for and deliver better health and a better care experience, not just traditional medical services. These steps can include the following activities:

1. Identifying regions or markets where reforms can succeed, where provider organizations have the willingness to implement new models of care and payment based on the emerging examples of success and the capabilities to implement them successfully – or the willingness and partnerships to rapidly develop those capabilities.
2. Reducing the cost and time for contracting to implement these new partnerships by developing more standard and scalable approaches for key features, such as basic payment model design: key performance metrics, including patient experience and outcomes; data sharing; and other supports.
3. Building tools, resources, and analytics or identifying and supporting organizations with the capabilities that can partner with health care

providers to accelerate the ability of providers to address gaps in care, improve equity, provide transparent results for accountability, and succeed in the new care and payment models.

4. Developing strategies for engaging employees in these initiatives, both to ensure that all employees can benefit and that the reforms have maximum impact.
5. Aligning with CMS, states, and regional leaders, such as through state multi-payer initiatives and public-private collaborations, to create more effective support for providers to implement needed changes.

Specific and actionable outcomes measures are particularly important to enable sharing of information around accountable care models and scaling. **Figure 2** shows some of the key results that should be linked to these steps—with the focus on keeping employer efforts as effective as possible to drive access for all workers to high-value, coordinated care built on a strong primary care foundation.

**Figure 2. Potential Outcome Metrics for Measuring Primary Care Partnerships**

**Accountable Provider Reimbursement To Support Care Transformation**

**Examples:** Person-level, capitated payments; support for infrastructure investments to improve data analytics and focus on “upstream” care; care model redesign; diversified provider teams

**More Convenient, Timely, Navigable Care for Beneficiaries and Families**

**Examples:** Increased access to in-person and virtual care; improved coordination across primary, specialty, and behavioral providers; strong experience of care assessments; attention to social needs

**Improved Health and Health Outcomes for Individuals and Families**

**Examples:** Improved measures of health status; patient-reported outcomes and functional status; condition-specific (e.g., maternity, cardiovascular) outcome measures; reduced complications and ED use

**More Affordable, Equitable Health Care**

**Examples:** Slower rate of cost growth; reduced out-of-pocket spending; improved outcome measures across race, ethnicity, geographic region, gender, and socioeconomic status

The need for these reforms to improve health and equity while reducing costs has never been greater, with the pandemic underscoring their urgency. With both broad employer support for these reforms and increased commitment to implement these reforms

now, the opportunity for employer leadership to drive system-wide progress to improve outcomes and value has never been greater.

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The Robert J. Margolis, MD, Center for Health Policy at Duke University is directed by Mark McClellan, MD, PhD, and brings together expertise from the Washington, DC policy community, Duke University and Duke Health to address the most pressing issues in health policy.

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