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We can help you create it.

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Launching health plans and services on exchanges, direct-to-employers
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Assess your position on the risk continuum at Optum.com/risk.

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PARTNERSHIPS
A model for health plans and providers.

TREND WATCH
The rise of risk-based contracting.

CMS STATISTICS
Lowering costs. Improving care.

PROVIDER PERSPECTIVE
A marketplace of convergence.

Meet the ACO that took on risk and won
Dominique Morgan-Solomon,
Vice President, Population Health
Dr. Sanjay Shetty,
President, Steward Health Care Network
Optum looked beyond the curve to see a shifting health care system long before it presented itself. We prepared—carefully developing strategies and solutions—so that we could partner with executives, like you, who will lead the journey toward a new future. Optum can bring experience, insights and technology to guide the development of integrated, efficient and sustainable health care systems. We hope to modernize every element of the health system infrastructure and support a sustainable shift to value-based care. We believe Optum can make the health system healthier and stand ready to serve those who are leading the way.

We invite you inside Risk Matters to see our latest research, opinions and experience in health care.
TREND WATCH
Health plans are making risk-based contracting a reality

PROVIDER PERSPECTIVE
Providers must partner with health plans for long-term success

EXECUTIVE INTERVIEW
See how the Steward Health ACO is a pioneer and profitable

PARTNERSHIPS
Optum provides a model for value-based partnerships

CMS STATISTICS
New stats reveal great potential for Medicare ACOs
Risk-based contracting and the future of health care payment and delivery.

Accountable care organizations, patient-centered medical homes, bundled payments and other fee-for-value arrangements will continue to gain in popularity among insurers, providers, and consumers.

Q: Are risk-based contracting arrangements between health insurers and providers here to stay?
A: Follow the money.

In health care, the lion’s share of the money is controlled by health plans, and health plans are investing in and paying for an increasing amount of care covered by risk-based contracts. And these contracts aren’t just with the obvious accountable care organizations (ACO) and patient-centered medical homes (PCMH)—large health systems and integrated delivery networks are also engaging in various forms of risk contracting.
Data Points

Large health plans have made significant inroads into risk-based contracting:

- **$500 million**
  The Blue Cross Blue Shield association announced in July 2014 that approximately one out of every five dollars BCBS companies spend on medical care—around $65 billion—will now be directed through value-based programs. About 24 million members are accessing care through such programs, which they estimate saved their plans $500 million in 2012.²

- **45 percent**
  Aetna’s members in value-based care arrangements numbered about 1.7 million, and 20 to 25 percent of their medical costs go through value-based networks. By 2017, they see that percentage rising to 45 percent.⁴

- **$30 billion**
  UnitedHealthcare said it will spend $30 billion on medical care for members within risk-based arrangements this year, and they plan to be spending $65 billion on value-based care by 2018.³

- **50 percent**
  Humana anticipates that half of its Medicare Advantage membership will be enrolled in full-risk bearing accountable care organizations by 2017.⁵

“As we think about health care, I’m excited about the future. We are moving
Why is risk-based contracting gaining such a foothold with the health plans?

Fee-for-service models become obsolete quickly as patient care shifts predominantly to chronic disease management rather than treatment of acute illness and injury.

• Insurers can’t do much more with fee-for-service programs to keep costs down. At its core, fee-for-service incentivizes providers for seeing more patients.

• Insurers are keenly aware that the price point of their product is becoming cost-prohibitive.

• The big insurers are pushing value-based contracts with providers, and have announced plans for more.
The degree to which providers can successfully manage risk for patient care and outcomes will become a competitive advantage.

**SOURCES**

1. All quotes were taken from a panel discussion at Forbes Healthcare Summit 2013.
4. Ibid.
5. Ibid.
TAKEAWAYS
What are the next steps?

Health insurers large and small will need to take a market-focused, population-centric view to determine how quickly to accommodate fee-for-value in their coverage options.

Health care providers should prepare for continued change:

- **Improve financial performance** through revenue cycle optimization.
- **Determine market dynamics** (population growth, coverage shifts, speed of change, etc.)
- **Appraise financial impact** of transition from fee-for-service to fee-for-value.
- **Define population** health needs.
- **Assess provider network** and care management resources.
- **Invest in data** and analytics necessary for risk-based decision-making.
- **Build capabilities** around population health management.

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PROVIDER PERSPECTIVE

Understanding the provider perspective in a rapidly converging marketplace
It is no longer a question of “if” the system will change…but rather how quickly it will be radically transformed.

**Rising medical costs and developing regulations** have led to new initiatives targeting clinical quality outcomes and managing financial risk. These and other market forces are transforming the way health plans, providers and consumers interact:

- **Health Plans** are accelerating risk-contracting efforts.
- **Plan Distribution** is moving to direct-to-consumer.
- **Care Models** are increasingly consumer oriented.
- **Risk is shifting** to consumer and providers.
- **Health Plans and Employers** are increasing use of tiered/narrow networks.

[View at optum.com/risk](http://optum.com/risk)
## Key trends driving value-based payment

### MARKET TRENDS

<table>
<thead>
<tr>
<th>PROVIDERS UNDER PRESSURE</th>
<th>IMPACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CURRENT</strong></td>
<td><strong>FUTURE</strong></td>
</tr>
<tr>
<td>Providers faced with market share, consolidation and profitability pressures</td>
<td>Cost shifting and performance-based reimbursement will continue to put pressure on providers</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>COST SHIFTING</th>
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<tbody>
<tr>
<td><strong>CURRENT</strong></td>
</tr>
<tr>
<td>Employers are increasingly focused on affordability and shifting to implementing narrow network products</td>
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<table>
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<tr>
<th>CMS REIMBURSEMENT OVERHAUL</th>
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<tbody>
<tr>
<td><strong>CURRENT</strong></td>
</tr>
<tr>
<td>CMS has already implemented the Pioneer ACO Model, Medicare Shared Savings Program to formally tie reimbursement to clinical outcomes</td>
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<tr>
<th>PAY-FOR-PERFORMANCE</th>
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<tbody>
<tr>
<td><strong>CURRENT</strong></td>
</tr>
<tr>
<td>Commercial health plans are beginning to implement risk-sharing, pay-for-performance programs to manage MLR</td>
</tr>
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</table>
IMPLICATIONS

Need to proactively manage health care costs

Providers are at the epicenter of change

Need to move to value-based payment models

Providers will need to start taking and managing risk

INSIDER OBSERVATION:

Health plans and providers are both challenged to adapt or be left behind. At this pivotal time, health plans can help enable providers to identify and implement innovative ways to provide care in more effective, less costly ways.
Where are providers in the transition to value-based care?

All providers are at some point on this continuum. Many seek to move forward. But not all will move to the full-risk model. Providers must ask themselves these critical questions:

**How much risk can I successfully manage?**
**How fast should I move across the continuum?**
**How far is my organization prepared to go?**

This is not a one-size-fits-all approach. Each provider must identify and pursue the appropriate level of risk for that organization.
Transformational times call for strategic relationships

At Optum, our unmatched depth and breadth of experience enables us to understand both health plan and provider perspectives. We have the people, processes and technologies to help ensure clear accountabilities, budget controls and staged solution evolution.

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**RISK-BASED ENABLEMENT LEADERSHIP**

- **Health Plan Contracting And Finance**
- **Network Management And Development**

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**SUCCESS CHARACTERISTICS**

<table>
<thead>
<tr>
<th>SUCCESS CHARACTERISTICS</th>
<th>KEY ATTRIBUTES</th>
</tr>
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</table>
| PCP Network             | • **Have opportunity** to form a high-performing PCP network  
                          | • **Have a clear and easily** communicated value proposition for PCPs |
| Risk Contracts          | • **Have a clear** and easily communicated value proposition for health plans  
                          | • **Understand financial impacts** of risk contracts on organization and have executive team alignment that the organization can achieve targets necessary to transition |
| Infrastructure          | • **Recognize that ideal solutions do not exist** and are willing to co-invest in innovation |
| Clinical Model          | • **Recognize the need for a new clinical model** that can support Population Health Management  
                          | • **Willing to invest** in the clinical leadership and fund incentive plans to execute the transformation |
| Adaptive Leadership     | • **Executive team alignment** on vision and that vision is clearly understood by the organization  
                          | • **Organizational structure** supports transition  
                          | • **Understand key leadership** needs/skills required and aggressively hire for those roles |

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optum.com/risk
Steward Health Care System leverages analytics to turn risk into results

It was a huge risk for Steward Health Care System to become a Pioneer Accountable Care Organization (ACO) in 2012, bringing 35,000 patients into an organization that serves more than one million persons annually in eastern Massachusetts. The system is now widely regarded as one of the most successful ACOs in the United States.

The risk increased in year two of Steward’s ACO program when it grew an astounding 25%, making Steward one of the largest Pioneer ACOs in the nation. Charting a course through the maze of clinical, financial and organizational changes taking place with the implementation of the ACO was the partnership between Steward and Optum.
Working together, Steward and Optum used analytics to decipher the health care system’s population data, understand the needs of that population, update existing plans and implement new programs using claims and clinical data.

“This has certainly been a real partnership,” said Dominique Morgan-Solomon, Steward ACO Vice President of Population Health. “Collaboratively, we have focused on figuring out where we can impact the most, how well we’ve been doing and what the future looks like. They recognize our driver is decreasing unnecessary admissions along with decreasing total medical expenses. It signals a significant paradigm shift from fee-for-service to a risk-bearing, global payment perspective.”

Director of the Steward ACO Program is Young Joo, who said the opportunities to provide better care were there but they had not yet identified where to concentrate their efforts. “The analytics helped us focus on where those interventions are going to give us the most impact,” he said.

Dr. Shetty echoes the sentiment, “The most interesting or important thing was to actually start to break down the huge mountains of data and try to figure out all of these possibilities.” He goes on to say, “The initial partnership with Optum was particularly helpful. It helped us understand where the opportunities were and where we should focus our efforts in order to drive real results.”

The efforts paid off with significant progress against key goals in the first year. Steward presented a 15% drop in readmissions; a 10% reduction in the per-member, per-month costs; and a nearly 9% decrease in the length of stay at skilled nursing facilities. Steward was one of the few ACOs that showed a surplus in its inaugural year.

“We were one of just 13 ACOs that were able to realize a surplus,” said Morgan-Solomon. “I have hospital presidents who used to say, ‘You’re going to take admissions out of my hospital.’ Now they are calling and asking, ‘How can we best collaborate?’ because they see the benefits.”

<table>
<thead>
<tr>
<th>Improvement</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Drop in readmissions</td>
<td>15%</td>
</tr>
<tr>
<td>Reduction in the per-member, per-month costs</td>
<td>10%</td>
</tr>
<tr>
<td>Decrease in the length of stay at skilled nursing facilities</td>
<td>9%</td>
</tr>
</tbody>
</table>
In the program’s second year, Steward continued to increase its savings, improve quality and achieve significant success by maintaining high performance in patient experience. The system generated $19.2 million in savings for the Medicare program, the second best performance of all Pioneer ACOs in the nation.

From the start, Steward’s intent was to take the lessons learned and the programs built specifically for the ACO program and expand these to their general population, benefiting patients across Steward’s entire network.

According to Stephanie Milligan, Director of Clinical Programs at Steward, the analytics generated by the partnership with Optum has a real benefit to individuals. “In partnering with Optum we have the ability to look at where our needs are in terms of case management. Our nurses are seeing that they have been making a real difference in our patients’ lives.”

Said Joo, “One of the great things about Optum is they can adapt really well to our big dreams.”

Every year, said Morgan-Solomon, from 30% to 40% of their ACO population changes, necessitating another round of analytics on the shifting population. Steward dedicates more than 60 personnel to implement population health management strategies.

“I think one of the lessons learned is to get provider engagement upstream. The further upstream we can get provider engagement, the better. So we’ve infused medical directors and associate medical directors into so much of the work we’ve done, and involved them in messaging to clinicians,” she said.

For Morgan-Solomon, the key to Steward’s success with what many would claim to be a high-risk operation is a very simple directive. “Keep your eyes on the prize,” she suggests. “Everything involved here is about delivering better health care to patients, and that can be of value to your provider organization. And because we’re delivering it in a more cost-effective way, it will ultimately add value to care delivery.”
With the recent spotlight on accountable care, health plan and provider organizations are seeing an opportunity to collaborate to drive down medical cost trend and increase their commercial market share through lower premiums. Providers are creating integrated health care partnerships with health plan organizations to align financial incentives, focus on improving outcomes and reduce redundancies. In an eight-month period between 2011 and 2012, the market saw a 38 percent increase in ACOs with hospitals, health plans and physician groups. And 43 percent of organizations that are or plan to be part of an ACO will utilize a commercial shared savings model rather than a Medicare ACO or Medicare Shared Savings model.

Forward-thinking organizations can develop a strategic approach to accountable care by identifying unique partnerships. According to a 2012 Optum study, hospitals and physician groups are the most likely ACO partners, but other organizations, including health plans, skilled nursing facilities and long-term care facilities, are becoming involved as well (see Figure 1).

The purpose of this article is to outline the key actions required to drive successful accountable care:

- **Build** a governance structure that will operationalize decision-making, leadership and accountability
- **Engage** and align physicians for stronger partnership
- **Manage** clinical and financial risk to identify and measure probabilities and outcomes
- **Enable** physicians to make better decisions through measuring clinical performance
- **Help** providers clinically integrate to work better together
- **Focus** on population management to avoid costly outcomes and empower consumers
- **Invest** in information technology to connect and strengthen the delivery system

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**FIGURE 1. Physicians and Hospitals Are Most Common ACO Partners; Other Partnerships Less Common**

Q: Which groups or organizations are participating in the ACO you have joined or will join?

![Chart showing participation percentages by type of organization](optum.com/risk)
Governance Structure

Accountability and cross-organizational alignment are key components

Today’s health care market in the United States is a jumble of fragmented and siloed services where each stakeholder makes decisions to support its organizational needs instead of the needs of the overall population. The U.S. health care system has been built out of a reimbursement model that does not reward for coordination across the continuum but for providing a volume of services. As health plan-provider integration accelerates, governance and organization models must build in accountability for providing “integrated” care—high quality at a lower cost.

Internally, a governance structure that involves all partners is critical; strong governance that fosters financial and clinical accountability will lead to long-term stability and success. To drive overall strategic direction and accountability, a governance model that establishes an executive leadership team, an operational leadership team, a project management team and a physician leadership team is required. In addition, offices of clinical transformation, physician alignment, marketing and member engagement, analytics, technology and finance will be responsible for the delivery of the expected results. We utilize the term “office” to instill a sense of structure.

The executive leadership team is responsible for managing the venture’s overall direction. If the ACO is made up of separate organizations, leadership from both the health plan and provider organization is required to ensure collaboration and alignment of goals and decision-making. If the ACO is a single-provider organization, leadership should be composed of executives across organizational functions. Regardless of the ACO make-up, the executive team serves to define the guiding principles that align the partners to deliver on the defined clinical and financial goals. The operational leadership team comprises senior-level leaders who have the authority and accountability to make and implement changes to day-to-day operations.

These operational changes can include clinical, financial and support functions, including population management, network management and technology, but do not include changes to the provider clinical practice.

The physician leadership team, reporting directly to operational leadership, consists of key community physicians who act as evangelists to all physicians and clinicians for the partnership while fostering future success. The team should consist of PCPs, specialists and hospitalists who work in different settings and practices, offering a comprehensive perspective of the care delivery system’s opportunities and challenges.

It is critical that members of all leadership teams share the same vision of making health care more affordable, incentivizing quality rather than quantity and changing the care delivery model. A cohesive and consistent message among the partners’ leaders establishes and emphasizes the importance of the partnership’s mission and vision.

An ACO Project Management Office (PMO) has a place in the ACO’s leadership hierarchy and reports to operational leadership. The strategic importance of the PMO should not be overlooked; it coordinates and communicates across all functional offices. PMO team members work with subject matter experts to identify initiatives that meet overall partnership goals. The PMO manages scope, implements changes and measures success. It is accountable to the executive team and operational team and is responsible for reporting projected and actual budgets and financial performance.
The following key functional offices should be driven by tactical teams that report to the operational leadership team:

**Office of Finance is accountable** to the board and the senior operational team for the development and approval of the shared-risk contracts and cost reduction measurements. (Cost-reduction measurements should be validated by actuarial experts to ensure understanding of medical trend impacts.)

**Office of Clinical Transformation aligns** with the physician leadership team and is responsible for identifying and delivering clinical savings opportunities, including practice redesign, hospital service line design, population health management and continuity of care. This office must be led by clinical experts, including physicians, nurses, care managers, behavioral specialists and social workers.

**Office of Marketing and Member Engagement** is accountable for the cross-organizational marketing strategies for member enrollment and engagement and for product and benefit design.

**Office of Analytics mainly supports** the clinical transformation initiatives in developing information to evaluate opportunities, validate saving targets and measure the results for each initiative.

**Office of Technology is responsible** for driving the overall IT strategy to leverage current systems and capital investment, while ensuring information sharing across the continuum of care.

**Office of Physician Alignment works closely** with the physician leadership team and is accountable for engaging with the entire network to communicate upcoming changes, educate on new policies and obtain feedback on progress/challenges.

### Engage and Align Physicians

Utilization improvement is possible only when physicians are aligned with the ACO. Physician engagement is essential for turning paper savings into actual savings. While organizations can contract to get better unit cost pricing, taking on risk is a useless effort until care delivery and utilization patterns change. To engage physicians, consider the following practices:

1. **Engage physicians early to listen to concerns**—Engaging physicians early in the move toward accountable care to listen to their issues and barriers will help the ACO organization address the challenges proactively.

2. **Identify physician champions**—Physicians who can act as trusted change leaders need to be identified early and selected carefully. Physician leaders should be involved in every aspect of clinical transformation and ultimately champion the transformation to the larger provider community.

3. **Support transparency and peer discussions**—The design and review of physician reporting, practice variation and care redesign must be driven by practicing physicians in the ACO with support from health plan medical directors. Physician-to-physician feedback is key to effecting long-term change in practice patterns.

4. **Involve physicians in monitoring cost savings**—Provide physicians with information on opportunities for savings and the positive impact to their revenues and outcomes.
Manage Clinical and Financial Risk
Upside and downside risk should be part and parcel of ACO financial arrangements

Most provider organizations today are not built to manage risk. In many of the current fragmented payment models, physicians continue to be reimbursed on a fee-for-service (FFS) basis, although there may be some pay-for-performance (P4P) stipend attached. FFS reimbursement encourages volume-based care and discourages care coordination and cost reduction. Even the P4P models, while sometimes based on quality, do not focus on efficient and effective use of resources or evidence-based medicine to drive cost reductions.

Fee-for-value, on the other hand, takes costs out of the system through improved utilization. To incentivize decreased utilization, providers take on a level of risk-based on their ability to impact outcomes. The essence of a health plan-provider approach is to create interdependence between the partners so that each organization has a vested interest in reducing costs—instead of the old model of shifting costs or maximizing revenues.

An upside and downside (profit and loss, respectively) risk-sharing financial model is a key driver of success for an ACO partnership. ACO models at the Centers for Medicare & Medicaid Services (CMS) have upside as well as downside risk on a defined population, capping both downside and upside savings based on a predefined cost-of-health-care baseline.

According to the 2012 Optum study, few providers feel prepared to take on financial risk (see Figure 2). Providers can prepare for risk by developing competencies in clinical performance management, clinical integration and population management, as outlined in the following three sections.

FIGURE 2. Though Few Providers Prepared for Greater Financial Risks, ACO Partnership Has Positive Effect

Q: How prepared are physician/hospital practices in your community to assume greater financial risk for managing patient care?

<table>
<thead>
<tr>
<th>Physicians</th>
<th>Hospital Executives</th>
</tr>
</thead>
<tbody>
<tr>
<td>Already Part of ACO</td>
<td>29%</td>
</tr>
<tr>
<td>Expect to Join</td>
<td>15%</td>
</tr>
<tr>
<td>Don’t Expect to Join/Not Sure</td>
<td>10%</td>
</tr>
<tr>
<td>Already Part of ACO</td>
<td>42%</td>
</tr>
<tr>
<td>Expect to Join</td>
<td>24%</td>
</tr>
<tr>
<td>Don’t Expect to Join/Not Sure</td>
<td>20%</td>
</tr>
</tbody>
</table>
Manage Clinical Performance
Define and share the right financial and clinical benchmarks with the right leadership teams

It is important for accountable care partners to understand their financial, clinical and quality performance on a macro level and on a micro level—a macro level to see overall progress toward goals and a micro level for specific populations and for specific interventions. Monthly macro and micro financial, clinical and quality metrics offer the organizations a current-state view, allowing them to see the impact of their interventions and the opportunity to realign strategies and priorities. Metrics should help the leadership teams understand utilization, costs, patient satisfaction, evidence-based care adherence, trends and outcomes.

As the partners come together, the executive team in conjunction with physician and operational leadership defines the clinical benchmarks and performance goals early. These benchmarks and goals become a road map for value, can help identify the areas of opportunity and can subsequently define industry-accepted targets that make sense for their organization.

Performance metrics must be transparent to all levels of the organization to encourage integrated accountability and ownership of change. The metrics should be shared on a monthly, quarterly and yearly basis and compared to the previous month’s and previous year’s performance. The goals of the metrics should be to:

- **Define** the per-member-per-month (PMPM) savings on savings at macro and micro levels
- **Illustrate** physician performance and variation to drive change
- **Measure** hospital utilization and costs
- **Identify** in-network and out-of-network utilization and PMPM
- **Measure** adherence to evidenced-based protocols
- **Measure** patient satisfaction with care delivery, programs and physicians
- **Validate** that the implemented interventions had a positive impact on clinical outcomes
- **Understand** trend deflections on savings at macro and micro levels
- **Measure** quality improvements of targeted programs

Executive leaders must not just compare the organization to other non-ACO groups but also benchmark performance using industry-accepted benchmarks that have been agreed to by all parties. This will allow the team to identify inpatient, outpatient, professional and pharmacy utilization and cost outliers.

As outliers are evaluated, a root-cause analysis should identify specific interventions for improving results. The root-cause analysis should evaluate opportunities, including physician variation, alternative care settings, evidence-based adherence, population health management failures and out-of-network opportunities to reduce inappropriate utilization—ultimately reducing costs.
Clinically Integrate
Care integration requires re-thinking the care delivery processes at macro and micro levels

The term clinical integration is consistently referred to as a fundamental cornerstone to accountable care and fee-for-value, but there is no consistent, single definition of clinical integration.

Based on Federal Trade Commission (FTC) statements, the following can describe five primary legal characteristics of clinical integration. Organizations must achieve efficiencies by:

- **Monitoring** and controlling quality, service and costs
- **Selectively choosing** a physician network that includes primary care and specialist
- **Having a well-developed** care management program that uses evidence-based guidelines for a broad spectrum of diseases and disorders
- **Showing significant** investment by physicians in both time and capital
- **Integrating data** management, enabling extensive data collection, information sharing, quality reporting and utilization review.

Clinical integration is far from easy. Clinical processes can be fragmented, redundant, conflicting and—perhaps most daunting—heavily ingrained. Integration of care requires rethinking the delivery processes to coordinate patient care services across people, functions, activities and operational units to maximize the value of services delivered.

Clinical processes can be fragmented, redundant, conflicting and—perhaps most daunting—heavily ingrained. Integration of care requires rethinking the delivery processes to coordinate patient care services across people, functions, activities and operational units to maximize the value of services delivered.

As part of this effort, evidence-based guidelines should be reviewed and approved by the clinical team, and physicians need to be informed of and held accountable for following the protocols.

In addition to redesigning clinical services and programs, clinical integration must redefine continuity of care. The redesign must focus on care transitions to support patient-centered care delivery across the continuum: from the primary care physician (PCP), to specialty care, to the facility, to long-term care and to the home.

Changes to clinical processes across services can offer opportunities to improve clinical care and increase overall patient satisfaction at the macro level. For example, more emphasis could be placed on providing support and services to PCPs to change the way they manage a patient population and deliver care. Clinical processes could also be targeted to the micro level, such as identifying specific physician outliers or less-effective inpatient processes.

As the ACO addresses issues at macro and micro levels, a new integrated process will emerge that removes duplication, leverages resources and improves outcomes.

The goal is to create trusting and lasting relationships that support long-term behavioral change by focusing on the member’s individual needs.
Manage the Population
Understand population and individual needs and provide support using all partner resources

To succeed, provider and health plan organizations need to find ways to consistently and cost-effectively interact with and coordinate patient-centered prevention and care. But it’s not just engaging the providers—it’s also empowering the patient to make better health care choices to prevent or manage illness.

Each day, people make decisions that affect both their health and, subsequently, their health care costs. The Centers for Disease Control and Prevention found that 50 percent of an individual’s health status is determined by behavior—not genetics, environment or access. Even when the best treatments are offered, patients do not always adhere to the prescribed treatments. Studies have shown that half of chronically ill patients do not follow long-term treatment plans. Patient-centered health management ensures that all individuals have access to reliable health care tools, resources and information to enable appropriate and lasting behavior change.

According to a 2006 study released by the Department of Health and Human Services, of the $2.3 trillion annual health care spend, about $1.5 trillion could have been prevented, delayed or curtailed through lifestyle modifications.

Under all commercial ACO models, health plans and providers play a critical role in patient empowerment that can lead to better outcomes. For example, organizations can engage patients/members in wellness and health initiatives through targeted, timely communications and embedded advocates or other specialists. Such programs can reduce an organization’s risk exposure over time by increasing individuals’ awareness of the personal and financial benefits of better health.

Another patient empowerment technique is benefit plan design that drives positive member behavior, including the use of rewards for members who engage in improving their health or, for members who do not, additional premium, deductible or copayment increases.

Central to successful population health is identifying and prioritizing the individuals in need of help. The first step is to define a standard risk-stratification process, which will identify and mitigate the impact of at-risk populations and disease conditions. Once the population is stratified, evaluate the information from both a population level and an individual level.

- **Population-level management**—Identify and stratify by disease to define the areas that the ACO should evaluate to implement evidence-based care and disease management programs; these programs should incorporate evidence-based medicine protocols and the appropriate services, tools and technology by risk level (high, medium and low)

- **Individual-level management**—Identify and stratify the population on an individual basis to find the riskiest patients in the population; included in this stratification are the risk factors, total costs, inpatient costs, pharmacy costs, outpatient costs and probability of inpatient stay

After stratification of the population, the next step is the creation of a comprehensive program focused on medically fragile and high-risk populations using multiple outreach channels and standard evidence-based protocols. To create such a program, develop standard cross-organizational criteria to ensure consistent identification and selection of these patients. As patients are identified, new care delivery standards and processes are collaboratively developed that support all individuals who could interact with the patient.
To manage high-risk members, a community-based approach that leverages a care management team that includes a physician, care manager, pharmacist, behavioral specialist and social worker delivers the most value. Health plans typically have the most experience with care management, but a 2012 study confirmed that providers who are part of an ACO are preparing for care management as well (see Figure 3). Even so, a care management team should not only include members of the medical group but could also include individuals from the health plan, community resources and vendor partners. While the physician provides the care, the care manager can support the patient as an extension of the practice. The care manager leads a collaborative process of assessment, planning, facilitation and advocacy to meet the patient’s individual needs. The care manager’s interventions focus on ensuring that patients are seeing the right care provider as indicated by the physician, taking the right medications, receiving the right and most clinically appropriate care and living a lifestyle that will afford them improved health.

FIGURE 3. ACO Partners Better Prepared For Additional Care Management Responsibilities

Q: How prepared are physician/hospital practices in your community to assume greater responsibility for managing patient care?

For those members who are not at high risk, a “health advocate” or “health coach” approach can ensure the proactive support of consumers’ health care needs. The advocate is a source for a member’s health-related questions and needs, helping the member navigate the health care system and promoting access to care and overall well-being. The goal is to create trusting and lasting relationships that support long-term behavioral change by focusing on the member’s individual needs.

SOURCES

Information Technology

Leverage technology to support the sharing of information and drive decision making

Integrating IT systems and aggregating data across multiple organizations will lead to higher quality, more effective and more efficient patient care. The components an ACO requires to accomplish these goals include an electronic health record (EHR), a health information exchange (HIE), data management resources, a clinical analytics solution and patient registries.

An EHR system that captures necessary patient data, supports care-related transactions and provides clinical decisions to support the use of the evidence-based protocols is critical.

Real-time data sharing through an HIE solution will promote clinical integration and support the goals of the ACO. The HIE enables the electronic distribution of all types of information—including laboratory, radiology, prescriptions, orders, hospital discharge summaries, continuity-of-care documents and transcribed reports—to all physicians and health plans within the exchange. The use of an HIE allows physicians, health plans, hospitals and care managers to proactively engage with one another to manage care and costs.

Real-time sharing requires more than just setting up pipelines for data transfer. There needs to be a shared data warehouse, whether physical or virtual, with meaningful, compatible clinical information and claims data for standardized reporting across the organization. Sitting on top of the data warehouse is an analytics solution that supports predictive modeling, quality measurements, gaps-in-care analysis, evidence-based medicine and financial performance. With compatible data, augmented with analytics and predictive modeling, value-based partnerships can measure progress against their clinical, financial and utilization goals—and ensure population health management, clinical integration and care improvement.

As part of the integrated data solution, the ACO should utilize common patient registries to identify patients at risk for poor health outcomes based on specific risk factors. These registries allow clinicians and other care managers to proactively address these concerns to minimize disease progression and maximize health outcomes by precisely targeting interventions for patients who will benefit most.

Conclusion: True Partnership Is the Key to ACO Success

Creating a fully functional ACO requires significant investment, including infrastructure development and the hiring of resources to coordinate care, measure performance and engage patients. But when health plans and providers partner, start-up costs can be minimized across participating organizations and significant savings can be achieved by leveraging each organization’s assets and resources.

When health plan and provider partners are aligned through upside and downside risk, it drives fundamental change in health care delivery, not just reimbursement changes. These arrangements ensure each partner shares in the savings but also shares in the risk if the targets are not met. The organization achieves its clinical and financial goals as the partners focus on accountable care.

Smart ACOs are Mapping the

Pioneer ACOs

$96 MILLION
Estimated total amount saved by Pioneer model ACOs in year two.

$68 MILLION
Shared savings earned by Pioneer ACOs in year two.

28 of 33
Pioneer ACOs showed improvements in almost all quality measures.

While not every Pioneer and Shared Savings Program ACO has shown the same results, many other organizations have been inspired by the potential for success. There are currently over
Optum looked beyond the curve to see a shifting health care system long before it presented itself. We prepared—carefully developing strategies and solutions—so that we could partner with executives, like you, who will lead the journey toward a new future. Optum can bring experience, insights and technology to guide the development of integrated, efficient and sustainable health care systems. We hope to modernize every element of the health system infrastructure and support a sustainable shift to value-based care. We believe Optum can make the health system healthier and stand ready to serve those who are leading the way.

We invite you inside Risk Matters to see our latest research, opinions and experience in health care.

### Journey Toward Success

#### Shared Savings Program ACOs

- **$652 MILLION**
  - Estimated total amount saved by 53 Shared Savings Program ACOs who held spending below targets in year one.

- **$300 MILLION**
  - Shared savings earned by 49 of the 53 by achieving quality reporting requirements in year one.

- **30 of 33**
  - Shared Savings Program ACOs showed improvements in almost all quality measures.

- **360 established ACOs**, serving over 5.6 million Americans with Medicare, mapping their route to a higher quality, lower cost health care future.
You see a new world. We can help you create it.

Transferring fee-for-service to shared savings

Launching health plans and services on exchanges, direct-to-employers

Aspiring to stand up provider-owned plans

Managing limited, dual-sided risk

Accepting delegated risk with full capitation

Optum supports health system leaders as they manage their progression along the risk continuum to a sustainable future. From health plan strategies to network partnerships, and from care management to data analysis, we help leaders make informed, timely decisions to strengthen long-term financial stability and improve patient care quality.

Assess your position on the risk continuum at Optum.com/risk.