



Foundations for the Future: Building a Better ACO

WHITE PAPER

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IDC HEALTH INSIGHTS OPINION

The current business and reimbursement models, which incent and reimburse providers for volume of services rendered and not for outcomes, are simply not sustainable. Healthcare organizations recognize that a major transformation is being driven by healthcare reform and will require massive changes to ensure survival. As a result, they are embracing the fundamental tenets of accountable care that emphasize population health and chronic condition management, improved care team collaboration, and coordinated transitions in care to improve outcomes and improve their financial standing.

Some of the key findings from IDC Health Insights' research include:

- The business case for the Medicare Shared Savings Program, or Medicare accountable care organizations (ACOs), remains uncertain in the near term. In the meantime, private sector initiatives are under way that are focused on the "triple aim" — improved outcomes, reduced costs, and improved patient and caregiver satisfaction.
- A new commercial/public model is emerging — which Optum calls the "Sustainable Health Community" — that is broader than a Medicare ACO in that it engages the entire community, not just silos of care.
- Aligning incentives among all the players to create a Sustainable Health Community will require extensive collaboration across the ecosystem, investment in healthcare technology to enable care team collaboration, and a long-term vision.

IN THIS WHITE PAPER

This white paper is presented by IDC Health Insights and sponsored by Optum. The objectives were to provide guidance regarding:

- The transition to an accountable care model

- The steps healthcare organizations can take to prepare
- How technology can support the transformation to what Optum calls a "Sustainable Health Community"
- An overview of Optum's strategy to build Sustainable Health Communities

SITUATION OVERVIEW

Drivers Leading to Health Reform

Healthcare providers are under intense pressure from all directions to improve quality of care, patient safety, and patient outcomes while simultaneously reducing the costs of delivering that care. Demographic factors, such as an aging population and consumers with multiple chronic conditions, are driving more healthcare spending, and along with clinician shortages, are exacerbating access issues. Employers and purchasers are pressing providers (and the payers that contract with them) to be more accountable for the quality and cost of care because the current trajectory of healthcare spending is unsustainable. National healthcare expenditures were 17.6% of gross domestic product (GDP) in 2009 (the last year for which data is available), up from 16.6% in 2008, according to the Centers for Medicare & Medicaid Services (CMS). The 2009 per capita spend was \$8,086. If this spending continues unchecked at its current rate, CMS projects that healthcare spending will nearly double from \$2.5 trillion in 2009 to \$4.5 trillion in 2019 and will account for 19.3% of GDP.

The Affordable Care Act and the Emergence of the ACO and Collaborative Care Model

On March 23, 2010, President Barack Obama signed into law the Patient Protection and Affordable Care Act of 2010 (HR 3950), which aims to provide health insurance coverage to approximately 32 million uninsured Americans and reform health insurance for all Americans. Provisions to prevent payers from excluding members with preexisting conditions and rescinding their coverage or imposing lifetime limits will result in more patients with chronic conditions being covered by health insurance.

The health reform legislation creates a Center for Medicare and Medicaid Innovation (CMI) to test new service delivery and payment models, such as patient-centered medical homes and ACOs, respectively. These new models, which reimburse providers based on quality care measured against evidence-based medical guidelines and improved patient outcomes, will require care management strategies that promote compliance with medical regimens and patient engagement so

that consumers make healthier choices. Bundled payments for episodes of care, rather than encounter-based or per-procedure reimbursement, will require better care team collaboration and coordination across care settings. Other provisions to improve quality include value-based purchasing, increased quality measures reporting, and the creation of a "National Strategy for Quality Improvement."

The definition of an ACO varies widely and has evolved since the term was originally coined by Dr. Elliott Fisher, director of the Center for Population Health at Dartmouth Medical School, during his testimony to the Medicare Payment Advisory Commission (MedPAC) in November 2006. He defined ACOs as "providers who are jointly held accountable for achieving measured quality improvements and reductions in the rate of spending growth." (Mark McClellan et al., "A National Strategy to Put Accountable Care into Practice," *Health Affairs*, 2010, 29:982–990.)

Key elements of the ACO movement involve holding providers who have accepted responsibility for treating and coordinating care for a defined population of patients accountable (i.e., they assume risk) for measured improvements in terms of quality and cost of care. ACO models range from public models, such as the Medicare Shared Savings Program, to private models that coordinate care for a specific employer or commercial population, to public/private models that cover a more diverse population. ACO providers can be organized as multispecialty group practices, independent physician organizations (IPOs), physician hospital organizations (PHOs), integrated delivery networks (IDNs), and even virtual physician organizations. ACOs will have to include hospitals, home health agencies, long-term care facilities, and other healthcare organizations to provide and coordinate the full spectrum of healthcare services.

KEY STEPS TOWARD ACCOUNTABLE CARE

Building Sustainable Health Communities

It is clear that the current business and reimbursement models, which incent and reimburse providers for volume of services rendered and not for outcomes, are simply not sustainable in the long term. Healthcare organizations recognize that a major transformation is required for survival and are embracing the fundamental tenets of accountable care that emphasize population health and chronic condition management, improved care team collaboration, and coordinated transitions in care to improve outcomes and reduce inefficiencies and costs.

Providers will pursue either an offensive or a defensive strategy to remain viable healthcare organizations in a post-reform marketplace. Provider consolidation will continue as an offensive strategy for IDNs

seeking to improve their negotiating positions with payers and a defensive strategy for smaller physician practices and hospitals seeking to be acquired because they recognize the need for critical mass to survive in a turbulent health reform market.

The business case for the Medicare Shared Savings Program, or Medicare ACOs, remains uncertain in the near term until further clarification is provided through the rulemaking process. In the meantime, private sector initiatives are under way, such as reimbursements based on episodic bundling, readmissions, and quality results reporting, which are driving investments in technology to aggregate and analyze patient health information and better manage and coordinate patient care.

There are five models of ACOs operating in the marketplace that will help healthcare organizations to shift accountability closer to the delivery of care:

- **Health reform driven.** CMS released the notice for proposed rulemaking for ACOs under the Medicare Shared Savings Program on March 31, 2011. Providers that meet the statutory definition of an ACO professional may participate in an ACO, which takes responsibility for at least 5,000 Medicare beneficiaries for a period of three years. Participating ACOs would receive a certain percentage of the shared savings according to whether they met or exceeded quality performance standards. They would also be expected to share in the losses.
- **Provider/employer.** The health system establishes an ACO for its employees to pilot a risk-bearing, collaborative care structure.
- **Payer/provider realignment.** This model is usually found in markets where the performance of the health system is below the national benchmarks. Higher than average per member per month (PMPM) costs across the community will encourage payers and providers to collaborate to control healthcare costs and better coordinate care to improve outcomes.
- **Expansion of risk.** Over time, the ACO may expand its reach to cover additional patient populations, including both commercial and Medicare beneficiaries.
- **Comprehensive.** This is a full risk model for a large population. The comprehensive model involves collaborative participation of multiple providers and payers, including, potentially, Medicare, and engages the community of independent and hospital-employed physicians.

A new commercial/public model is emerging — the Sustainable Health Community — with the guidance of Optum. A Sustainable

Health Community is the ultimate goal and may take many forms as the market evolves. The Sustainable Health Community is broader than a Medicare ACO in that it engages the entire community, not just silos of care. Aligning provider and payer incentives and drawing in patients and their families to create a Sustainable Health Community will require collaboration across the ecosystem and a long-term, shared vision. Leading indicators for the development of a Sustainable Health Community include highly organized, large physician groups with significant market share (30% at a minimum, 40% to 50% is better), plus strong clinical integration, patient engagement, population health management, and risk management capabilities. Some health plan competition is healthy, but a dominant player with at least 50% market share helps establish critical mass for contracting and patients with similar coverage plans. In addition to a large Medicare population, commercial business will also play a critical role.

THE ROLE OF TECHNOLOGY IN HEALTHCARE TRANSFORMATION

The journey to accountable healthcare requires a transformation in healthcare IT that starts with the implementation of meaningful use solutions at a minimum — electronic health records (EHRs), computerized physician order entry (CPOE), eprescribing, and health information exchanges (HIEs) — to automate and connect healthcare applications and processes across the care community and create a common virtual longitudinal patient record.

Electronic Health Records

The deployment of EHRs accelerated in 2010, especially among smaller hospitals and physician practices, to meet meaningful use deadlines and qualify for ARRA incentives. According to an IDC Health Insights survey conducted in 2010, approximately 44% of respondents reported accelerating (34.1%) or aggressively accelerating (11%) their deployment of EHRs to qualify for ARRA incentive payments.

Electronic medical record (EMR) and EHR technology ensures fast, simple, and efficient access to clinical data for authorized users that helps enhance — rather than impede — productivity and workflow. Combined with clinical information systems, such as picture archiving and communication systems (PACS) and CPOE systems, this offers powerful tools for providers to access complete sets of information on patients as well as the decision support and automation tools that will incorporate evidence-based medical guidelines and protocols to help reduce practice variation and medical errors, which will lead to higher quality care. It also makes data available to other providers, to nursing and billing functions, and for medical research.

Health Information Exchange Technology

HIE technology facilitates data aggregation for operational, clinical, and financial performance and quality reporting from disparate systems and siloed data warehouses. Clinical and operational efficiency gains, consumer and clinician loyalty, and improved referral patterns lead to a sustainable business model and a demonstrable return on investment.

Flexible HIE technology solutions will be critical for developing Sustainable Health Communities, which will undoubtedly continue to evolve as they advance new healthcare delivery and reimbursement models. It is also unlikely that any accountable care group will own all of the trading partners that provide services across the continuum of care or be able to acquire them fast enough to respond to this new payment reform mechanism. Thus, interoperability strategies must cross not only the continuum of care but also affiliated and even competing organizations.

Analytics/Business Intelligence

Providers faced with the additional demands of accountable care will need to develop strategies for better understanding and addressing their cost structures and improving patient safety and quality of care. These strategies are spearheaded by investments in EMR, CPOE, and HIE technologies that have ARRA funding attached; the next wave of IT investment by providers will build on this foundation. A key component of this next wave will be business intelligence (BI) applications that combine data from clinical, operational, financial, and other applications. These analytics tools are essential if hospitals are to realize the operational, financial, and clinical benefits from their investments in technology.

With newly implemented EMR, CPOE, and HIE technology and data warehousing support in place to help aggregate data, providers will have unprecedented visibility into their costs, trends, outcomes, and operational issues. Combining data from clinical and other systems and across care settings will allow providers to identify points in the process that need improvement and develop best practice-based guidelines and strategies for improvement. Gaps and opportunities to improve care and safety can be identified using these business, operational, and clinical intelligence tools and then operationalized using clinical decision support applications. Interventions at the point of care will ultimately be required to meet targets for efficiency, patient safety, and quality care.

Patient Engagement

Controlling costs starts with better chronic disease management and engaging patients and families to take a more active role in healthcare. A wide range of personal health and fitness monitoring devices are available on the market today at pharmacies, mass merchandisers, and online. End-to-end remote patient monitoring solutions combine wired and wireless personal monitoring devices connected to an appliance that provides feedback and educational content to the consumer, uploads collected information for remote monitoring and analysis, and facilitates bidirectional communication between consumers and their clinicians and caregivers, along with care management applications for clinicians.

Patient noncompliance is a significant issue and costs the U.S. healthcare system \$100 billion annually, according to PwC's Health Research Institute (HRI). Automated medication dispensers remind patients to take their medication at appropriate intervals and dosages. Hundreds of mobile health applications are available for free or for a modest fee that help consumers keep track of and provide reminders for all sorts of health issues. ACOs will need to develop multiple strategies for reaching consumers according to their communication preference (e.g., telephone, patient portal, mobile application, or text messaging). Contact call centers are well understood in the payer sector. However, their use in the provider sector is fairly limited to outbound calls to collect outstanding debt or fundraising. The size of the call center should be tied to the operating model. That is, one does not need a huge call center for 40,000 consumer participants.

OPTUM'S ACCOUNTABLE CARE STRATEGY OVERVIEW

Optum is focused on early adopters of the Medicare Shared Savings Program model, or Medicare ACOs, as well as the various private collaborative care models described earlier, which are also often referred to as ACOs. These private ACOs have begun to gain traction over the past several years as both payers and providers have sought new models to improve care coordination and reduce costs in a preemptive effort at health reform before it became mandated. The driving force behind Optum's accountable care strategy is to build Sustainable Health Communities that are truly:

- **Connected.** Data sharing occurs through EMRs, HIE and electronic data interchange technologies, network management, and patient and physician portals. Data aggregation and data warehousing provide a longitudinal view of the patient's medical history, thus supporting better population health management, care team collaboration, and transitions in care. The Optum Axolotl HIE solution not only provides interoperability tools but also supports meaningful use of EHRs and includes a patient and physician portal.

- **Intelligent.** Once data has been collected and aggregated, it must be assessed and actionable intelligence must be applied to identify the patients at greatest risk, who represent the highest costs (especially unnecessary costs), and to reduce unnecessary practice variations. Optum's portfolio of products includes a number of analytic tools, such as the Impact suite, and clinical decision support tools that can be brought to bear to provide actionable intelligence to the Sustainable Health Community.
- **Aligned.** When all stakeholders, including consumers, and their respective incentives are properly aligned, risk management is optimized and consumers change their behaviors, resulting in improved outcomes. Previous managed care or health reform efforts focused primarily on controlling healthcare costs and failed to align the disparate economic interests of all stakeholders. Simply put, one stakeholder's (i.e., provider's) revenue was another stakeholder's (i.e., payer's) cost. Addressing the misalignment of financial incentives is crucial for becoming a Sustainable Health Community and encouraging providers to make the requisite investments in healthcare IT and to provide more preventive care and care management services.

In particular, for providers to be successful, payer alignment is key. This alignment consists of performance monitoring across a set of predefined metrics. The ACO should develop case studies to demonstrate that it can manage population health risk and work with payers to properly align these risks with the appropriate incentives.

Optum Solutions Framework

The Optum solutions framework for Sustainable Health Communities is deployed in three phases: design, build, and operate.

- **Design.** During the design phase, the organization and its partners assess their current state of readiness and identify potential barriers that would prevent them from partnering to achieve a set of overarching objectives. A critical assessment is network viability. Questions to address include what the network looks like today in terms of coverage by zip code and specialty and what gaps need to be filled in. The next step within the design phase is organizational alignment and governance planning to establish the ACO structure. Actuarial and financial modeling rounds out the design stage and confirms financial feasibility. ACOs should start with data they have on hand, such as Medicare data, to gauge overall readiness. Proprietary data (either from within the system or brought to bear through partners) can help hone the analysis and further establish feasibility.

- **Build and operate.** It is critical that ACOs not overbuild their infrastructure. Instead, they should incrementally deploy capabilities that are needed today and roll out functionality as needed. Among the first tools to be deployed are analytics and connectivity through HIE. Other key technologies and services include consumer communications, care management support, network management and operations, and provider-sponsored health plan support.

STRENGTHS AND CHALLENGES

Optum is well positioned to help its customers develop Sustainable Health Communities by offering the following:

- **Broad portfolio of products and services.** Optum offers a broad portfolio of products and professional services across its three business segments — OptumInsight (formerly Ingenix), OptumHealth, and OptumRx (formerly Prescription Solutions) — that are critical to accountable care:
 - **OptumInsight** provides analytics, HIE, and other healthcare IT and consulting services. OptumInsight processes health information for one out of every four U.S. patients.
 - **OptumHealth** specializes in population health management and services approximately 60 million consumers.
 - **OptumRx** is one of the largest pharmacy benefit managers based on claims volume, processing 350 million adjusted retail, mail service, and specialty drug prescriptions annually on behalf of 12 million consumers.
- **Experience working with both payers and providers.** Optum has made a series of strategic acquisitions of vendors of provider solutions, starting with the 2007 acquisition of LighthouseMD and including the acquisitions of Axolotl, Picis, Executive Health Resources, and A-Life Medical. The acquisition of this variety of provider solutions that cross care settings will enable Optum to leverage opportunities from healthcare reform and accountable care organizations in particular. According to Optum, approximately 50% of its revenue is generated from the provider market.
- **Dedicated Accountable Care Solutions business unit.** Optum recently established an Accountable Care Solutions (ACS) business to centralize its efforts in this burgeoning area and to respond to its customers' needs with a strong cross-market, cross-company solution portfolio. The ACS business will help hospitals, participating physicians, and health plans collaborate to better coordinate patient care, improve financial performance, improve quality, and,

ultimately, improve consumers' satisfaction with the health system. These efforts are designed to help organizations design, build, and operate what Optum calls "Sustainable Health Communities." While a separate unit within Optum, the ACS business will be able to leverage the expertise, consulting services, and technology solutions of the entire organization for its clients and communities.

- **Deep track record in managing population health and risk.** Optum has extensive experience from the standpoint of payers, employers, and providers. For example, Optum Actuarial Services and Analytic Solutions is used by nearly 170 health plans and represents more than 200 million covered lives. Optum TPA and Care Management Services is used by 70 self-insured health plans and represents 35 million members. Optum Connectivity and Physician Alignment solutions are used by nearly 2,500 provider organizations.

Optum faces many of the same challenges faced by other technology/service providers in developing solutions for ACOs:

- **Fragmented market.** Despite consolidation among providers and suppliers of IT, the healthcare market remains highly fragmented. Strong HIE technology will be required to overcome interoperability issues that will continue to challenge accountable care organizations as they establish connections among the many stakeholders that compose a Sustainable Health Community.
- **No one approach to forming an ACO.** Flexibility will be essential when it comes to consulting and technology solutions. Some healthcare organizations will want to experiment and start by covering their employees first, before offering an ACO on a wider scale. Others will want to create an ACO around a specific condition such as diabetes or heart disease.
- **Lack of provider experience in managing risk.** Historically, there has been a lack of trust among physicians, hospitals, and payers, making it difficult to effectively manage risk. Furthermore, providers lacked electronic health information to analyze and monitor clinical, operational, and financial performance. Deployment of meaningful use technologies, including analytics, will allow providers to take a more active role in assessing their own risk and negotiate more favorable risk and shared savings contracts.

PARTING THOUGHTS

Healthcare organizations embracing accountable care and other collaborative care models must be committed to making a cultural change. Clinician leadership should be involved from the onset as the changes required to evolve from fee for service to fee for outcomes or value will create a sea change for physicians and how providers deliver care today. Consumers will also play an important role in

accountable care. Patient engagement, innovative benefit/product design, and an appropriate combination of incentives and penalties will encourage consumers to make smarter health decisions.

Ideal accountable care solution partners are conversant in both payer and provider contracting and can provide a range of consulting, technology, and services. Ideal solutions will support a "now, next, and later" model that will allow the ACO to start small but be architected to scale as it expands to become a Sustainable Health Community.

ABOUT IDC HEALTH INSIGHTS

IDC Health Insights provides research-based advisory and consulting services that enable healthcare and life science executives to:

- Maximize the business value of their technology investments
- Minimize technology risk through accurate planning
- Benchmark themselves against industry peers
- Adopt industry best practices for business/technology alignment
- Make more informed technology decisions and drive technology-enabled business innovation

IDC Health Insights provides full coverage of the health industry value chain and closely follows the payer, provider, and life science segments. Its particular focus is on developing and employing strategies that leverage IT investments to maximize organizational performance. Staffed by senior analysts with significant technology experience in the healthcare industry, IDC Health Insights provides a portfolio of offerings that are relevant to both IT and business needs.

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