Plans must provide population health incentives to promote provider risk sharing

Expert presenters

Scott Howell, MD,
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During the past several years, the delivery of health care has changed dramatically. These changes, which stem from government-mandated health insurance as well as competitive, socioeconomic and demographic forces, have a direct impact on health plans' growth strategies, care management approaches, and cost and quality initiatives. Among these initiatives is risk sharing, which calls for all health care stakeholders to take on more risk in order to improve health outcomes.

To encourage physicians and hospitals to participate in integrated risk-sharing models that advance population health management, health plans will need to develop incentives that are both significant enough to ensure stakeholder buy-in and simple enough that they can be implemented in a reasonable and timely manner, according to Dr. Scott Howell, senior national medical director, Optum.

"There are hundreds of ways to design population health management programs, but if risk-adjustment model incentives are minor and bonuses get paid out 18 months later, providers will not be interested," Howell said, adding that regardless of how plans design their programs, they have to first acknowledge that the status quo in health care is long gone.

"Over the past three years, we have seen one of the most transformational periods in medicine. Right now, plans are under exceptional pressures, which include changes in Medicare risk-adjustment models, sequestration and performance standards," he said, "so models have to be extremely fine-tuned to meet cost, quality and performance goals while firing on all cylinders."

Howell noted that various factors — from geography to health information technology (HIT) adoption rates — contribute to success or failure in meeting important performance measures. "According to an analysis of key community benchmarks from Optum,[1] health care today is 'both local and uneven,'" said Howell.

Geographic differences evident for three key measures

To demonstrate the inconsistencies in care, cost and population health, Howell turned to Optum data, which tracks certain health care indicators as a way to identify key enablers of better performance. To understand certain quality benchmarks, the data set includes avoidable hospitalizations, hospital readmissions and medication adherence rates. "From a quality-of-care perspective, looking at large data sets is crucial for understanding geographic trends," comments Howell.

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Optum data shows the following:

- **Avoidable hospitalizations:** Commercial data reveals that avoidable hospitalization rates are lowest in the West, the Midwest and the Northeast, while the highest rates can be found in the South and certain rural and urban regions. These higher rates are associated with chronic illness, low economic resources and poor patient health behaviors.
- **Hospital readmissions:** For 30-day hospital readmissions in the commercial population, the highest and lowest rates are less centralized. Among the Medicare population, 18 percent of patients are readmitted within 30 days, while just 8 percent of commercial plan patients are readmitted within 30 days (see Figure 1). The highest rates for readmission for Medicare patients are concentrated in the Appalachian and Ohio Valley regions, as well as in the states of Mississippi and Louisiana.

"When you look at the Medicare map, the data are striking, because they indicate that there are 2,100 hospitals that essentially forfeited about $280 million in reimbursement for 30-day readmissions last year," Howell said.

- **Medication adherence:** Medication adherence is characterized by the World Health Organization as a leading cause of preventable morbidity, mortality and high health care costs, and is a key patient-centered care measure that varies widely across communities. For example, communities in the South and mountain regions have lower rates of medication adherence relative to the rest of the nation. Communities with high rates of medication adherence often have fewer avoidable hospitalizations.

Factors that drive performance

Beyond the general observations about the quality and cost of care, Howell explored other dynamics that may be driving the performance of health plans in certain geographic areas. Factors that drive health system performance fall into two categories, he observed: 1) community social and economic capital — defined as wealth, employment, education, literacy, charitable and volunteer activity; and 2) community incentives and alignment — defined as value-based payment and accountable collaborative care.

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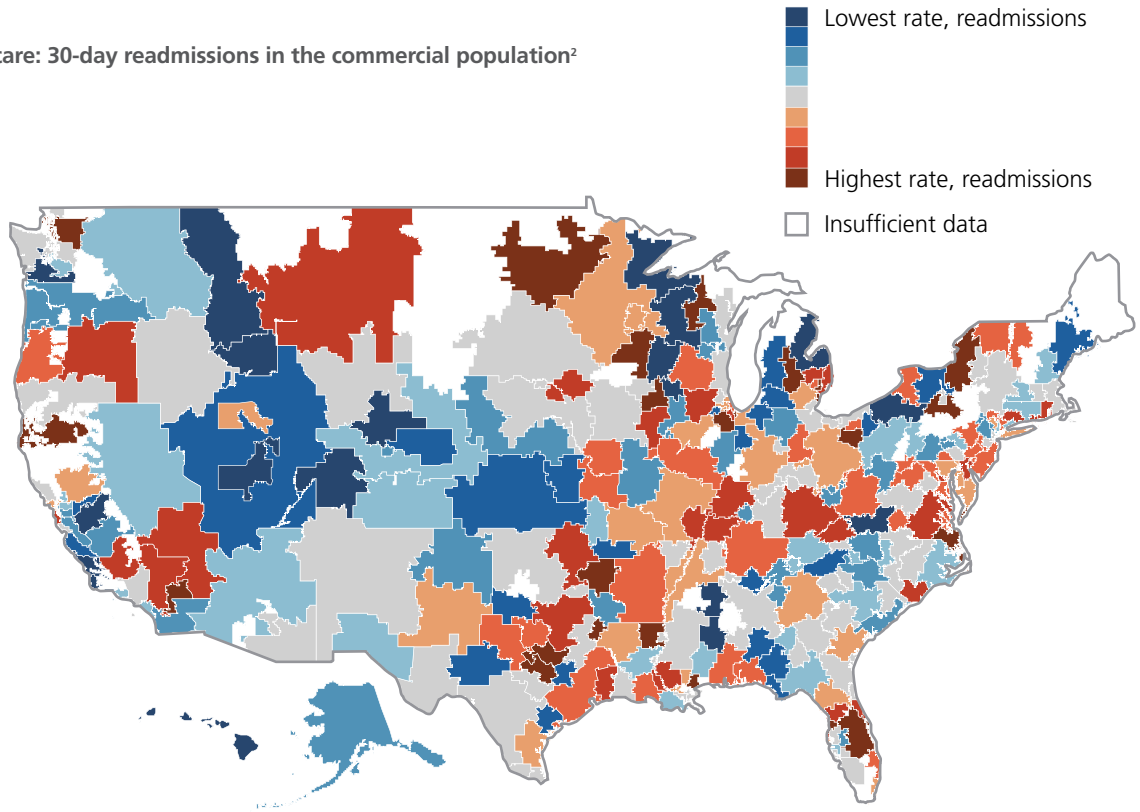
"There is no single factor that will change performance, but there is a whole host of factors that drive aspects of differentiation," according to Howell. "However, incentive alignment, social capital, economic resources, technology and health behaviors all contribute to good outcomes. Some early findings from our data show that adoption of HIT, value-based incentives and provider alignment — as opposed to not having those — contribute to higher performance levels, especially for quality."

Figure 1

Quality of care: 30-day readmissions in the commercial population[2]



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"Looking at how a very large data set maps out, you can see where health plan performance is, what types of interventions are sophisticated and where there are good outcomes," he says, "and it all points to a high level of HIT adoption and value-based incentives."

However, in individual communities and regions that are not high performers and that do not have some of the high-performance drivers in place, providers may not be quite ready to take on more responsibility for the care of populations.

In a Harris Interactive multi-stakeholder survey commissioned by Optum in late 2013, 1,602 physicians and 400 hospitals were asked questions to determine their readiness to take on more accountability for managing patient care and dollars, improve population health management and manage population health initiatives. Although some physicians (34 percent) and hospitals (43 percent) said they were adequately prepared to take greater responsibility for managing patient care, only 16 percent of physicians and 30 percent of hospitals were similarly prepared to take greater financial risk for that care, Howell explained.

Further, the survey shows that when you add consumers into the equation (3,400 consumers were surveyed), their perception of health care delivery in their communities does not always match up with the doctors and facilities providing that care. For example, Howell pointed out that although 38 percent of consumers stated that health care is coordinated in their communities, only 22 percent of physicians and 29 percent of hospitals thought that was true. And when asked whether they thought patients received needed preventive care, 51 percent of physicians thought they did, while only 35 percent of consumers thought so.

Integrated risk adjustment drivers must be in place

To drive population health management, which Howell defines as "improving member care and quality of life in an integrated manner using a framework that leverages best practice analytic capabilities to provide a holistic view of your population and provide the right intervention at the right time to drive member and provider behavior," providers need to implement such population health initiatives as clinical integration, high-risk patient management and readmission reduction programs.

Surprisingly, the survey results show that only one-third of providers have implemented population health initiatives or have them underway (see Figure 2). Hospitals are further along in meeting those goals. This delta in implementation rates is likely due to hospitals having greater incentives in place to do so and in providers' "wait-and-see" approach to developing value-based payment capabilities, said Howell.

The factors behind this provider reluctance to adopt value-based opportunities stem from concerns over complexity, administrative costs and increased risk without adequate reward, according to Howell. "The marginal aspect of this situation is determining how much of a reward you need to provide to move forward on the risk front," he said. "You can't add risk without enough reward to keep the lights on. Also, providers want to keep things simple so they can understand the targets; plans need to design value-based programs with this information in mind."

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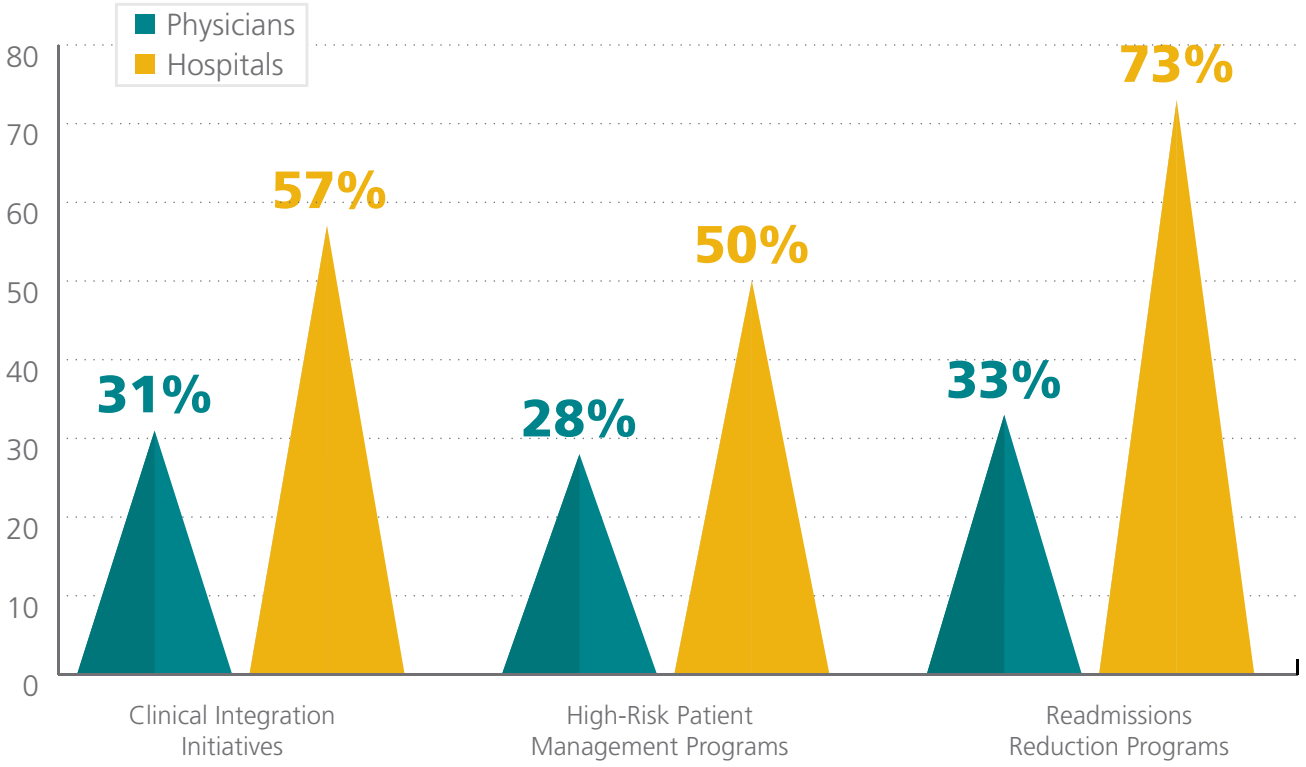
Figure 2

Population health management: Are providers ready to manage population health initiatives?[3]



A member-centric, collaborative approach is ideal, he noted. "Plans need to surround the member in an interactive and integrative manner," he said, adding that Optum collaborates with a health plan's quality and clinical teams and works with its disease management and other program staff to drive programs toward a prospective service model. Prospective services include:

- Analytics and reporting (population segmentation, risk and quality segmentation, Stars measures implementation)
- Care gap analysis (HEDIS/Stars, HQPAF, chronic condition management, in-home assessments)
- Provider and member engagement (market consultation, provider training and education, member outreach)

"Looking at the current state of the nation, it is important to integrate population health, cost measures and quality initiatives to drive change moving forward," Howell says. "As seen in these data, we are not there yet, but we need to start heading in that direction…to move the needle on risk management, he advises. "It is going to be important to ramp up from where we are today, so that five years from now, the whole industry will be willing to take more risks based on outcomes and performance."

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How Optum can help

Optum helps health plans improve care by the accuracy, thoroughness and timeliness of their reporting through outsourced services that include a clinical orientation. Our solution set helps you:

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- Manage risk adjustment analytics and reporting.
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1 The Optum Labs Community Measures Project provides new data and analyses on the performance of the health care system in 306 communities across the United States; its results underscore that health care today is both local and uneven. The Optum Labs Community Measures Project evaluates the local cost of care for commercially-insured and Medicare populations, utilization of health care services (including analyses that pinpoint potentially avoidable care and excessive use), and quality of care. It uses a portfolio of measures that are well validated and capture a range of outcomes across points of care and health care conditions. Performance measures include readmission rates, physician compliance with chronic care guidelines and patient medication adherence. Population health is captured in measures of life expectancy and prevalence of disease.

2 Commercial claims as analyzed by Optum

3 Multi-stakeholder Study, October 2013 conducted for The Optum Institute by Harris Interactive

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