



Risk adjustment: Questions everyone should be asking in 2014

Expert presenters

Jay Baker, Director, Commercial Risk Adjustment, Optum

Scott Howell, MD, Senior National Medical Director

For members population, both in and out of the health benefit exchanges, health plans are faced with a daunting task: determining new enrollees' health care costs and understanding their clinical management and network needs well enough to appropriately calculate risk adjustment. Evaluation, planning and intervention are three key steps that health plans can take to address the risk adjustment challenges presented by newly insured individuals.

Risk adjustment strategies that track these steps will help plans navigate the "perfect storm" of Affordable Care Act (ACA) obstacles that plans must overcome, according to Jay Baker, director, Commercial Risk Adjustment, Optum. Baker, who spoke at an Optum webinar, "Risk Adjustment: Questions Everyone Should Be Asking in 2014," described these ACA obstacles as:

- Short timelines to impact care and capture conditions
- A need to provide pricing and financial guidance despite many unknown variables
- Unknown and changing regulations
- Uncertain health history and utilization of membership
- Transient population

The good news, Baker told attendees, is that these challenges are leading to "a lot of innovation around systems and technology." He added that "technology is becoming a bigger, more important component in the effective use of information and reporting." This technology is likely to play an even larger role as plans try to define their financial exposure on members whose eligibility changes over time and attempt to provide continuity of care for members who shift back and forth between Medicaid and the health care exchanges.

Evaluation starts with learning more about plan members

Predicting risk for unknown populations is not easy, but plans' goals for the evaluation phase of risk adjustment are gathering as much data as possible to find the "right 20 percent" of the covered population that has very specific needs and getting to know those members better, according to Baker. "Not everybody needs intervention or the same type of intervention, but plans really have to identify those people at the top of the bubble who do need it," he said.

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To get to this level of understanding, he explained that plans should evaluate:

- Member data, including:
 - History of chronic conditions, treatment and care and utilization
 - Current claims and utilization
 - Socio-demographic factors (e.g., based on what plans know about beneficiaries, what are some expected utilization and member outreach programs they should expect to deploy?)

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- Population characteristics, including:
 - Average risk scores
 - Member mix
 - Member selection of products

Plans can use tools like telephonic surveys or clinic outreach to begin to build relationships with new members, but they also should consider the pros and cons of using other types of data, such as consumer data, pharmacy data, HRA data, prior authorization/concurrent review and underwriting data, said Dr. Scott Howell, senior national medical director, Optum.

For example, plans can gain early insights into utilization and current health status through pharmacy data; gather history and member data through Health Reimbursement Accounts (HRAs) — but will need analytics to determine whom they should complete HRAs for, because this tool is not effective for the entire population; and supplement knowledge of the market using market-level models that address complex features of member movement in the market and predict financial performance (including risk adjustment, reinsurance and risk corridors), Dr. Howell explained.

“Using concurrent review, prior authorization and case management program data as an ‘early warning system’ within the first three to four months is essential,” Dr. Howell said. “And if these data are siloed, plans need to integrate them as soon as they possibly can.”

Planning is an art and a science

To plan appropriately, health plans should be developing targets and stratification models that align the right intervention to the right member, a process that requires both a strategy and a plan partner, Baker noted. “Plans and their partners should use integrated technology solutions that take advantage of the same data and leverage those data against different components to identify people who are in need and who have either gaps in coding or gaps in care,” Baker said.

After identifying which gaps should be pursued, plans should work with their partners and engage providers to close those gaps. “Pulling together the work and accomplishments that industry has made with Medicare Advantage for the commercial side ... is going to be a huge win,” Baker stated. “Many plans have a history of engaging providers and partnering with them for Medicare Advantage. Plans that don’t have that experience are going to have to learn to adapt and incorporate some of the best practices that other plans have learned,” one of which is integration, he said.

At the core of an integrated system are analytics that combine data points from various sources to create forms, lists or stratification models that can be used by providers — especially those with little Medicare Advantage experience — to target members with gaps in care and/or coding, Dr. Howell added. “It is important to use every data point available; analytics are essential for providers who may not be accustomed to this group of members to help them close as many gaps as possible,” he commented, noting that analytics-powered prospective member segmentation and coordination drive the member intervention plan and engagement model (see Figure 1).

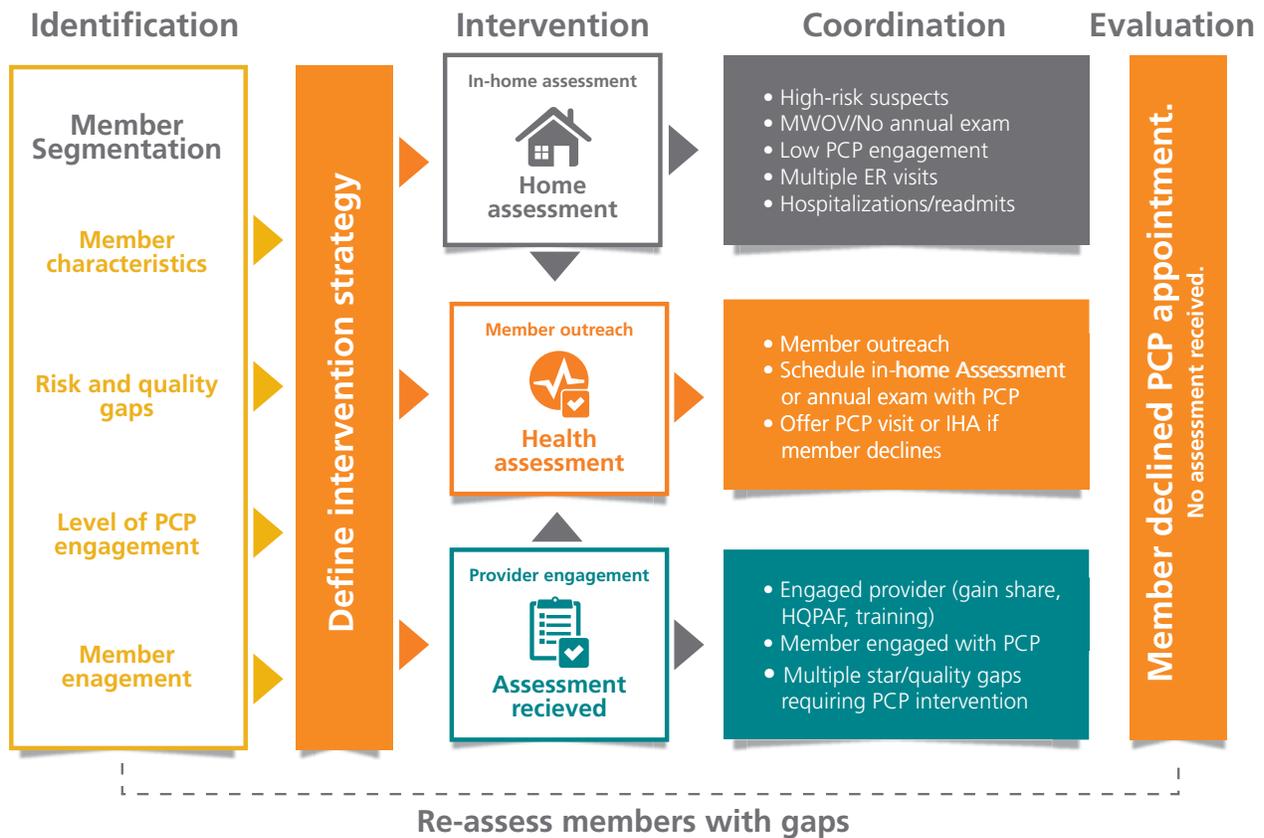
Dr. Howell also explained that sample member and provider stratification can facilitate a plan’s view of how the health system is organized. With robust analytics, plans achieve a complete look at member care status and gaps; interactions based on a longitudinal view of the member and delivery system “provide the most desired results,” he said.

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Figure 1

Prospective member segmentation and coordination



The best intervention is holistic

After evaluation and planning take place, plans should take a holistic approach to intervention by engaging both the member and the provider, Baker told webinar attendees. “Using the right tool for the right job requires evaluating your network and provider relationships as well as the relationships you have with beneficiaries,” he said. “Intervention is not an individual contributor goal — it’s a team sport that involves the provider, administrative staff, the member and the caregivers at home.”

Plans also must decide whether prospective intervention (driving comprehensive assessment of conditions face to face with the member) or retrospective intervention (capturing conditions after the visit that get missed due to coding or data challenges) is best for a particular situation, although Baker stated that a balanced strategy across multiple interventions likely is ideal, because no single intervention addresses all gaps.

“One of the keys here is to engage providers and members while keeping administrative costs down using efficient breakthroughs in technology and integration with electronic medical record (EMR) systems,” according to Baker. “Deploying these systems and operationalizing some new technologies and efficiencies is the direction that industry is taking,” he said. “It’s very exciting.”

Baker recommends that plans use prospective member assessments — member-specific forms that request information on diagnoses, hospitalizations and prescription history — because they bring together data points. The data supplied on these forms reinforce early detection efforts, ongoing assessment and accurate reporting of chronic conditions, he indicated.

Additionally, chart reviews provide another layer of support and data analysis. In Baker’s view, optimal chart review should include:

- Program timeline management (clear understanding of reporting periods, focused planning around chart review activities and reporting periods and submission deadlines)

- Suspecting and analytics (targeting the “right” charts at the “right” sites where they are going to have a high likelihood of closing gaps, evaluating rendering logic and specialty physician selection, and EMR data mining)
- Retrieval process (EMR integration, EMR retrieval, provider engagement and interaction)
- Quality assurance (certified coders, established and measured accuracy rate, over-read for QA, CMS documentation requirements and ICD-10 coding guidelines)
- Compliance (claims verification that “looks both ways” to determine not only whether current coding is correct but also that the chart actually supports what was done already, maintaining images and coding results for risk adjustment and data validation (RADV) support)
- End-of-project reporting (charts retrieved/codes, new and unique Dx, impact analysis)

Quality drives risk-adjustment efforts

Baker concluded by remarking that quality efforts should go beyond traditional clinical measures to include a focus on improving behaviors that ultimately result in more sustainable health and financial outcomes. Plans would be wise to mirror their efforts in commercial programs on the Medicare Advantage side and engage providers in achieving quality measures through actionable data and timely reporting.

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Measures for inclusion in provider quality programs should include:

- HEDIS/state quality program measures
- Clinical care management programs
- Wellness/preventive care measures
- Risk adjustment measures (coding, documentation, compliance)

“RADV and data validation overall are going to be critical components to ensuring that the risk adjustment program is successful and that it is a true reflection of the quality state of that plan’s population,” Baker commented. “When the dust clears on the first year of health benefit exchanges, quality is going to become an area of focus and those plans that are ahead of the game are going to be the most successful with commercial risk adjustment,” he said.

How Optum can help

The integrated Optum approach to quality, risk adjustment and utilization provides health plans with a holistic view of their member population, enabling them to provide the right intervention at the right time to drive member and provider behavior. Our goal is to deliver better, more integrated care, increase efficiency in the health system and reduce costs through:

- Predictive analytics and member assessments
- Comprehensive member and provider outreach and engagement services
- Integrated network services
- Operations and management reporting
- Program effectiveness studies and continuous improvement programs

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