# Newly Covered Members in 2014 Represent Uncharted Territory — and Opportunity

## Expert presenters

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The rapid pace of health care industry change will accelerate further as tens of millions of newly covered members enter the insurance marketplace. Exchange-based enrollment is expected to add 12 to 30 million new members, and expanded Medicaid rolls could increase the insured population by 15 to 20 million consumers. Most new populations will come from the currently uninsured.

Without claims or utilization history to understand the risk that health plans are taking on, plus uncertainty around initial member volumes, plans are entering a period of unprecedented potential risk and volatility. Yet there are remarkable opportunities as well.

As a result, payers must position their organizations to adapt swiftly to opportunities and recover quickly from missteps. Institutional agility is at a premium, with the most agile plans holding the advantage.

Focusing on four assessment activities — related to integrated, strategic investments in care management, quality improvement, and provider engagement — will maximize payer preparation and agility to manage expanded-population complexities and benefit from the opportunities newly covered members present.

## 1 Understand population characteristics and risk.

The standard analytics approach to population identification and stratification leverages available claims or self-reported data to create broad, patient-centric risk profiles used to intervene appropriately with members. The new member infusion from exchanges, however, will not include the robust 12 to 24 months of experience customarily used to quickly engage people in appropriate care programs.

In the absence of complete claims data, plans can deploy pharmacy-based risk prediction tools that use prescription data and classification systems to understand and measure member health risk in a timely manner. By analyzing pharmacy data, which comes in much more quickly and completely than medical data, payers can create markers of health risk that enable prospective risk assignment by classifying disease prevalence, severity and comorbidities. Actuaries can then more accurately predict future health care costs.

## 2 Ensure the network is adequate for new populations.

As health plans work to put new members into the right care programs, they also aspire to place them with the correct and the best-performing providers. Considering providers' relative cost performance, quality-of-care metrics as measured by evidence-based medical rules, episodic cost and efficiency analytics helps segment networks to identify providers that will deliver the best member experience and the greatest cost-saving opportunity.

### Figure 1

**Four core competencies**


In addition to evaluating network adequacy for newly covered members, understanding the relative performances across a network aids a payer in building the narrow networks that help plans position themselves on exchanges. Four core competencies (see Figure 1), are critical in optimizing a network to achieve business objectives around how a payer engages with providers to provide members with the right care at the highest possible level of quality.

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>
> *— Steve Griffiths, PhD, MS, VP, Medical Informatics Consulting, Optum*

## 3 Decide how to provide clinical services to members.

A clinical management framework (see Figure 2) incorporates key components across the medical management continuum. It is fundamentally driven through the domains of value: clinical quality, risk-adjusted reimbursement and appropriate use of provider services. Building the clinical services concept begins with broad and meaningful strategy and design.

Key elements of the framework include:

- Determining whether a function should be centralized or decentralized.
- Identifying the correct level of intensity and staff ratios.
- Confirming that processes are correct and being leveraged consistently.
- Establishing a robust analytic engine to identify and prioritize members for interventions.
- Delivering longitudinal and episodic programs correct for the population.
- Putting a process in place to measure and improve across multiple domains of value to ensure that models impact utilization, quality of care and satisfaction outcomes.
- Supporting the clinical concept with appropriate underlying technology solutions.

Figure 2

**Clinical Management Framework**

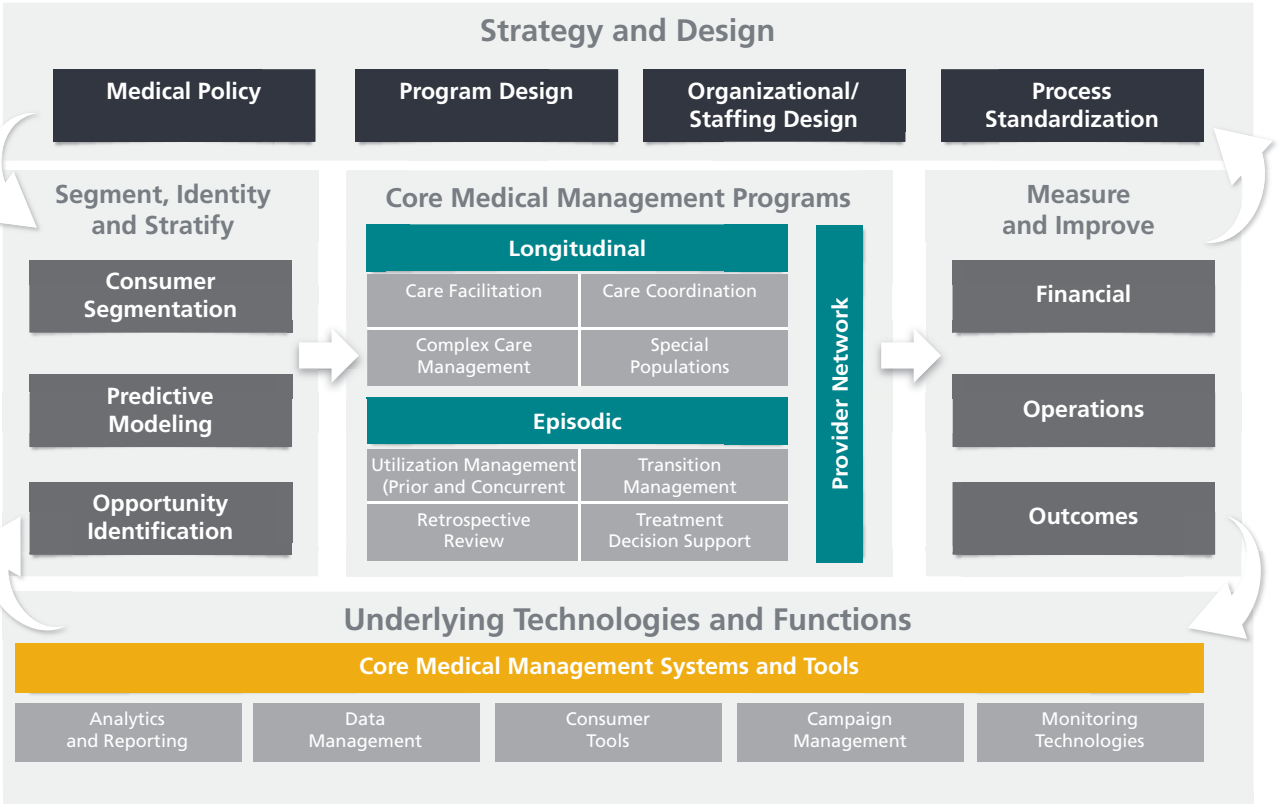
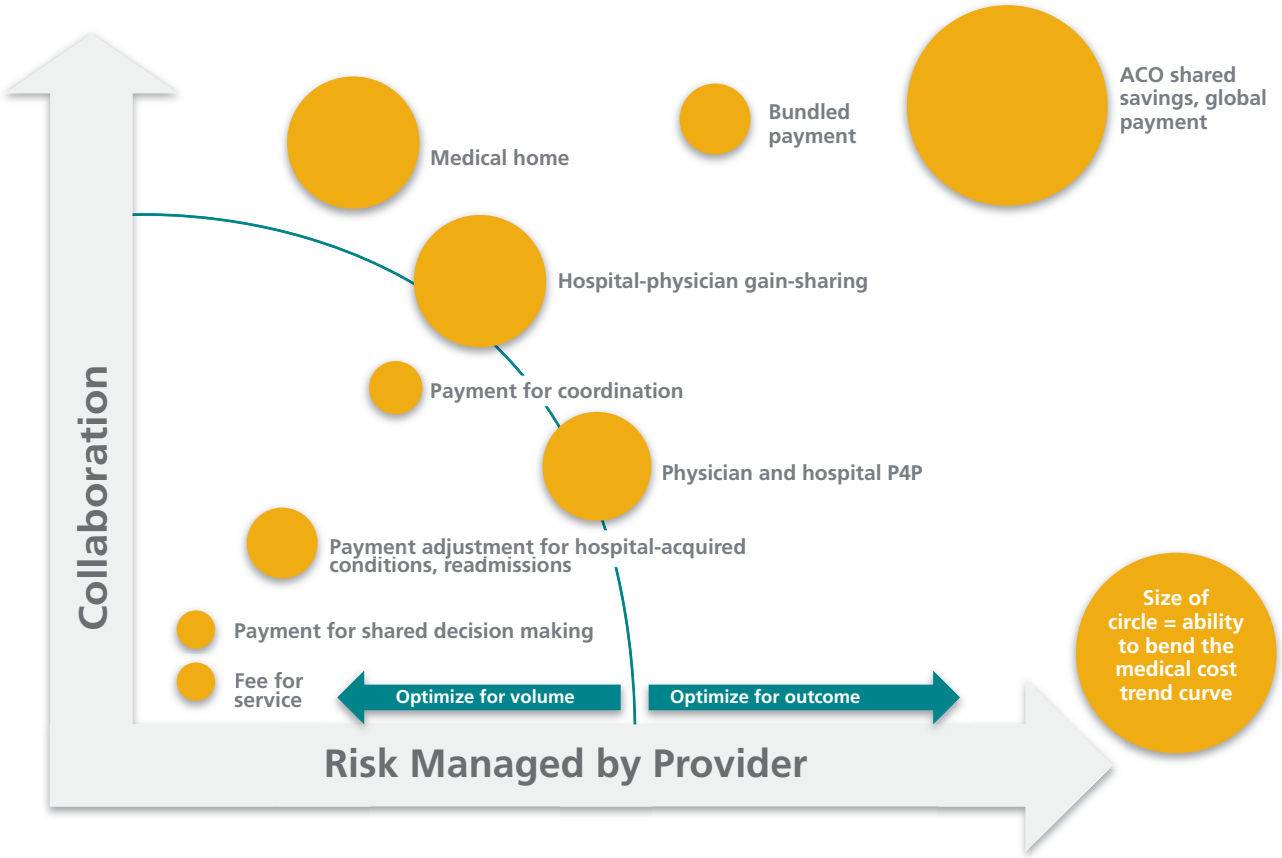


Figure 3

**RAND Corporation study: *Payment Reform: Analysis of Models and Performance Measurement Implications*[1]**




## 4 Ensure that provider programs are in place to drive quality and efficiency.

A recent RAND Corporation study identified 90 current payer/provider payment models classified into 11 types defined by levels of collaboration and provider-managed risk (see Figure 3). The bubble size assigned to a model indicates the potential for a plan to bend the medical cost trend curve, with the ACO model (upper right) offering the most opportunity.

Payers have begun to identify and invest administratively in arrangements to realize cost-saving potential, but the endeavors are fairly tepid and early stage. Optum estimates that greater than 90 percent of health plan dollars and memberships remain in the least-impactful fee-for-service (FFS) space (see Figure 3). In addition, the investment to date in value-based programs has been too small and non-scalable to achieve a fundamental shift.

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With payer reimbursement increasingly dependent upon quality scores, using care management and leveraging the network to deliver on quality goals is critical. Moving provider programs into the high-return quadrant — and making them assets for creating strategic and competitive advantages — will require making meaningful contributions of medical cost incentive dollars. Ideally, at least 15 percent of total revenue for a provider should be in the form of contract incentives that compensate for behaviors that generate value.

In addition, payers must engage and collaborate with provider communities on a robust basis — particularly via technology, data, communication, care management support and member incentives — to help providers maximize the incentive program on a real-time basis by enabling behavior changes. One example: Integrating the administrative records the health plan has historically managed with the medical records historically owned by providers. Putting those two pictures together and then feeding the information back to a provider in a consumable way so the data is actionable at the time of care to close identified care gaps.

## Assessment Key to Benefitting From Increased Population

Marketplace churn and volatility accompanying the addition of as many as 50 million new members clearly brings uncertainties and challenges that may exacerbate existing stress points within health plans.

Although the appetites and consumption levels of this new population initially will be a question mark hanging over the marketplace, the evolution is driving significant behavior change in the payer community and throughout the health care system. On a positive note, the changes are renewing interest and investment in care management, quality improvement and provider engagement activities viewed as essential to driving health care quality and cost efficiency.

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Addressing the expanding member population requires addressing key implications that cut across all health plan aspects, from operations and cost efficiency to quality and compliance. Positioning payer organizations to benefit from opportunity, while mitigating risk, benefits from a four-part assessment.

The elements include: understand population characteristics and risk; ensure network adequacy; optimize clinical services delivery; and move provider relationships toward relationships that increase collaboration and risk sharing.

## How Optum can help

Optum offers a variety of solutions to help detect evidence-based medicine gaps and provide targeted intervention strategies to directly impact members' health outcomes and decision making. Our solutions are aimed at helping members:

- Get healthy
- Navigate care options
- Live with a condition
- Live with an advanced illness

## Want to learn more?

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1 Schneider E., Hussey P., Schnyer C. Payment Reform. Analysis of Models and Performance Measurement Implications, 2011. RAND Corporation, Santa Monica, CA. rand.org

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