Benchmarking helps plans identify medical cost management opportunities

Expert presenters

Derek Pederson, Vice President, Medical Informatics Consulting, Optum

Steve Griffiths, PhD, MS
Vice President, Network and Population Health Consulting

There is no question that new regulations are putting pressure on payers (health plans and risk-bearing providers) to explore business models that will allow them to reduce their medical loss ratios (MLRs), strengthen clinical performance and enhance relationships with providers. As part of this process, payers need to consider how benchmarking their performance against local, regional and national norms can help them identify areas of opportunity for harnessing resources, improving care and managing medical costs.

"At the local, state and federal levels, there are lots of new forces — legislation and regulations in progress — that require plans to really rethink their business models and identify new approaches to help them grow and become more effective in how they manage and develop their business," Steve Griffiths, PhD, vice president, medical informatics consulting, Optum, said at a recent Optum Perspectives webinar.

These forces, Griffiths explained, also include new member populations, evolving quality measures and an increasing need for operational and cost efficiencies. "Organizations need to understand how their prevalence rates, cost and utilization profiles, and distribution of services across various categories of care are benchmarked at a population level — and also from a clinical perspective — within episodes of care."

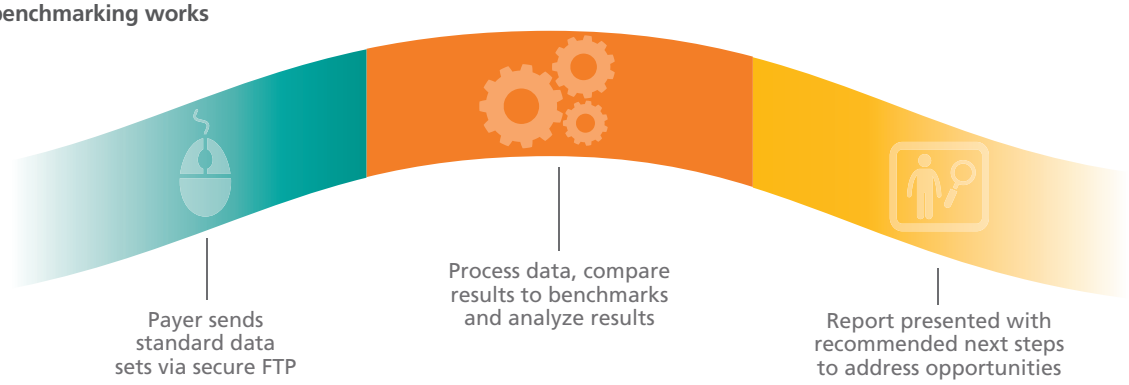
Leverage data to prioritize between multiple opportunities

Griffiths told webinar attendees that because plans are working with limited resources, it is crucial to their success that they use the information they have at their disposal "to really prioritize opportunities [for improvement] and have a robust process for remediating those issues." Many plans may not understand that benchmarking can provide a more accurate picture of the plan's current status and help them develop a measured strategy for improving operations and lowering costs.

He described a payer that came to Optum with an MLR that was greater than 95 percent. Plan managers started throwing out ideas that might decrease that rate, such as "we need a transplant program," or "we need a diabetes program," which amounted to little more than "throwing darts at a wall," he said. Instead, before investing in new programs, they first needed to understand what their performance landscape was by using data and comparative information to identify performance issues that should be addressed.

Figure 1

How benchmarking works



Addressing benchmarking challenges head on

Optum conducts benchmarking using simple standard claims along with member and provider data sets "to give us a view of financial, clinical and network performance," according to Griffiths. To reach that high-level view of performance, Optum directly tackles the following benchmarking challenges:

- **Data access** — Optum benchmarks are composed of a multi-payer, multiyear data set of 16 million commercially insured members in all 50 states. It is structured to create a national benchmark, nine regional benchmarks and more than 40 market-specific benchmarks.
- **Common definitions** — Griffiths stated that common, standardized definitions for different types of services are extremely important. As one of its key tools, Optum uses Episode Treatment Groups (ETGs) to help capture all services related to the treatment of diseases and conditions. Age/gender results are then compared to the appropriate benchmark.
- **Opportunity impact** — Benchmark results can only prioritize opportunities if variances are quantified based on a health plan's actual cost information. For example, remediating one area may save $2 million per year but remediating another area could save the plan $30 million per year.

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>
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> *Vice President, Medical Informatics Consulting, Optum*

Using benchmark results to monetize opportunities

Indeed, comparing a payer's results to benchmarks not only will help plans prioritize where to put resources, but also will verify that current payer programs, such as disease management, care management and network initiatives, are producing the intended results, according to Derek Pederson, vice president, medical informatics consulting, Optum. Pederson explained that plans should benchmark data covering inpatient facilities, outpatient facilities, professionals and episodes or conditions.

During the webinar, Pederson described a plan that demonstrated a high level of inpatient/emergency department utilization (73.8/1,000) compared to benchmarks. Optum looked at moving the plan's admit rate per thousand down to the median benchmark in the Mid-Atlantic regional rate (51.7/1,000), which would save the plan between $80 million to $90 million per year.

An additional level of analysis could identify the primary care providers who may be responsible for the patients being admitted for avoidable conditions and identify the hospitals and systems where readmissions are occurring most often. "Our goal is to leverage the data to create that monetization … to focus on those opportunities that will make the biggest difference in MLR or total cost of care," Pederson said.

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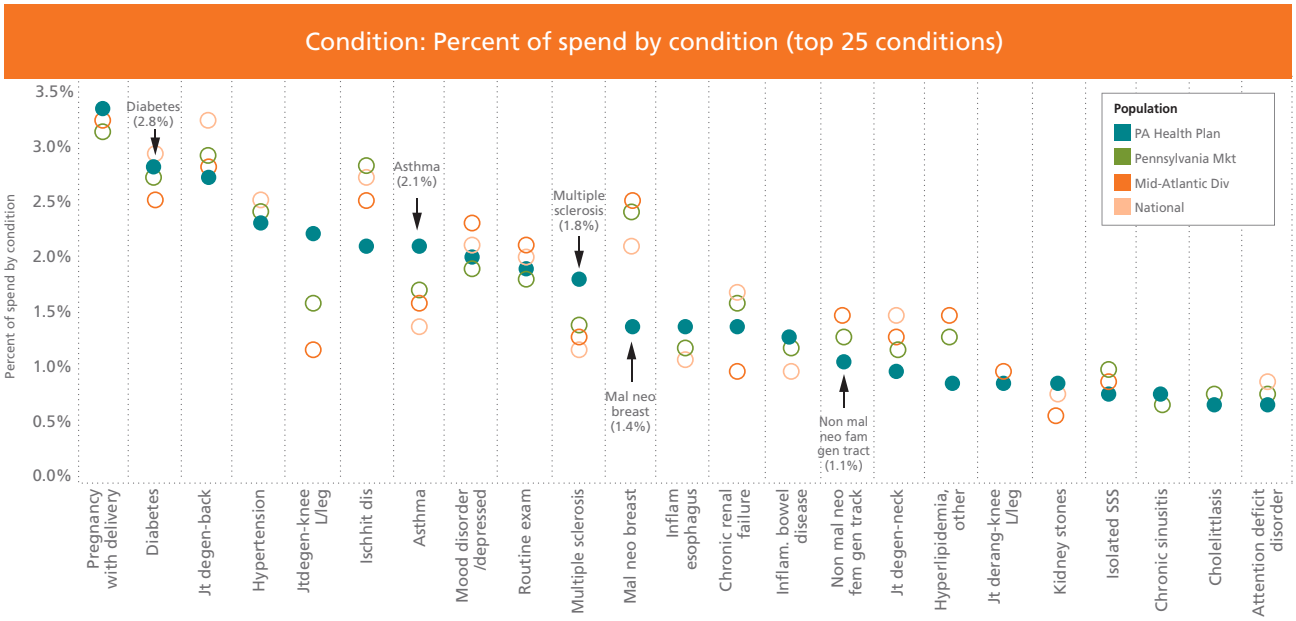
By benchmarking the top 25 conditions driving the cost of care, plans can leverage the Episode Treatment Groups that differ from traditional cost and use benchmarks, he continued. For example, if a plan has a gender-adjusted knee replacement rate at the 93rd percentile, moving that rate to the median rate (43rd percentile) would yield a savings between $32 million and $39 million per year.

Further, taking a closer look at specialty pharmacy spend for the plan could help the plan determine "if there are opportunities to partner with the pharmacy benefit manager and the medical care management team to impact the cost trends," Pederson noted.

Figure 2

Top 25 conditions driving total cost of care



As a proportion of overall spend, diabetes, asthma, obesity and multiple sclerosis, are all above benchmark rates. Joint degeneration of the knee and lower leg is substantially above the benchmarks. Note: Percent of spend is not age/gender adjusted.

Developing a plan of action

When considering benchmarking, Griffiths said, plans need to focus on engagement and system change as they move from collecting and analyzing data to taking action. He noted that benchmarks alone will not effect change — instead the payer must organize resources to effect that change and maximize the improvements. The following elements are integral to this change:

- Strategic plan
- Executive support and investment
- Program management
- Measurement and tracking tools
- Contracting evolution/aligned incentives
- Network optimization
- Population health — optimization

Plans also should be aware that "knowing how similar or dissimilar some of these important measures are compared to local, regional and national benchmarks — measured in the same way and viewed from a financial, clinical and network perspective — helps to provide a road map" regarding which areas to remediate, Griffiths said. He concluded by adding that the benchmarking process can be updated on a regular basis to identify ongoing system change and to help refocus priorities in the future.

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"Benchmarking supports a greater focus on being more effective from an operational perspective as well as being strong around clinical issues," he said. "It allows plans to use information in an impactful way to create change."

How Optum can help

Benchmarking can provide a more accurate picture of your health plan's current status and help you develop a measured strategy for improving operations and lowering costs. Optum directly tackles the following benchmarking challenges:

- Data access of 16 million commercially insured members in all 50 states
- Common definitions to help capture all services related to the treatment of diseases and conditions
- Opportunity impact by quantifying variances based on a health plan's actual cost information

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11000 Optum Circle, Eden Prairie, MN 55344