Provider engagement has a major impact on quality, costs and outcomes.
Because health care market dynamics now impose risk adjustment and quality standards on financial performance across all market segments — Medicare Advantage, Managed Medicaid and commercial plans — in order to balance risks, improve quality and decrease costs, health plans must move beyond retrospective claims analysis and basic assessments. To optimize potential health plans must fully engage those who serve on health care’s front lines: providers.

Providers are the linchpin in improving plan performance, according to Stephanie Will, senior vice president Optum, who spoke at a recent Optum Perspectives webinar, “Enhancing Engagement with Providers to Improve Cost, Quality and Revenue Outcomes.” She explained that plans are underperforming for a variety of reasons, many of which involve a lack of adequate interaction and engagement with providers.

**A changing market presents obstacles**

Due to market changes, new obstacles are taking hold, such as member movement, coding variables, physician resistance, and documentation and data accuracy. However, she noted that overcoming obstacles to plan success is not easy. “If it were easy, everyone would be doing it,” she said.

In light of these obstacles, plans should focus on the following actions:

- Prioritizing and refreshing a list of members to engage — “Don’t treat all members equally,” Will said. “Focus on those who can have an impact on the plan.”
- Overcoming physician resistance with physician engagement tools and services
- Filling gaps in physician engagement with member engagement tools and services, “so assessments are beneficial to both”
- Establishing an overall performance management infrastructure

**Figure 1**

*Why are plans underperforming?*

1. No outcomes lead (accountable, end-to-end process orchestrator)

2. No target list (prioritized and refreshing list of patients)

3. No member outreach (not getting the right patients to see their doctor)

4. No information at physician fingertips (so MDs know the gaps needed to be assessed during patient visit)

5. No visit capacity (physician schedules are booked and no time for increased visit volume)

6. Poor paperwork (not documenting for diagnosis, incorrect coding or submission)

7. No performance management (not monitoring and improving results)
Successful organizations “don’t treat risk adjustment and quality as a separate area,” Will said. Instead, these organizations make these elements “a core part of their organizational strategy and the foundation of their funding mechanism.”

— Stephanie Will
Vice President, Risk Adjustment, Optum

Plans can work toward these goals by using a best practice model that employs multiple steps on a continuum.

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Focus first on top tier opportunities

Steven Mueller, senior vice president, business platforms and operations, Optum, told webinar attendees that although getting started down the path toward better provider engagement may seem daunting, plans should focus first on the top 30 percent of the member population which typically drives “about 90 percent of all of your care gaps.” Of course plans also need to provide “foundational support” to the remaining 70 percent of the member population, but honing in on the members who are at greatest risk “puts the right capabilities in place to close care gaps,” he said.

For example, plans can support providers serving members in the top tier by recapturing previous hierarchical condition categories (HCCs), embedding clinical extenders or establishing physician champion programs. This support often will yield improved closure of previously identified care gaps, improved comprehensive review of suspect data with patients, and improved verification of suspects, Mueller said.

Figure 2
Best practice model

Tailored provider engagement
- PAF-actionable integrated gap information at point of care
- Healthcare Advocates engage providers in field, and offices deliver PAFs, provide training and feedback
- Facilitate targeted gap closure

Coding/QA
- Coding actual activity to document appropriate HCCs and clinical gap closures
- Deliver program-compliant files for submission

Suspecting/stratifying
- Leverage analytics
- Tier opportunities and make program recommendations

Member engagement
- Home assessment - target high risk, least engaged members
- Direct member aptt. scheduling
- Medication adherence
- Coordinated member touch

Reporting and attribution
- Weekly, monthly and end-of-project reporting
- Financial RAF, ROI. Attribution valuation, quality gap closure and projections

Quality and Program Controls
He also explained that plans have to identify where their providers are on the spectrum of physician engagement and then develop plans to move them along on that continuum, recognizing that there is not a single approach that will work for every provider. “We especially want to move physicians up to the ‘engagement continuum’ where they have responsibility for the members that have the most significant care gaps,” he said.

“This should be a very focused effort,” he continued, adding that Optum deploys Coding Educators to work side by side with physicians, and it helps to ask provider relations teams to work with and influence physicians “to really make a difference” by assessing high-risk populations and bridging care gaps.

“It’s exciting when you see physicians start to understand how to code better and get through the critical membership faster and more accurately,” Mueller stated. Further, with proper engagement, providers “apply better quality standards documentation along with their assessments to make sure that everything passes a quality audit.”

Three stage of engagement

Plans generally are at one of three levels in terms of their provider engagement: (1) no foundation/just starting out; (2) foundation exists, but needs enhancement; or (3) foundation is established, but refinement will enhance results.

No foundation. Plans without established risk-adjustment programs need to start with a foundational infrastructure,” Will told attendees, adding that capitalizing on engaged physicians will drive results. She said that plans should have at least the following “boxes checked” as they build their foundational programs:

- Opportunity analysis/targeting (identify members to engage to achieve expected value and ROI cut points)
- Retrieval (use basic analytics and retrospective chart review)
- Coding/QA (ICD-driven, possibly CPT®)
- Reporting and attribution (program value and attribution reported by provider and member attributes, and comprehensive weekly, monthly and end-of-project reporting)

Will also stated that establishing a foundational model has been successful in improving the documentation of risk. If plans are not seeing a progression in risk score improvement, they should ask “Is that appropriate? Does that feel right?” she said. “People often want to know what their risk score ‘should’ be, but there is not a standard answer. Your risk score should reflect the burden of disease in your population … and you may need to employ more tactics or solutions to reduce risk exposure.”

Limited foundation. Plans that already have a foundation in place should add suspecting analytics, member outreach and provider engagement to the mix. For example, “plans have to do that recapture or their scores will drop, but they need to move past recapturing,” Will said.

Figure 3
Provider participation strategies

<table>
<thead>
<tr>
<th>Strategy</th>
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<tbody>
<tr>
<td>• Sophisticated management process for supporting provider participation</td>
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<tr>
<td>• Escalation path defined</td>
</tr>
<tr>
<td>• Leverage Healthcare Advocates to engage with providers to resolve issues</td>
</tr>
<tr>
<td>• Year over year analysis of PNPs and engagement strategies for each chart review project period</td>
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<table>
<thead>
<tr>
<th>Resources</th>
</tr>
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<tbody>
<tr>
<td>• Strong Client Management team</td>
</tr>
<tr>
<td>• Healthcare Advocates leverage previously established relationships with providers and their staff</td>
</tr>
<tr>
<td>• Supporting teams clinically trained with subject matter expertise in RA Services; located in provider communities</td>
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<table>
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<th>Reporting</th>
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<table>
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<tr>
<th>Health plan value and results</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased provider record retrieval participation</td>
</tr>
<tr>
<td>• Improved provider satisfaction rates</td>
</tr>
<tr>
<td>• Weekly PNP reporting by reason code including days pending to resolution</td>
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Established foundation. After plans have a firm foundation in place, they can extend the suspect analytics, along with member and provider engagement. During this stage, Optum typically deploys an “outcome lead” or a “quarterback” to manage in the market and in the field, according to Mueller, “where we have that physician treating the membership and making sure that we iterate on that data from that physician to an annual assessment process. We are constantly bringing that data into our engine and rerunning that engine to stratify the membership to ensure that we are always focused on the highest uncovered recapture or suspect opportunities in a blend that we establish with our clients.”

Will then described some provider participation strategies plans can use to assess where they are and what they can do to get to the next level. “I don’t believe there is enough you can do to engage with your providers,” she told attendees. The message for plans on both the provider and member side “is that you don’t want to treat everyone the same,” she said. “You have to figure out how to meet the providers where they are and help them to take the next step up the spectrum to be in that effective, engaged quadrant.”

Engagement solutions yield results

Mueller then shared a case study covering a physician organization serving 27,000 patients in the Southwest United States. The plan was concerned that it was leaving patient conditions undetected, and it faced challenges with its physician and member engagement. Among several activities, Optum provided people, processes and technology to assist clients in such areas as:

- Network assessments
- Analytics to identify high-priority patients on an ongoing basis
- Member outreach
- Meaningful reports for physicians to support patient quality of care
- Capabilities to improve the documentation and coding process

The results, Mueller concluded, were increased Medicare Advantage star ratings, increased patient visits for high-priority patients, improved risk scores and increased awareness of the physician practice by reopening and staffing a clinic location.

“If we can get members onto care pathways early, we will decrease costs over time and accurately reflect the costs of the programs needed to treat that membership and ultimately improve health outcomes,” Mueller said. Optum “uses the data analytics that work best across the organization to drive through processes with the most important assessment tool that we have: the relationship between the physician and the member.”

How Optum can help

In order to balance risk, improve quality and decrease costs health plans must move beyond retrospective claims analysis and basic assessments. To optimize potential, health plans must fully engage those who serve on health care’s front lines: providers. Optum can provide help to people, processes and technology in areas such as:

- Network assessments
- Analytics to identify high-priority patients on an ongoing basis
- Member outreach
- Meaningful reports for physicians to support patient quality of care
- Capabilities to improve the documentation and coding process

Want to learn more?

Visit optum.com or call 1-800-765-6807.