Defining and Understanding Population Helps Plans Deliver Better Care, Quality and Reimbursement

Expert presenters

Dr. Scott Howell, Senior National Medical Director, Optum
Scott J. Fries, Senior Vice President, Optum
Because health plans today are faced with managing extremely diverse populations, which requires services spanning neonatal intensive care to end-of-life care and everything in between, knowing more about those populations — through data analytics, predictive modeling and provider/member engagement — will help plans to design and align programs that meet the individual consumer’s needs and improve clinical quality and satisfaction performance.

“Population health management helps plans get their heads around managing health care for each individual in a way that can be both effective and efficient, and provide the right intervention at the right time,” according to Scott J. Fries, senior vice president, Optum. Population health management allows health plans to identify and understand, at a consumer level, “opportunities to improve disease identification, compliance with evidence-based medicine guidelines, and the appropriate utilization of benefits and services,” Fries said at a Feb. 26 Optum webinar, “Population Health Management: A Systematic and Integrated Approach.”

The first step is using a systematic approach to aligning individuals with specific needs with interventions that are proven in research and in practice. Every plan has a range of individuals including those who are generally healthy, those who live with one condition or disease, and those with multiple conditions or diseases. Understanding who those individuals are and what they need — on a very specific level — will differentiate population management programs that are successful.

**New model is emerging**

Traditional disease management approaches “do not resonate with consumers and have not been successful in reducing cost or increasing satisfaction with them,” he stated, adding that in spite of plan efforts, when faced with a health decision, the consumer makes a “less than optimal choice 46 percent of the time.”

Where targeting the top 1 percent of members in a commercial plan is the norm, addressing the needs of the top 10 percent of members with a high-risk-type program is one way to affect cost, quality and reimbursement, particularly in a Medicare Advantage (MA) plan or a Medicaid Aged, Blind, and Disabled plan. For example, Fries told webinar attendees, nursing home certifiable consumers represent the highest-cost, the highest-risk and the fastest-growing segment of the Medicare and Medicaid populations. Because these individuals have a broad set of needs and special circumstances, programs that help to reduce nursing home placement rates, hospitalization, specialty services and pharmaceutical costs will be beneficial. Identifying these individuals in your overall population and effectively engaging them is critical for the plan’s viability in both the short and long term.

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> “Clearly there is a need to understand and analyze your populations from a systematic standpoint so you can match interventions to the needs and desires of all members,” he said. Additionally, plans “need to look at each program’s return on investment, including the contribution to quality, utilization and risk-based reimbursement.”
Getting members and physicians on board

After a plan has segmented its population into intervention groups using data analytics, health risk assessments and claims information, it needs to effectively communicate the information to the consumers’ primary care physicians (PCPs). The PCP is the linchpin in the population health management efforts, both because members trust their physicians and because PCPs and their office staffs understand the patient in the context of their culture, health literacy and social environment, Fries explained. During physician visits, PCPs gain insight into their patients’ circumstances, including what barriers to their care — such as a lack of transportation, health literacy or financial resources — might exist.

Fries is a strong advocate of both in-office and in-home primary care assessments and care planning. These face-to-face visits with primary care providers improve the consumer’s adherence with clinical protocol, as well as meet the current requirements for gap closure on most quality measures and all risk-adjusted reimbursement measures.

In order to enable a continuous improvement approach, plans should use a closed-loop system that allows them to link the outcomes (quality, utilization, revenue) of each intervention (member and provider programs). This closed-loop system will allow for meaningful medical economic studies and accelerate the improvement cycle for each program.

Figure 1 — Plan should be “integrator”

Dr. Scott Howell, senior national medical director, Optum, explained that in the current health care environment, Medicare Advantage plans need to operate at their maximal capacity. To promote maximum performance, a primary function for health plans is to encourage a strong and sound member-provider relationship. The health plan should integrate the complex clinical information in a simple format for providers to identify at-risk members and execute gaps in care.

If plans are going to be successful in integrating members, it is “exceptionally important” for them to use more than one method to identify those members, especially when members are likely to fit in more than one category or subcategory, he said. “Demographics and predictive modeling allow plans to assess their entire population and identify all the ways members are engaged in the health care system.”

Plans also should help to bridge any gaps between the provider and the member by giving providers actionable data they can use to improve care. “A good, strong relationship between the member and the provider is how health plans are going to execute better health care and close quality gaps,” he said. “The plan has clinical data and the capability to provide 100 percent of known claims to providers so they have a 360-degree view of the member.”
To build on that valuable information, Howell and Fries both recommended that Medicare Advantage plans provide “specific and personalized patient assessment forms” and clinical information to their network providers to fill in any data gaps and add pertinent non-claims information to patient profiles.

Further, plans should determine on a routine basis which providers are top performing and which might need assistance in meeting quality performance goals. Howell walked webinar attendees through a case study for aged, blind and disabled populations and explained how a health plan can help identify their complex needs and build programs to meet those needs. “Optimal identification and stratification of the health plan population can effectively determine which members require intervention through the most appropriate methods. Care coordination and facilitation can be so much more effective when plans can place sections of their population into a group and then stratify that group to determine which members they need to touch and in which manner,” he said.

At least every two years, Fries advised, plans should conduct medical economics studies to “ensure that programs are both effective and warrant additional investment, and to get rid of those programs that do not work.” He remarked that plan administrators trying to convince upper management to put resources behind population health management need to “make sure that the chief medical officer, the head of provider management and the chief financial officer are all speaking the same language.”

That can be accomplished, he suggested, “by building a story that includes best practices from a clinical standpoint, appropriate incentives, objective review of the provider’s ability to contribute to closing gaps, and very good quantitative analysis around the financial contribution to each of the programs.”

Figure 2
Health Care Quality Patient Assessment Form

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How Optum can help
Optum’s integrated 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.

- 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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