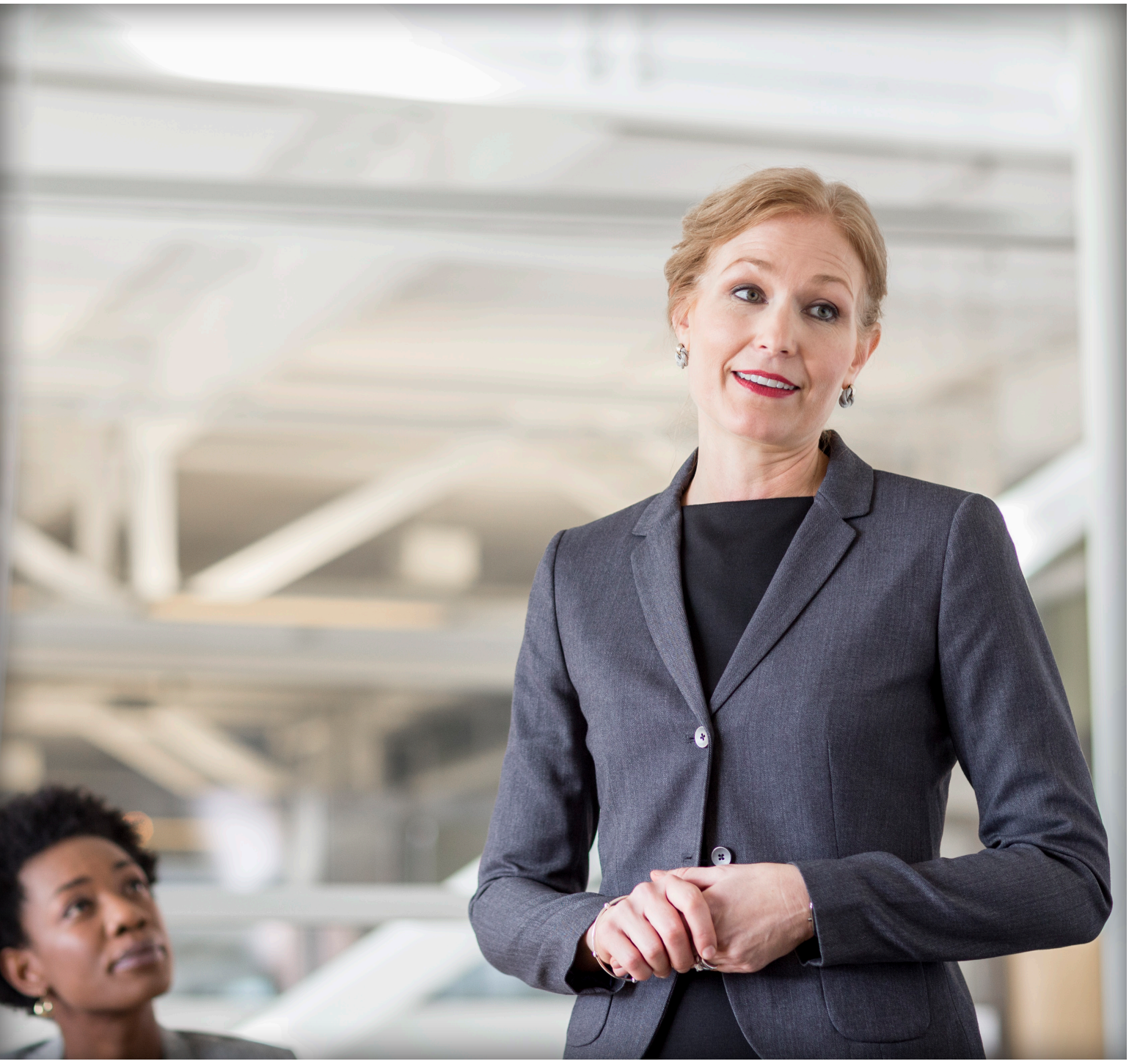

Integrating risk adjustment and quality aligns plan resources, goals

Expert presenters

Mary Larson, Risk Adjustment Lead, Network and Population Health Consulting, Optum

Ryan McKeown, Quality Lead, Network and Population Health Consulting, Optum

Developing a framework that balances the need for stepped-up risk adjustment and quality programs may seem like a tall order, but health plans can streamline this process by using best practices as a road map to increase provider engagement, improve member touch points, better align funding and improve program efficiency, and drive better results. Knowing where to start and how to prioritize resources can give plans a jump-start and help them create integrated risk and quality programs that have a significant impact on providers, members and their bottom lines.

"As you step through the framework built for your risk and quality programs, you are thinking first of your organizational structure and your strategy," said Ryan McKeown, quality lead, network and population health consulting, Optum, at a recent Optum Perspectives webinar, "Evaluating the Effectiveness of Your Organization Against Best Practices for Risk Adjustment and Quality Programs."

According to McKeown, plans need to assess the status of their organizational structure and strategy, identify opportunities and prioritize areas of focus and return on investment, engage providers and members (as well as internal clinical and operational management teams), and inform and sustain performance using data, analytics and reporting.

A risk-plus-quality strategy involves multiple moving parts

"When you are thinking about starting or improving your risk and quality integration, an important place to start is making sure that groups that often are siloed in your organization are coming together to have conversations, at least to start with, about what programs each group has going on currently and how those can be better aligned," Mary Larson, risk adjustment lead, network and population health consulting, Optum, remarked during the webinar.

Larson told attendees that there are five basic components to designing an integrated risk adjustment quality program. These are:

- Analytics — collecting data and building member and provider profiles
- Targeting — determining which programs are the best fit for your specific members and providers, which is "one of the most important and strategic areas"

Figure 1

Comprehensive risk adjustment model

- Intervention — deploying activities that close clinical and coding gaps to improve quality
- Submission — collecting, reporting and submitting data to the Centers for Medicare and Medicaid Services and the Department of Health and Human Services
- Compliance — integrating active compliance surveillance and monitoring throughout the entire program

The compliance component checks that "as you are performing your interventions, such as prospective chart reviews, that you are validating the data that is being collected and looking at how that compares to the claims that you are seeing from the provider," Larson explained. Optum has broken down the elements of a comprehensive risk adjustment model further, into three sections that each have specific action steps (see Fig. 1).

Creating an integrated approach to risk adjustment and quality can be complicated, so health plans should be aware that there are a number of factors to consider beyond the core elements of analytics, chart review, in-house assessments and in-office assessments, Larson continued. "There are a lot of outside influences that are going to have an impact on the strategy and execution of your programs," she said, such as the Healthcare Effectiveness Data and Information Set (HEDIS) and Medicare Advantage (MA) Star ratings, the Affordable Care Act (ACA) and others.

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> *Network and Population Health Consulting, Optum*

For example, she noted that health plans might be located in a state that risk-adjusts for Medicaid, or plans may have ACA membership and will have to determine how to apply their risk programs to that population. Another influencer is the implementation of ICD-10, Larson added. "How does the pending implementation of ICD-10 in October influence your programs? Your providers will be going through a lot of training and preparedness for ICD-10 in the last half of the year, and that's going to take a lot of attention away from risk adjustment education and prospective programs, especially in-office assessment programs," she said.

This scenario on the provider end "could lead to less complete and accurate documentation and data during this period, so plans may want to increase chart reviews in 2016 against those 2015 dates of service to ensure you are capturing completely everything that they've documented in the chart," she advised.

Integrating quality for end-to-end results

Because quality is the key to any health plan's success, they should approach quality management holistically, looking for people, process and technology opportunities across all capabilities (see Fig. 2). As plans "are expanding what is measured and what is monitored, you have to look at the scope of quality in your organization with a holistic lens," McKeown said. "When plans do that … [they] have identified clear opportunities to align with risk adjustment to minimize abrasion and realize efficiencies," he continued.

While assessing quality in provider strategy and engagement functions, for example, plans need to consider what the best investment is for their provider network, and what type of reporting or data exchange would benefit that function, McKeown told attendees. And when looking more closely at data and reporting, which touches all quality capabilities, he said, it is imperative that plans understand the "interplay of these mechanisms."

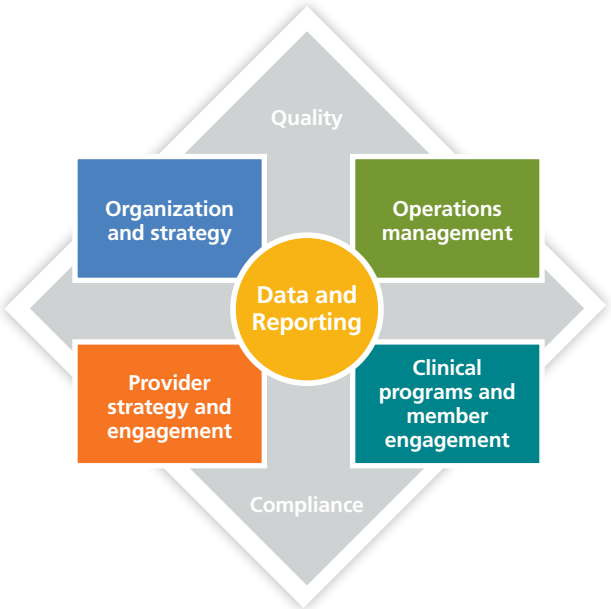
Integrating risk and quality starts, McKeown said, with aligning structure and governance, includes the following elements:

- Communication and collaboration — Plans need to gather the right people across teams and buildings to address the intersection of quality and risk.
- Need for joint understanding — Plans should determine where to put money to improve the entire enterprise.
- Alignment of goals and financial impacts — Plans need to understand they must both pull the same lever together and understand that there are longer-term goals, such as higher MA star ratings at stake. In other words, plans need to communicate among core functions that "there is a longer-term play for higher benchmarks, and [the governance function] should say 'can we integrate into your process or you into ours, so we can, nearer term, offset quality programs from a budget perspective using risk-adjustment revenues?'" McKeown asserted.
- Governance structure — Plans must take into account both the team (IT/analytics and medical informatics, finance/risk, quality/clinical for star ratings and HEDIS, member engagement, provider relations and contracting) and the process (regular cadence, documentation and escalation process).

At the intersection of risk and quality, plans will need to "use all of the tools in the toolbox," McKeown noted, stating that both risk and quality programs are essential to building toward and supporting the comprehensive annual assessment. To be successful, plans must establish relationships with members and providers, offer providers useful data at the point of care, build

Figure 2

Quality Framework



Organization and strategy
- Executive support
- Strategic roadmap
- Program governance
- Culture, organization and accountability
- Prioritization and investment

Operations management
- Vendor management
- AandG, complaints, CTMs
- PBM optimization
- Compliance
- Call centers
- Chart chase processes

Provider strategy and engagement
- Provider contracting
- Provider communications
- Provider incentives
- Provider collaborations/risk sharing (ACOs/PCMHs)
- Provider profiling/ segmentation

Clinical programs and member engagement
- Clinical program strategy and design
- Member incentives
- Benefit designs
- Member insight management
- Member engagement strategies and operations

Data and reporting
- Data sources
- Data latency
- Data processes/flow
- Data completeness and accuracy
- Population registries
- Dashboard reporting
- Performance management operations

and continually reset strategies and goals, and provide integrated reporting that uses resources wisely, he said.

Larson also reminded attendees that coordination on the plan side correlates to better results and outcomes on the member side and greater satisfaction on the provider side. "Think about your programs from a member point of view and try to consolidate them, so that when you have a member on the phone for one purpose … you can layer in the other pieces you need and you are not calling that member seven times in a year to manage all of your programs," she concluded. "The same thing holds true with providers — if you are in there focusing on risk adjustment, try to layer in that quality education as well."

How Optum can help

As regulations continue to expand in the health care market with risk adjustment programs and requirements related to quality metrics, it is challenging for health plans to determine what operational infrastructure and programs need to be in place and how to evaluate effectiveness of current organizational structures. Optum can help with:

- Optimizing organizational structure for efficient execution
- Getting the right analytic infrastructure in place to help guide decisions
- Integrating the right programs to improve quality results and compliance

Want to learn more?

Visit optum.com
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