

## How to combine risk and quality: Secrets from the pros



### Quality as a revenue lever

Historically, risk adjustment and membership growth have been the largest revenue levers for government program payers. But that's evolving. Due to a shifting regulatory landscape, the quality bonus payment is an important new revenue lever.

However, a significant number of plans are not achieving four stars or better. In addition, the points of differentiation among those plans are very narrow, with a significant pocket or grouping of plans that are within half a star point of each other from receiving quality bonus payments.

Moving forward, plans that understand how to address some of the more complex issues associated with quality — and can use data across programs to find leading indicators to identify gaps in care — are going to be the high performers.

### Understanding the provider perspective

Just as health plans are growing by maximizing quality bonuses, providers are seeking new ways to grow through value-based care. In moving to this model, it's increasingly important for providers to view payers as strategic partners to have the data that drives visibility into the value they deliver.

In a recent Optum® survey, roughly half of the payers participating said that they were going to increase or pursue alternative payment models. However, more than half of payers are not currently leveraging financial incentives tied directly to Star bonus performance. Yet 70 percent say that's going to be key to their success in the next year.

**\$2.4B+** in quality bonus payments is available to payers.<sup>1</sup>

**60% of Medicare Advantage** health plans were rated below 4 stars in the 2016 ratings

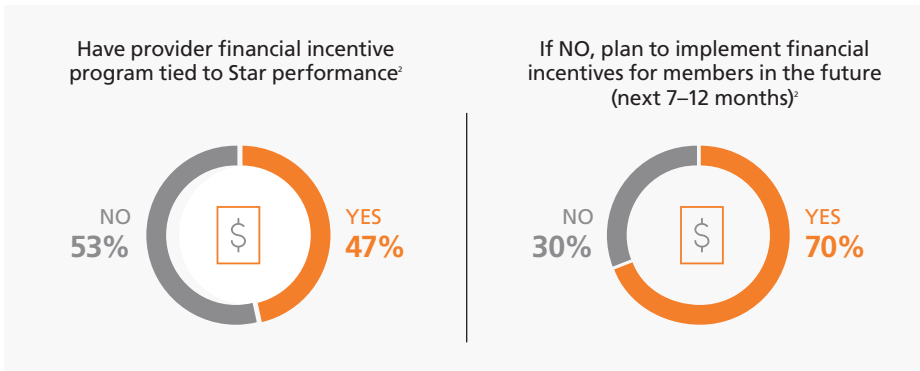
**36% of the market** is within 0.5 stars of receiving Star bonus revenue

**5% of revenue** is available as a quality bonus payment in several states for managed Medicaid plans

[cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html](https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html)

Increasingly, providers are seeking ventures with payers and other providers.

As providers move to a value-based payment structure to get more for the value they provide, payers need to incentivize properly to achieve their quality bonus payments.



### The journey from fee-for-service to fee-for-value

For both provider and payer, there have been a lot of changes on the continuum moving from fee-for-service to fee-for-value.

In the ideal, full fee-for-value state, provider and payer are nearly fully integrated. That means:

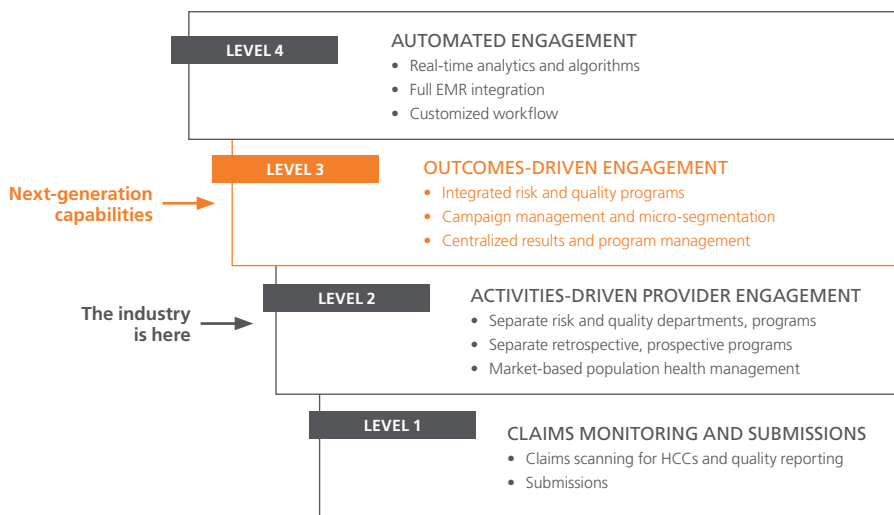
- Real-time data exchange
- No barriers to entry in terms of electronic medical records (EMR) data exchange
- Real-time insights through the lens of the provider and payer
- Completely coordinated outreaches and interventions

So how can health care succeed at moving along the continuum and getting closer to the full fee-for-value model? Providers and payers have to see each other as strategic partners. They have to work together to move forward.



### What's ahead: Outcomes-driven engagement

The next generation of capabilities along the continuum is defined by outcomes-driven engagements. That means integrating risk and quality programs to leverage information across both programs for the betterment of each.



This level requires being more strategic in how a payer approaches campaign management and member engagement. It features:

- One centralized system or centralized vendor to see and manage all activity
- The ability to customize workflow on demand and to be able to have more flexibility and shift as your needs change
- Full EMR integration to present gaps in care nearly simultaneously with the care providers
- Ensuring real-time analytics, benchmarking and algorithms are in place to provide the most up-to-date insights possible to facilitate better decisions

### The four parts of a comprehensive risk and quality management program

In combining risk and quality, evaluate where you may be lacking in each of these four critical areas:



**Infrastructure.** It's important to have as close to real-time analytics as possible. This enables you to use predictive models that determine the gaps in care that can be addressed to yield the most benefit.



**Interventions.** How well can you coordinate interventions across multiple programs to minimize member abrasion? You may have a really strong plan for outreach, measure by measure. But those individual interventions can lead to a member not taking action and ultimately abrasion. You can also use efficacy data to continue to advance your models.



**Field resources.** These resources engage your providers directly to assist with burdens of day-to-day gaps and make sure providers can readily identify gaps in care. Field resources also help providers understand and maximize their incentive programs.



**Data acquisition.** This goes beyond the ability to consume and engage data from EMR and real-time lab connections to being able to view that data clinically and from a predictive lens. The result: a 360-degree member view that enables you to gauge likelihood of gap closure at an individual measure rate and leading indicators that reveal a member could be eligible for a particular future gap.

### The Optum approach to interventions

We use OptumIQ™ — our health care intelligence — to inform analytics and strategies that deploy personalized and targeted interventions and communications. We leverage a number of different data sources, including socio-economic, financial and demographic data, as well as consumer and clinical data. This broad spectrum enables us to understand each member's propensity to engage, what modalities that member prefers to be engaged with, then how to re-engage the member in the event that you don't get the outcome you want.

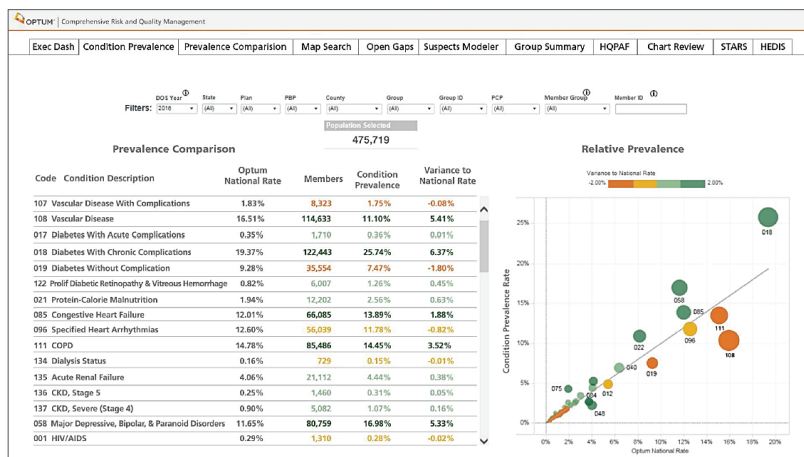
With **OPTUM IQ**™

### Leveraging risk and quality data

By combining data and viewing it across both platforms, you can gain a number of insights today that you weren't able to previously.

For example, someone on the quality side can use risk-adjustment data to look for leading indicators for members eligible for a measure. Perhaps you see that a member is being prescribed medications for diabetes. You can be more proactive in engagement with that member to increase the probability of them being adherent in their medication.

Risk data can also be used for quality programs to combine similar activities — benefiting risk and quality. You can use quality charts that have been retrieved for risk, and review risk charts to close quality gaps during the retrospective quality season.



### Easy-to-use, centralized provider-facing tools

In addition to payer-facing assets, it's important that providers have the assets they need in order to effectively close gaps in care and prove they were successful. A tool such as the one shown here, provided by Optum, enables the provider to see member appointments in real time.

**D18 Diabetes with Chronic Complications**

018	Type 2 diabetes mellitus with diabetic nephropathy	E11.21	Suspected Condition	<input type="radio"/> Confirmed	<input type="radio"/> Currently Not Present	<input type="radio"/> Keep on List	<input type="button" value="Clear"/>
018	Type 2 diabetes mellitus with diabetic polyneuropathy	E11.42	Previously Coded	<input type="radio"/> Confirmed	<input type="radio"/> Currently Not Present	<input type="radio"/> Keep on List	<input type="button" value="Clear"/>
018	Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene	E11.51	Suspected Condition	<input type="radio"/> Confirmed	<input type="radio"/> Currently Not Present	<input type="radio"/> Keep on List	<input type="button" value="Clear"/>

**Screenings & Counseling**

Chronic Illness to Consider	Considerations	Response
Cognitive Function	Screening using tool such as 6CIT	<input type="radio"/> Completed <input type="radio"/> Ordered <input type="radio"/> Keep on List <input type="button" value="Clear"/>
Depression	Screening using tool such as PHQ-9	<input type="radio"/> Completed <input type="radio"/> Ordered <input type="radio"/> Keep on List <input type="button" value="Clear"/>
Diabetes	Eligible tests: Quantitative Urine Glucose, GTT, HbA1c	<input type="radio"/> Completed <input type="radio"/> Ordered <input type="radio"/> Keep on List <input type="button" value="Clear"/>

**Clinical Quality & Preventive Care**

Quality Measure	Response
COL: Colorectal Cancer Screening	<input type="radio"/> Completed <input type="radio"/> Exclusion <input type="radio"/> Keep on List <input type="button" value="Clear"/>
ABA: Adult BMI Assessment	<input type="radio"/> Completed <input type="radio"/> Exclusion <input type="radio"/> Keep on List <input type="button" value="Clear"/>
CDC: Comprehensive Diabetes Care	<input type="radio"/> Completed <input type="radio"/> Exclusion <input type="radio"/> Keep on List <input type="button" value="Clear"/>

The tool delivers full insight into the gaps in care each member has and provides the ability to upload evidence of gap closure at the point of care, as well. This significantly streamlines a traditionally paper-based process, freeing the field team to focus on closing gaps and maximizing incentives. It also saves the provider time and makes gaps in care more transparent to all stakeholders.

### Why Optum?

Today, it's more important than ever to maximize your quality efforts. Focusing on combining risk and quality can yield even greater success. Using OptumIQ, Optum provides the knowledge, resources and best-practice tools introduced here to maximize your quality bonus payments and quality efforts overall.

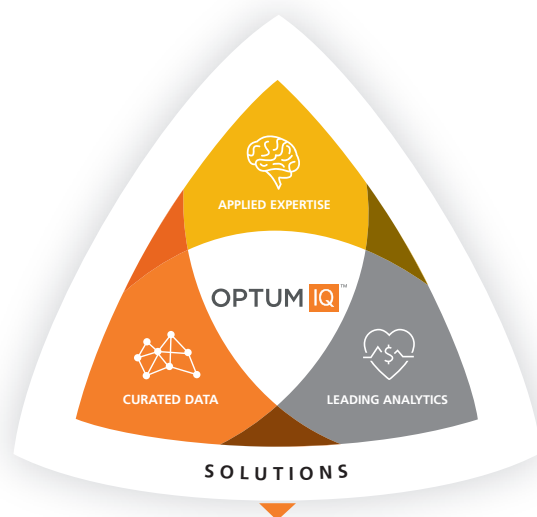
Learn how Optum can help you drive all the value you can from quality as a revenue lever. Contact an Optum representative.

**Email:** [iq@optum.com](mailto:iq@optum.com)

**Phone:** 1-800-765-6705

**Visit:** [optum.com](https://optum.com)

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### What is OptumIQ?

OptumIQ is the unique blend of curated data, leading analytics and applied expertise that is infused into Optum products and services. OptumIQ harnesses the wisdom of over 26,000 experts to take data and build a common language, innovate with purpose and guide action for success.

#### SOURCES

- Centers for Medicare and Medicaid Services. Part C and Part D performance data. [cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html](https://cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovGenIn/PerformanceData.html)
- Optum Payer quarterly panel surveys



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