

Risk adjustment and quality management: The case for alignment

In many plans, risk adjustment and quality management are distinctly separate entities with purposefully siloed objectives and metrics. But a model that brings the two into alignment, enabling true transparency from data to analytics, can deliver a surprising wealth of benefits, including:

- Revenue growth
- Improved outcomes
- Reduced medical spend

This white paper identifies considerations to bring risk adjustment and quality management together to expand your line of sight, enabling a full picture of your opportunities and gaps.

Aligned, not redundant

Health plans need appropriate controls and protocols in place to accurately capture and manage the relative health of their at-risk population. For government-sponsored plans in particular, risk adjustment and quality management both may use retrospective chart review, prospective physician engagement and prospective member engagement to achieve their individual goals.

However, successful organizations don't try to overlap risk adjustment and quality management. Instead, they use transparency to achieve alignment between the two.

Unintended consequences: Member and provider abrasion

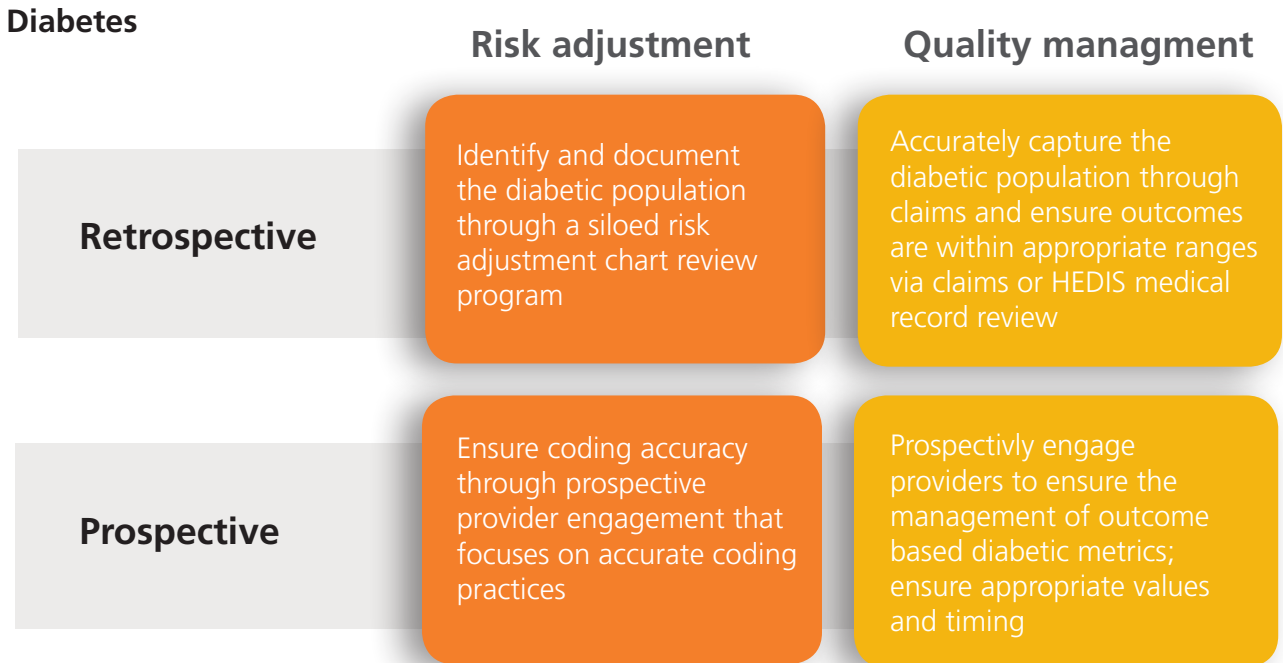
In pursuit of separate risk and quality objectives, members and providers can be unduly disrupted. Member outreach is effective until it becomes intrusive; for providers, chart retrieval can be very abrasive. So the more you can align your risk and quality programs, the better the experience for these key stakeholders.



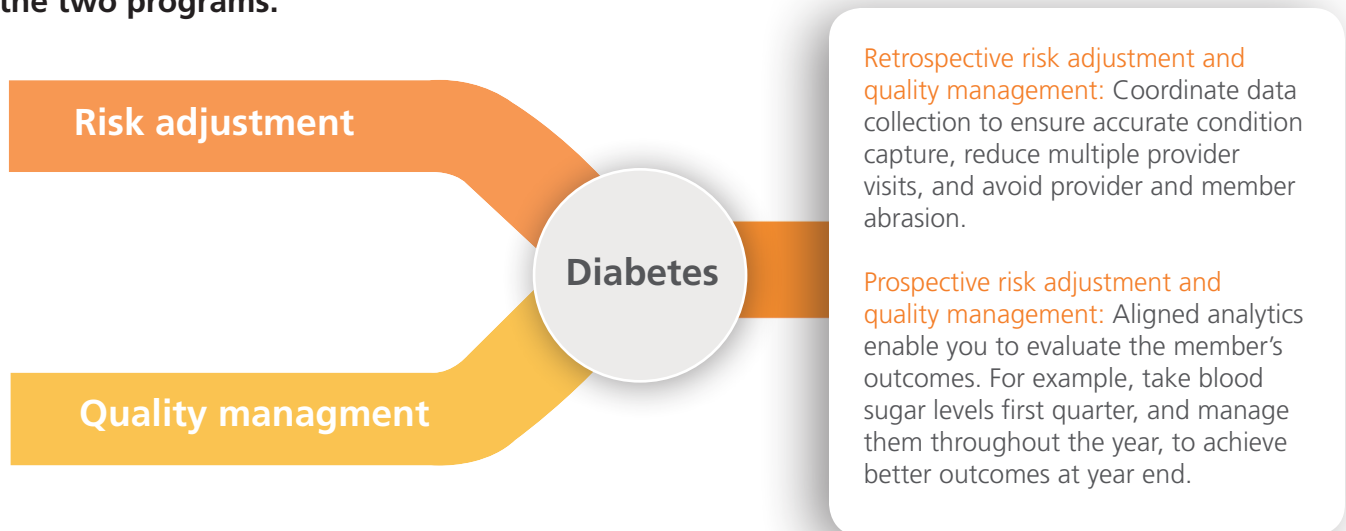
Achieving 20 / 20 vision

By sharing data across risk adjustment, HEDIS and Star Ratings practices, you bring the full picture into focus. In the words of one medical director, "Without the data you are flying blind."

Consider the diabetic membership within a health plan: The appropriate identification and management of the diabetic population within a Medicare Advantage plan is critical to the overall success of a plan's risk adjustment and quality management programs. The graphic below illustrates a siloed approach that can lead to sub-optimized results.



Now consider the benefits of aligning the two programs.



How does alignment deliver costs savings? Consider this example:

Optum estimates 60–70% ...

- Of member charts pulled for risk adjustment could be used for quality, saving an average \$15–20 per chart
- Of the members targeted for risk intervention programs could also be included in quality intervention programs

Best-practice takeaways

For risk adjustment:

To accurately identify and document the at-risk population, prevalence reporting is an important enabling tool. This process prioritizes conditions that may not be diagnosed or coded. Constant evaluation and intense coding education for providers also helps ensure accurate identification and documentation.

For quality management:

Performance ratings help ensure that members get seen for conditions they have or are at risk of developing. The key is to make the connection between the provider and member. In-office assessments can help advance HEDIS and Star Rating objectives and drive accurate coding.

For both risk and quality:

Correlate the data between the two programs to see opportunities and gaps. Then use the info holistically to drive engagement more comprehensively. The more frequently you do this, the more you can positively influence outcomes.

Also, purposefully coordinate data collection, member outreach and on-site visit assessments to make the most of each visit and intervention — from both a risk and quality standpoint.

Trust but verify:

Considerations for vendor management

How many different suppliers are there between you and your constituents? The more touchpoints, the more you are exposed to variability in reporting and accuracy. If consolidation to one vendor isn't feasible, it is important to achieve visibility between vendors.

Consider having one trusted vendor partner oversee the others to deliver a disciplined line of sight and control. Make sure you can monitor all the touchpoints to achieve complete transparency across your programs.

Timely insights: Prevalence reporting

With prevalence reporting by Optum®, we provide trending, benchmarking and other analytic insights based on approximately nine million Medical Advantage members to help clients understand where they are in the mix and identify opportunities.

We can see from our multi-payer data sources where gaps are, where deltas are, and how best to deploy resources to address them. Clients have found this data visibility highly valuable to drive performance.

An expectation of collaboration

It can be challenging for separate internal stakeholders to work together to create a concise view into overall performance. But for many top-performing organizations, this culture shift is essential to each program's success.

As one medical director notes: "I can go into one site and see all measures. If I want to know the medical risk Star Rating in a specific area, it takes me five seconds to get that information."

Best-practice takeaways

Why settle for a sub-optimized approach that leaves money on the table? Grow revenue, improve outcomes and reduce medical spend by aligning your risk adjustment and quality management programs.

About Optum

Optum® is an information and technology-enabled health services business platform serving the broad health marketplace, including care providers, plan sponsors, life sciences companies and consumers.

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