

## Health Care's New Frontier: Quality Program Integration

Medicare Advantage (MA) plan providers have roughly 15 minutes with each plan member to deliver care that drives both quality improvements and better outcomes. To ensure that these 15 minutes are used wisely—and competitively—MA plans need to consider a key strategy for maximizing their plans' success under the Five-Star Quality Rating System payment guidelines: integration.

The Centers for Medicare & Medicaid Services (CMS) instituted its Five-Star Quality Rating System to evaluate the quality provided by MA plans and to provide Medicare beneficiaries with a means to compare the quality of care and customer service that Medicare health and drug plans have to offer.

By integrating quality programs, such as case management, disease management, member outreach, and provider outreach, plans will be able to achieve a consistently high star rating and also generate the most revenue, according to Scott Howell, MD, national senior medical director, consulting services, OptumInsight.

"Everything comes down to what we do with those 15 minutes," explained Howell during an OptumInsight webinar, *Integrating Quality Programs and Measurement Tools: A New Approach for High-performing Health Plans* held on May 19, 2011.

"During those 15 minutes of patient interaction we have to close gaps in care, gaps in communication, and gaps in documentation. The plans that integrate and coordinate their programs to close these gaps are the plans that are going to exceed benchmarks year over year and survive," he said.

Conversely, plans that fail to integrate their quality programs are unlikely to receive a high star rating and thus will not be granted bonuses under the quality bonus payment (QBP) demonstration project, which ends in 2015. Indeed, for 2011 enrollment, MA plans that received fewer than three stars for three consecutive years will be flagged on the Medicare website as low-quality plans. In 2015 and beyond, QBPs will be limited to four- and five-star plans only. "CMS is taking quality very seriously," Howell said. "For many plans, there is a dire need to move the needle on quality."

### **Plans need to take action on quality integration**

Currently, many plans are in the same quality boat, with a majority of plans in the three- to four-star ratings range. Of the 53 measures being evaluated in the Five-Star Quality Rating System program, 36 measures are in the Part C domain and 17 measures fall under Part D. Two of the Part C domains—(1) staying healthy: screenings, tests, and vaccines, which incorporate 13 measures; and (2) managing chronic (long term) conditions, which include 10 measures—must be well-integrated within the larger plan context, Howell explained.

These measures also closely match those evaluated as part of the Healthcare Effectiveness Data and Information Set (HEDIS), which is used to determine where plans need to focus improvement efforts for care quality and service. "Of the 23 measures in just those two domains, 15 are HEDIS measures as well," he said, adding that shifting toward an integrated quality approach as 2012 draws near is vitally important, as that year is a HEDIS measurement year and will serve as the basis for 2015 payments.

“How plans perform against these measures today will have a significant impact on what will happen with them in a few years, so plans should begin a paradigm shift to integrate and coordinate their healthy lifestyle and disease management and chronic condition outreach activities today,” he advised. “Waiting until 2014 to start would be a critical error.”

### Pressure to address quality is mounting

There is no question that plans have ample incentives to invest more in their approach to quality. Under changes in the CMS Hierarchical Condition Categories (HCC) modeling, which identifies individuals primarily by their demographic, health history, and enrollment status, plans are facing lower reimbursement rates. At the same time, under the QBP, plans that achieve quality performance outcomes will receive bonuses.

“To achieve continued revenue support, plans have to do so much better with their approach to quality,” Howell suggested. “To get there, plans have to understand that they cannot improve quality in a vacuum because all aspects of the plan are interdependent.”

To illustrate this point, Howell shared a case study with webinar attendees. He described a 76-year-old man who presented with a foot ulcer and had a history of hypertension and diabetes, as well as a history of prostate cancer that had been treated surgically several years ago. Howell described a litany of screening tests and measures for which this individual—based on his age and conditions—was eligible. These tests included colorectal screening, glaucoma screening, monitoring persistent medications, diabetes measures (e.g., eye exam, nephro testing), blood pressure control, and osteoporosis testing.

He used the chart below to show that for this patient, an integrated, comprehensive approach including appropriate levels of care and screening, the identification of conditions with supporting documentation, and the correct coding for all conditions, resulted in a risk-adjustment factor (RAF) score for reimbursement that was nearly triple the RAF score for the same patient, with diabetes coded to the highest level of specificity but without manifestation coded.

2010 RAF Case Study Example—Inappropriate Submission of Prostate Cancer Dx RAD-V Liability

Hx of Prostate Cancer Not Coded		Inappropriate Use of History of Prostate Cancer Dx	
76-year-old male	0.457	76-year-old male	0.457
Prostate cancer (HCC 10)	X	Prostate cancer (HCC 10)	0.190
Diabetes w/o renal complications (HCC 19)	0.162	Diabetes w/o renal complications (HCC 19)	0.162
No renal failure (HCC 131)	X	No renal failure (HCC 131)	X
No polyneuropathy (HCC 71)	X	No polyneuropathy (HCC 71)	X
Total RAF	0.619	Total RAF	0.809

“This is the difference between proactive care and reactive care for just one member. When you think about multiplying this variance by thousands of members, it’s a significant problem,” Howell asserted. “HCCs, medical management, and quality initiatives all need to be consolidated to maximize interactions with patients, deliver coordinated care, and meet HEDIS checkpoints, as well as foster highly accurate clinical documentation and coding.”

## Four areas needing quality integration

Consulting experts at OptumInsight recommend that plans focus their integration efforts on four main areas: patient care management, quality improvement, risk-based reimbursement, and provider performance measurement. According to Howell, coordination among these four areas will help plans improve overall quality and close care gaps, screening gaps, documentation gaps, and outcome gaps.

In patient care management, plans can improve the cost effectiveness of health services by applying data, analytics, and related consulting services to drive consumer engagement with and adherence to evidence-based treatment protocols and healthy lifestyles, Howell explained. Quality improvement efforts can be ramped up by measuring adherence to established quality standards, such as HEDIS, and to support newly emerging reimbursement programs targeted at quality metrics (i.e., the Five-Star Quality Rating System's payment guidelines).

Further, improving risk-based reimbursement requires that plans support accurate assessment of patient health risk to enable accurate and appropriate reimbursement for health services risk-based payment programs. To boost provider performance, "plans need to measure, inform, and improve provider-specific and network-wide clinical effectiveness and financial costs associated with provider decisions in the care delivery process," Howell said.

He also stated that plans with high star ratings have the following elements in place:

- Executive leadership
- A comprehensive and integrated quality framework
- Targeted and stratified intervention and improvement priorities
- Concentrated membership
- An engaged provider network
- A member-centric focus
- Proactive and ongoing interventions
- Measuring and reporting tools
- Data and analytics tools

An organizational paradigm shift toward proactive and integrated quality activities dictates that quality is not an annual event. "Improving quality should be a year-round process that starts Jan. 1 and ends Dec. 31," Howell said. "Plans that do not start adopting this approach are not going to have the same performance levels as those who do."

"The plans that can execute better delivery and coordination of care are the plans that are going to excel in 2014," Howell said. The health care consulting experts at OptumInsight can help MA plans start today to identify areas needing improvement, close the identified gaps, measure progress, and integrate quality throughout the organization's operations. "Plans that really and truly embrace quality integration without a doubt will outperform their competitors," he said.

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For more information on how consulting services from OptumInsight can help your plan integrate quality programs:

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