Care management: The hidden gem for revenue optimization
Instead of rewarding quantity, pay-for-performance metrics reward quality delivery by rating and reimbursing plans by the percentage of participants who actually do what they are supposed to do within the prescribed time frames. Maintaining and improving those percentages, and the subsequent reimbursements that come from them, can be a challenge.

To thrive in this new world order, health plans have to engage a strong Revenue Optimization strategy. This includes enhancing reimbursements through accurate documentation, and implementing tactics to increase their HEDIS® scores and Star Ratings through increased participant compliance.

The Impact of HEDIS® and Star Ratings

HEDIS, or the Healthcare Effectiveness Data and Information Set, is a standard measurement tool created by the National Committee for Quality Assurance (NCQA) used by 90% of American health plans to judge care and service performance. Currently, HEDIS includes up to 81 measures divided into five domains of care. When followed, these measures impact both individual quality of life and the effective use of medical resources.

According to NCQA data, if all health plans were able to support Americans with diabetes in controlling their blood pressure...
like the plans that rank in the top 10% of commercially accredited NCQA plans, between $376 million and $784 million in hospital care costs could have been saved in 2011. Factor in these top plans’ success rates with breast cancer screening, cholesterol management, osteoporosis, smoking cessation and persistent beta-blocker treatment, and this number jumps to between $2.4 billion to $6.5 billion in projected hospital cost savings.

Using these HEDIS measures, the Centers for Medicare and Medicaid Services (CMS) created the Star Rating system to rate Medicare Advantage programs across 32 quality and performance measurements (plans with prescription drug coverage are rated on up to 47 measures). Star Ratings span five broad categories including outcomes, immediate outcomes, patient experience, access and process — with outcomes weighted three times as much as process measures. Ultimately the ratings, ranging from 1 for poor compliance to 5 for excellent compliance, are used to determine Medicare Advantage Quality Bonus Payments.

Improving HEDIS quality measures and Star Ratings improve the quality of care and increase revenue. According to HEDIS Program Manager and Improvement Leader La’Candra Plummer, for a health plan with just 100,000 members, each HEDIS quality measure would mean around $17 million in reimbursements from federal or state agencies. With 20 to 25 measures directly tied to reimbursement depending on the health plan and the population it serves, the financial benefits are substantial. Revenue Optimization opportunities for a large managed care organization with millions of people enrolled are significantly larger.

“Although the stakes are high, many healthcare plans continue to leave money on the table.”
Although the stakes are high, many healthcare plans continue to leave money on the table. Based on 2013 quality ratings, only 23% of plans reached the necessary 4-star threshold to receive bonuses in 2015. Meanwhile, nearly two-thirds of Medicare Advantage Prescription Drug (MAPD) beneficiaries are in plans with fewer than 4 stars. How can a healthcare plan improve HEDIS scores and STAR Ratings to realize the resulting financial gains?

Moving the needle requires a new approach to care management that employs analytics, technology and stratified patient outreach to effectively close the gaps in care.

**Broadening the focus of care management**

Although care management has always played a significant role in improving patient outcomes, traditionally, these efforts were focused on small patient populations with complex, catastrophic conditions. With the emergence of HEDIS, plans are rethinking and restructuring their existing case management organizations. Instead of exclusively dealing with ultra-high-risk populations, health plan providers are now broadening their care management focus to include lower-risk patients with prevalent chronic conditions especially as the prevalence of chronic conditions threatens to reach nearly one out of every two adults.

The idea is to zero-in on individuals who have missed required screenings or could benefit from lifestyle changes. Then, engage the primary care physician and other collaborators to ensure the patient not only receives the correct course of treatment, but also follows that course of treatment.

However, simply restructuring the care management function alone is not
enough to deliver the desired results. To be effective, plans need to support these efforts with the right tools, from advanced data analytics to technology platforms that provide visibility and reporting capabilities required to move the needle on quality care.

Using data analytics to identify previously “lost” patients

We live in a world with no shortage of data. Anyone can search the Web or browse products online, only to be inundated with targeted offers around that product category the next time they log on.

Although other industries have harnessed the power of data analytics, the healthcare industry has lagged behind many sectors.

Patient information, particularly for chronic conditions, is typically dispersed among multiple providers’ siloed systems.

One out of every two adults has been identified with a chronic condition.

A primary care physician might have records on a diabetic’s A1c screenings and data shared from a vascular specialist, but has no easy way of knowing whether the patient followed up with a routine eye exam to check for glaucoma, cataracts or retinopathy. This information resides in the individual providers’ systems. Unless all the doctors are in the same network, they only see a partial view of patient activity. On the clinician side, there’s no real method for fully exchanging healthcare information among providers. The only source for comprehensive patient data is often the health plan itself — the entity that’s collecting all claims from all doctors. The challenge for plans becomes effectively sifting through all of this information and transforming it into actions that improve member outcomes.

In the past, mining through masses of data to identify patients not yet at crisis levels but still falling short in areas like missed appointments or follow-ups was difficult, at best. As a result, patients with chronic illnesses who only need a little motivation to change their behaviors often fell through the cracks.
Today, the technology and data science capabilities are available to effectively conduct a HEDIS extraction that identifies out-of-compliant or high-cost participants measure by measure. Data analysts can identify who is at risk using claims data, diagnostic data, lab results and prescribed drugs. By putting a weighted value on those measures, analytics could then help plans identify the specific areas and individuals that could make the biggest rating impact the quickest, therefore optimizing revenue opportunities.

Stratifying intervention through targeted patient outreach

The second part of this process is outreach — communicating directly with physicians to alert them of patient needs, or communicating with patients to motivate them into action.

The promise of care management in the digital age is the wide range of communications methods available. Most plans and healthcare providers start out the patient relationship by capturing phone, cell phone number, address and email, as well as that patient’s preferred method of communication.

Many members with chronic conditions embrace the support provided through an extended care management team, while others would prefer to manage their own care. Given most plans have limited clinical resources it is important to deploy those resources where they can have the most impact to the member and to the health plans’ revenue from CMS. By analyzing data both internal and external to the health plan the likelihood of a member to engage and sustain behavioral change can be determined. For example, successful
outcomes for those members who self-manage may be better accomplished with scheduled mailers (or email, texts) that include supportive outreach and instruction while still respecting the member’s desire for autonomy. Similarly a Medicare member’s likelihood of getting the annual Medicare exam can be calculated based on a review of previous screenings. By using these metrics and others members can be stratified in a manner that effectively uses clinical resources to get the best outcomes.

If an individual consistently gets required screenings but is overdue for a mammogram, a reminder letter or text could serve as an effective, simple reminder. In more complicated situations, care managers can engage directly with members to motivate them to follow-up with screenings or appointments. By matching the type of communication to patient preference, level of discussion and type of motivation required, health plans can stratify interventions to get the greatest results at the lowest costs.

Outreach should continue beyond the initial contact. Information on whether or not that patient followed up should be fed back into the database to gauge outreach progress and to ensure the individual who actually got the mammogram or renal test doesn’t receive unnecessary reminders afterward.

If the plan has limited clinical resources for member follow up, it can outsource part of its outreach efforts to a clinical services provider. These individuals can be used to contact physicians, trigger alerts to gaps in care, or contact patients with routine test reminders.

By motivating plan participants to follow the prescribed guidelines and creating a continual cycle of improvement through the aggregation of real-time participant data, plans improve HEDIS scores and Star Ratings, incrementally increasing reimbursements. This process improves the chances a program can reach five-star rankings and helps those at the top of their game maintain that top-ranked status.
All of these efforts ensure plans maximize revenue opportunities and are duly rewarded for the service they provide.

**Giving care managers the right tools to affect change**

With so many moving parts, measures and complexities of today’s healthcare environment, even the most seasoned care manager can’t keep track of everything without the proper tools. A comprehensive care management system that provides a holistic patient view is critical to revenue optimization because it quickly identifies out-of-compliance plan participants.

The most effective systems simplify data retrieval and have the ability to link to other systems, allowing the care manager to get a full, accurate picture of the plan participant, diagnosis and treatment history. Flexible reporting tools and integration with other functional areas (like accounting) enable care managers to work more efficiently and better serve plan participants.

**Ensuring accurate documentation**

No discussion around Revenue Optimization would be complete without addressing the necessity for proper documentation. Since 2004, Medicare has used the HCC model to calculate payments to providers and health plans. However, most Medicare Advantage plans and their aligned physicians continue to miss significant opportunities to serve members and maximize revenue potential because of poor performance in this area.5

Data mining can improve accuracy by comparing a patient’s diagnosis with his or her prescriptions or labs. For example, if a patient was prescribed blood pressure medication but doesn’t have a hypertension diagnosis, the file is tagged for follow up with the primary care physician or prescribing doctor.

By helping physicians standardize their documentation processes to reduce the incidence of incorrect coding and implementing tools like a care management system to verify this documentation on the back end, health care plans can significantly reduce missed revenue opportunities due to human error.
Positively impacting revenue and patient outcomes

The measures, metrics and ACA reforms are designed to do what healthcare plans and providers have strived to accomplish all along: improve patient outcomes and the quality of care. By re-imagining the traditional concept of care management, utilizing data analytics and strengthening the communications between plan participant and the medical network that support their well-being, healthcare plans have an opportunity to optimize revenue while improving the outcomes and quality of life of the participants they serve.

Reference


3 Ibid.

4 Rincon, Hector; Choudhury, Joijit Saha; Subramanian, Sundar. “Medicare Star Quality Management: Creating a Path to Higher Ratings.” PWC.

EXL Analytics [NASDAQ: EXLS] provides data-driven, action-oriented solutions to business problems through statistical data mining, cutting edge analytics techniques and a consultative approach. Leveraging proprietary methodology and best-of-breed technology, EXL Analytics takes an industry-specific approach to transform our client’s decision making and embed analytics more deeply into their business processes. Our global footprint nearly 2,000 data scientists and analysts assist client organizations with complex risk minimization methods, advanced marketing, pricing and CRM strategies, internal cost analysis, inventory management and other logistic issues within the organization. EXL Analytics serves the insurance, healthcare, banking, capital markets, utilities, retail and e-commerce, travel, transportation and logistics industries.

© 2016 ExlService Holdings, Inc. All Rights Reserved.
For more information, see www.exlservice.com/legal-disclaimer