

INGENIX[®]

Clinical Assessment Solutions:

Improving Chronic Condition Identification to Increase Health Outcomes and Payment Accuracy at Managed Medicare and Medicaid Plans

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Improving Chronic Condition Identification

More than 40 percent of seniors have a chronic condition that is unreported.¹ That's a troubling statistic for today's managed Medicare and Medicaid plans. It means that members are going without the care they need to manage their conditions. It means that plans do not have the information they need to effectively apply disease management, evidence-based medicine, and other principles to improve patient outcomes. And it means that member chronic conditions may worsen, increasing the cost and difficulty of treating those conditions in the future.

The statistic is also troubling for managed Medicare and Medicaid plans because the Centers for Medicare and Medicaid Services (CMS) sets payment rates for plans based on the reported health status of the plans' members – members with chronic conditions will have higher medical costs, and CMS payment rates reflect this. Health plans whose members' chronic conditions are unreported are bearing more risk and receiving lower payments than CMS intended.

Unreported chronic conditions are a challenge for today's managed Medicare and Medicaid plans. However, they also represent a significant opportunity to improve health outcomes and receive appropriate reimbursement payments – if health plans can better identify and document the chronic conditions among their members. To capitalize on this opportunity, health plans are implementing comprehensive clinical assessment programs that include analytics, provider education and member outreach. The goal of these programs is to increase identification of chronic conditions and drive improved health outcomes through early detection, ongoing assessment, and accurate reporting of health status. Along with all of these benefits, experience shows that these programs better align reimbursement rates to the actual risks borne by the plans, increasing reimbursement rates by 5 percent to 15 percent per year.

Time for a Transformative Approach

Early detection of chronic conditions is the cornerstone of clinical improvement programs and involves three main components: membership analysis, member outreach and provider education. Membership analysis is already being done, but more often than not, it's being done poorly. At a simple

1. Ingenix customer experience.

level, managed Medicare and Medicaid programs can confirm this by looking at disease prevalence statistics. For example, statistics from the Centers for Disease Control and Prevention (CDC) report that 39.4 percent of seniors over the age of 60 have some degree of chronic kidney disease. Using this type of data, health plans can compare the statistics against their member data. Variances may indicate that chronic conditions are going unreported (as they do more than 40 percent of the time) or that the population is statistically different than the averages. Either way, further analysis is warranted to determine the cause of the variance.

Delving deeper into member data, health plans can improve the accuracy of chronic condition detection by analyzing a variety of claim types, such as professional, hospital, pharmacy, laboratory, etc. The challenge here is that managed Medicare and Medicaid plans are not required to include diagnosis codes in their bills to get paid, which may preclude using billing data. However, hospital claims include diagnosis codes (sometimes up to 30 diagnosis codes per claim), making them ideal for analysis. Health plans can accomplish this by importing claims data into data warehouses – rather than modifying claims systems – to analyze claims for diagnosis codes. The process can be automated with business rules that identify disease via diagnosis codes or by flagging members with pharmacy or laboratory claims that may indicate a chronic condition.

Using claims data for member analysis provides a retrospective look into the population. For a prospective analysis, health plans can subscribe to third-party data sources that reveal chronic conditions in specific regions and populations. This data gives health plans the ability to predict incidences of chronic conditions within a population, which helps to pinpoint conditions, target outreach programs, and tailor provider education efforts.

Member outreach can increase the detection of chronic conditions, but it is a method that is often untapped or poorly executed. These outreach efforts can be done inexpensively via regular mail, e-mail, health fairs and other means. The outreach efforts can be as simple as general reminders to schedule annual examinations, or highly targeted messages sent to at-risk populations or those with specific conditions. Educational materials provide members with information about conditions that often affect their demographic, and can alert them to symptoms that may be indicative of a chronic condition. In addition, the outreach efforts can increase participation in wellness programs and online communities where members can obtain support, monitor their conditions and receive instructions on when to consult with their providers.

Provider education needs to focus on chronic condition identification, intervention strategies, and the required methods to comply with documentation and coding regulations. Educational materials reinforce providers' clinical training on how to identify the symptoms of chronic conditions, and offer updates on the latest interventions. Statistical information on the prevalence of disease in specific demographics can include national or regional averages, or specific details on the member population obtained from third-party data sources or member analysis. Like membership outreach, provider education can be accomplished via regular mail, e-mail and Web sites. Onsite consulting services are effective as well, and provide an opportunity to review actual patient charts to examine documentation practices. In addition, chart reviews allow consultants to identify chronic conditions that were potentially missed and provide real-time education to providers to support documentation improvement efforts.

Chart reviews also provide an opportunity to assess regulatory compliance as it relates to documentation practices. For example, documenting the one-time identification of a member with a chronic condition only justifies a higher Risk Adjustment Factor (RAF) score – and a higher payment – for the year of the encounter. Each year going forward, clinicians must again document the condition for the health plan to earn the higher payment. Unfortunately, 30 percent of members with chronic conditions don't get their condition reported in the year following the initial diagnosis.² Audits conducted by state agencies and the Centers for Medicare & Medicaid Services (CMS) find that 30 percent of patients with chronic conditions have inadequate documentation in their medical records to support the diagnosis used in the RAF calculation.³

More extensive chart reviews can take place concurrently to help health plans improve member analysis by examining a larger number of charts to compare against RAF scores for the population. These chart reviews can examine a cross section of the population or target members with specific conditions to evaluate documentation practices and regulatory compliance.

Critical Elements for Success

Implementing a clinical assessment program is an extensive process that requires cross-department collaboration and substantial resources to develop and maintain the program. Although some managed Medicare and Medicaid plans may feel that they can implement such a program on their own, few have the resources to effectively handle provider outreach

2. Ingenix customer experience.

3. www.cms.gov.

efforts, nor do they typically maintain the additional technology staffing needed to develop and manage the data warehouse. As a result, outsourcing all or components of the program is a cost-effective and practical alternative. Plus, health plans benefit from the insight and experience that an outsourcing partner can deliver. Whether handling parts of the program in house or outsourcing, health plans will need to incorporate the following components for their efforts to be successful:

Encounter Data Capture – Collecting provider encounter data submissions to evaluate if organizations are maximizing diagnosis code data flow for use in member analysis and calculating RAF scores.

Chart Review – Evaluating patient charts to determine the impact of documentation on the health status assignment of members and to verify regulatory compliance.

Risk Adjustment Data Submissions – The processing of risk-adjustment data according to CMS guidelines to determine the most efficient and effective submissions processes.

Revenue Reconciliation – Comparing health plan data to CMS guidelines to determine if appropriate payments were made to the health plan.

Financial Analytics – Analyze the accuracy of risk adjustment data submissions that drive budget projections and forecasts, as well as bid support for future CMS filings.

Reporting – Leveraging pre-configured and custom reports to aid decision support and analyze performance at multiple levels within the organization. Making reports available via a Web portal simplifies distribution and improves access. .

Claims Validation and Submission – Automating the review of claims for errors before submission to CMS or state agencies (e.g., duplicate codes, non-compliance, or missed revenue opportunities) provides the health plan with the opportunity to resolve errors, improve the billing process, reduce rejections and optimize reimbursement.

Health Plan Return on Investment

Managed Medicare and Medicaid plans that have used components or the full outsourced capabilities of Ingenix's Clinical Assessment Solutions have observed a substantial increase in chronic condition identification. This early disease detection and ongoing reporting create opportunities to improve patient outcomes by providing appropriate interventions during the early stages of disease. In addition, these capabilities help ensure that plans are fairly compensated for the risks they bear, by identifying existing unreported chronic conditions

and improving documentation efforts that support billing requirements. These disease identification and documentation improvements raise the RAF scores that are used to calculate billing, and have typically resulted in a five percent payment increase in the first year of the program.

Additional increases in reimbursement were realized by health plans as they expanded the number of chronic conditions that they targeted for identification. In addition, better disease identification capabilities and the increased accuracy of risk-adjustment data facilitated improved payment forecasting.

For providers, Ingenix's Web-based reporting via a portal simplified distribution and facilitated easy viewing of performance indicators, such as average RAF score by provider. Other provider benefits were provided by Ingenix's extensive consulting group that was able to meet directly with providers for onsite education, training and chart review.

About the Company

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Shawn C. Merys, M.D., MPH — Dr. Shawn Merys has more than 20 years of experience in the health care industry as a practicing clinician, health system regional administrator, corporate medical director and managed care physician executive. As the national medical director of Ingenix Clinical Assessment Solutions, Dr. Merys establishes policies and programs that provide clinical initiatives for chronic disease conditions, using a foundation in evidence-based medicine, epidemiology, public health, and preventive medicine. His work promotes prevention, early detection and accurate and timely diagnosis to improve the health outcomes of the populations that Ingenix serves. Merys also supervises the clinical affairs team of three regional medical directors and two regional clinical program strategists.

Prior to joining Ingenix, Dr. Merys served as regional and national medical director for disease management and large employer group products at OptumHealth, and as manager of compensation and pension for the Department of Veterans Affairs. Previously, Dr. Merys held medical director and regional administrative positions at Concentra Managed Care; SSM Health System; and Mercy Health System in St. Louis, Missouri. He also has served as a consultant to the Social Security Administration and as an assistant clinical professor at the St. Louis University School of Medicine.

Dr. Merys received his doctorate of medicine from the University of Missouri-Kansas City and his master's degree in Public Health at the St. Louis University School of Public Health.

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