



CASE STUDY

MEDICARE ADVANTAGE RISK ADJUSTMENT

A meta-analysis of more than 1,000,000 Medicare Advantage member cases aimed at identifying causes for incomplete claims documentation and deriving comprehensive methodologies for achieving highly accurate claims documentation, optimized risk adjustment factors, and reporting for Medicare Advantage plans.

BACKGROUND

With the passing of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003, the Centers for Medicare & Medicaid Services (CMS) initiated the formal implementation of a fully risk-adjusted capitation reimbursement model. As a result, all Medicare Advantage (MA) Plans are ultimately financially dependent upon the specific documentation of each individual patient's diagnoses as classified within the highly specific CMS Hierarchical Condition Category (HCC) system. Failure to do so has both significant quality of care implications and financial ramifications. As a result, MedAssurant undertook an evaluation of more than 1,000,000 Medicare Advantage unique member / date-of-service period cases from its client base in an effort to identify primary causes and methods of efficiently correcting for incomplete claims and claims-related diagnostic documentation.

FINDINGS

WHY THE DETAILED DIAGNOSTIC CLAIMS DATA (AND THEREFORE THE HCC FACTOR VALUES) OF A PATIENT IS OFTEN INCORRECTLY UNDERREPRESENTED WITHIN MEDICARE ADVANTAGE PLANS

Upon analysis of member data and associated medical charts of more than 1,000,000 Medicare Advantage unique member / date-of-service period cases, many contributing barriers were ultimately found to consistently stand in the way of health plans having comprehensive, fully accurate, and optimized claims records necessary to drive a complete member disease status understanding. The following outlines the five (5) most commonly identified causes of incorrectly low reflections of patient population disease status and reflected HCC factor value found within the Medicare Advantage plans:

1. CLAIMS DATA DIAGNOSTIC “HOLES”: Historically, there has not been adequate emphasis for practitioners to note all diagnoses active for a patient's encounter, but rather only those of primary importance or relevance. The fact that this leads to a gap in claims documentation of a patient's fifth or sixth (for example) diagnostic condition is further exacerbated by the fact that practitioners are typically already stretched for time and do not commonly receive any remuneration for the notation of more than the necessary information to substantiate a particular level of encounter. Hence, whereas the medical chart may contain appropriate comprehensive disease documentation, such is lost in translation to the patient's electronic claims history.

2. CLAIMS CODE TYPE IRRELEVANCY: Claims are filed for patient encounters in many code formats. These include DRG, CPT, LOINC, HCPCS, NDC, Super Bills, and ICD-9 entry formats, amongst many others. Despite the fact that all of these data entry types and formats contain valuable and relevant information regarding the medical condition and service provisions to a patient, only a specific ICD-9 subset of only approximately 3,200 codes are relevant to CMS in the determination of each patient's HCC factor value. Although many systems of “translating” between code types exist, failure to be 100% complete or undertaking such endeavors in a fashion that may jeopardize the technical specifications of CMS or ICD-9 coding has been found to be highly costly to plans.

3. HIGHLY DISPARATE AND OVER-STRETCHED CLAIMS SYSTEMS AND PROCESSES: Many health plans maintain disparate data systems, claims warehouses, and claims processing pathways. This can be the result of platform migrations, acquisitions, mergers, outdated or incomplete data systems, and discordant claims processing procedures. Health plans have

often been found to fall into one of two categories: 1) larger plans which initiated Medicare Advantage plans, or 2) plans that are relatively small and which consist only of their Medicare Advantage plan as an entry into the health plan business arena. In the first instance, much of the minutia of CMS regulations and technical specifications are not comprehensively understood or applied by the data teams accustomed to the parent health plan's primary lines of business. In the second instance, smaller, younger plans typically have over-stretched data teams that are often unavoidably behind in CMS regulatory changes or communicated interpretations. In both cases, gaps in understanding or missing components of a complex end-to-end process lead to errors and the loss of valid claim entries. Not surprisingly, these errors and/or omissions are often not suspected by plans until identified by CMS audits, outside services, or comprehensive investigations into their processes.

4. OVER-STRETCHED OR INADEQUATE INFRASTRUCTURE: Medicare Advantage plans are typically expanding at a rapid pace. With the growth, few health plans have been found to adequately keep pace with the enormous demands to identify and review suspect clinical cases and claim coding entries, provide education programs to improve physician coding, and deploy field staff to perform chart and coding accuracy improvement reviews. Furthermore, in the setting of CMS audit processes, adequate documentation, process quality standards, and comprehensive document tracking and substantiation are equally critical and unfortunately lacking in the marketplace. In a nationwide marketplace plagued with nursing and certified coder shortages, let alone a scarcity of senior management personnel adequately familiar with the CMS technical and regulatory requirements, staying on adequate risk adjustment improvement has been found to be a great challenge for many plans.

5. INFERIOR OR NON-EXISTENT MEDICARE ADVANTAGE-SPECIFIC ANALYSIS & REPORTING CAPABILITIES: Medicare Advantage is a highly objective healthcare environment. In the absence of being able to obtain accurate reflection of the disease status of a member base, internal reporting and projection capabilities are suspect. In fact, it was found that the proper tracking of member active disease sets, disease progression, claims coding specificity, practitioner-specific performance, attribution, and associated factor and expected reimbursement is critical to a Medicare Advantage plan's ability to project financials, submit bids, and improve both quality of care and financial performance. Surprisingly, this case study analysis revealed that a significant number of Medicare Advantage plans are greatly challenged with the performance of these needs. As such, plans suffered from incorrect forecasts, inability to identify quality or performance shortfalls, and large-scale missed financial reimbursement opportunities.

SOLUTION

OPTIMIZATION OF CLINICAL CLAIMS DOCUMENTATION, ASSOCIATED ANALYSIS, AND CMS REIMBURSEMENT

Plans with comprehensive diagnoses documentation and associated risk adjustment programs were ultimately found to substantially avoid or correct for the barriers identified and presented in this meta-analysis case study. This study further clarified necessity and the significant beneficial quality and financial impact such a comprehensive process can have on Medicare Advantage plans. Ultimately these initiatives must provide for a comprehensive, end-to-end solution that is focused on the technical specifications and regulations of CMS' Medicare Advantage regulations and which additionally has not only a) an advanced and extensive healthcare data analytics capability, but also b) a significant in-field clinical and certified coder review personnel infrastructure to thoroughly implement (and therefore actually realize the value of) a documentation and risk adjustment initiative. Examination of health plans' internal programs and those of third-party vendors that were lacking in these areas proved them to be materially ineffective.

As a service to its clients, MedAssurant delivers the nation's largest and most comprehensive, end-to-end Medicare Advantage documentation and risk adjustment solution to Medicare Advantage plans of all types (HMO, PPO, PFFS, etc.) in both metropolitan environments as well as widely dispersed rural networks. With hundreds of centralized data analysts, clinicians, review project managers, review schedule coordinators, data cleaning, and quality personnel - combined with hundreds more of nationwide, in-field clinical review nurses, data collectors, and certified coders - MedAssurant provides value-added insight, quality, reliability, and end-to-end peace-of-mind to its clients in need of a dependable, complete, and truly effective Medicare Advantage risk adjustment solution. Known as the Capitation Risk Adjustment (CARA™) Solution, MedAssurant's processes are designed to not only identify documentation gaps in stratified and prioritized fashion, but also to fully implement documentation review, and provide for its Medicare Advantage clients a comprehensive, substantiated member disease state claims and documentation accuracy program for quality of care and CMS reimbursement improvement.

MedAssurant, Inc. is a leading provider of superior healthcare quality, care management, and financial performance improvement solutions empowered by advanced data analysis, abstraction, and verification systems. Applying a unique combination of nationwide personnel and an advanced technology infrastructure, MedAssurant provides local and national health insurance plans, care delivery networks, employers, pharmaceutical companies, regulatory bodies, and government organizations with powerful, turnkey services addressing disease management, clinical outcomes, quality of care, cost improvement, revenue enhancement, risk adjustment, and healthcare data verification.

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INTO INSIGHT, AND
INSIGHT INTO ACTION™