LEAN SOLUTIONS: MEDICARE

Lean Applications: Medicare

- Growth/Membership: Medicare Advantage (↑$42+mm)
- Risk Adjustment/HCC scores (↑8-18%; $35+mm/yr)
- Health Plan Operations/Admin Expense (↓5.2%): claims, member services, member enrollment, provider relations, etc.
- Medical Management/Med Expense (↓4.5%; $5+mm): utilization management, case management, etc.
- Member/provider/practice engagement & activation: population health, collaborative care, PCMH, outreach
- Support services/Admin expense: IT, configuration, etc.

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Overview: Risk based health plans, such as Medicare, offer unique opportunities for Lean and the *management systems* developed when mobilizing with Lean. In addition to the traditional lean operational improvements shared with the commercial lines of business there are also opportunities presented specific to the various Medicare products. Examples of operational improvements *shared* with other line of business include:

- Health plan operations impacting member satisfaction, member experience and key admin expense drivers (member services, claims, disputes, FWA, MARCOM, etc.)
- Medical management, population health and subsequent impact unto medical expense (medical management, case management, utilization management)
- Provider/practice relations to increase engagement and activation
- Member relations, engagement and activation

Lean and Medicare: Applying lean within the Medicare family of products can be used to drive key line of ***business objectives*** (growth, membership, risk adjustment, HCC scores, and cost), ***operational objectives*** (claims processing, member services, MARCOM, CMS communications and submittals, member satisfaction) and ***clinical performance*** (med expense, population health, disease management) objectives.

Medicare Enrollment: The period from early October through early January, is clearly a focus period for all Medicare programs. A case study with a 5 star health plan focused on *increasing Medicare Advantage enrollment*. Focusing in the Medicare *Sales Operations Center* and the processes used to support *ramp up* for the Medicare AEP, processes and systems were built to increase the *close/conversion rate* of seasonal support staff (28%) compared to the full time staff (35%).

The premise was that in building a *process* to onboard and prepare our seasonal staff (i.e. to build an onboarding module that captured and shared key lessons, key words, key phrases, and standard work), that we could fundamentally prepare our seasonal support to act, behave and *close* at a very similar rate to our full time staff. Results:

- *2012 AEP: Increased close rate for seasonal staff 36+% and all staff 20+%. Record enrollment resulting in 84% increase in enrollment from previous record ($19+mm in increased annual MA premiums)*
- *2013 AEP: Refined (from 2012) the selection process, training modules, pre AEP training curriculum, processes, systems resulting in an increase in total AEP enrollment of 18% from the previous record year (additional $23+mm in annual MA premiums from baseline).*

Improvements: Health Plan Operations

- Member enrollment: Productivity +42%, *Time to Member ID card* (-65%)
- Claims: Backlog (-76%), auto-adjudication 10+%, turnaround time (-56%)
- Member services: 1st call resolution +38%, ASA (-63), productivity +27%
- Billing: reduced disputed bill 29%, AR days (-8%)
- Medical Management (UM/CM): Inpatient, Rx and ED pmpm (-5.3%)

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Medicare Risk adjustment and HCC scores (improved 8% - 18%; $35+mm/year)**:** HCC scores and *effective* risk adjustment processes are imperative to a successful Medicare Advantage program. The rules for risk adjustment are clearly defined by CMS. The responsibility lies with the health plan to provide the data and supporting documentation (ICD-9 codes and associated efiles) and to submit the data according to the milestone dates established by CMS.

The challenge with risk scores is that the *codes* needed by the health plan to *risk adjust* are the ICD-9 (Dx) codes. These ICD-9 codes must come from the visit *and* be documented in the proper manner by the provider ~~and/~~or care team. The challenge for health plans is with influencing the provider to (1) supply 'all' of the ICD-9 codes appropriate to a patient and (2) appropriately document key conditions. Health plans must accomplish this even though providers themselves do *not* need these codes (providers submit CPT codes for payment). Hence the quandary for health plans and risk adjustment.

Traditional methods for 'risk adjustment' comes from claims data, however the ICD-9 data associated the claim is (1) after the fact (i.e. too late to *properly document the visit*), (2) *requires* data *mining,* and (3) often *incomplete* for patients with chronic diseases or comorbidities.

Although prospective and retrospective chart reviews are commonplace and necessary, the degree to which health plans rely on these methods as their *primary* source of risk adjustment can be reduced significantly. Decreasing dependence upon traditional charts reviews for risk adjustment, impacts both the accuracy *and* timing of submitted HCC adjustments (and subsequent timing of risk adjusted *payments).*

When an HCC process is viewed *proactively* vs. *reactively,* not only can risk scores be captured *upon enrollment* to best reflect the acuity of the new member, but also the timing of when risk scores are captured, submitted and payments are received can be shortened by 1-2 submittal cycles (up to 15 months sooner).

The work involved to *influence the behaviors* of those outside the health plan is classic Lean *Implementation & Deployment*, using a structured process to define, document, implement and deploy processes to those in the *extended* value stream. *Bridging the gap between health plan and care team is the key to shifting from a reactive to a proactive model for risk adjustment.*

Population Health, Disease Management & Collaborative Care with Medicare populations is another major driver to a successful Medicare Advantage health plan. Engaging and *activating* providers, care teams and physician practices in *real* population health, disease management and *collaborative care* is one such approach.

Using health plan data and coordinating medical management, case management and utilization management resources to define, document, teach and support (primary care) practices in how to fundamentally improve patient safety, the health of numerous patient groups and *reduce medical expense* is being practiced today and is yielding med expense improvements of 3-10% annually ($10mm - $50mm).

The challenge with *med expense* lies with the *disconnect* associated with transitioning from a traditional fee for service (FFS) business model to one where *both* FFS revenues and 'new' monies (i.e. 'risk sharing' dollars) are viewed together (by the practice and medical group leadership teams.

Today most organizations financial systems are not designed to recognize the impact of additional monies introduced by *risk agreements*. Key points:

- *Risk agreement* monies are almost always *additional* monies above and beyond FFS revenues.
- *Risk agreement* payments too often are paid 'every 12 months, 2-3 months *after* the financials have been calculated.' As a result, the *reward* for investing in 'non FFS generating activities' (i.e. risk payments) is *not* connected to the desired behaviors or practice financial performance.
- *Risk payments* (i.e. rewards) are not applied to monthly financial (operations) performance. This means that even when *risk monies* are finally received, organizations do *not* restate the previous 12 months of financials to 'discuss' the *real* financial performance/impact of the *costs* added to support population health, disease management and/or collaborative care
- Traditional FFS financials and management techniques all drive the *opposite* behavior needed to improve population health/disease management performance (e.g. staffing ratios, FFS profitability, etc.)

Lean Solutions: Medicare

- **Membership growth**
- **Risk Adjustment and HCC Scores**
- **Population Health, Disease Management and Collaborative Care**

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