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Applying Thought

IMPROVING PLAN RATINGS – A SIMPLE PLAN

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Medicare and Medicaid plan shoppers determine the future of the payer's business. Poor management of plan-buyer's grievances can lead to poor star ratings, which in turn have a negative impact on business. Managing Appeals and Grievances is completely in the control of the payer. How can this be leveraged to improve business?

The Importance of Star Ratings

In 2014, the US saw 54 million people on Medicare with 30% using Medicare Advantage (MA) plans. MA beneficiaries have multiplied threefold since 2004. There were 5.3 million beneficiaries then; there are 15.7 million now[i].With the Affordable Care Act (ACA) those numbers are expected to grow further. These plan shoppers are going to face a logical question that will determine their decision around health and prescription plans from payers: Which is the best plan for them in terms of quality, safety and performance? To assist plan shoppers decide on plan coverage, the Center for Medicare and Medicaid Services (CMS) provides an easily understandable star rating to plans. The ratings help shoppers compare plans and narrow their choices.

The star ratings are a reliable way for consumers to make informed decisions about their health care. But more importantly, they are a lever that compels providers to address and improve quality. There is yet another persuasive reason for payers to bring an obsessive focus to ratings: The US department of Health rewards high quality MA with a bonus payment and a lesser reduction in their share of rebate dollars. Naturally, for payers of all sizes, the direct revenue implications spell pinpoint focus to ensuring top ratings for their plans.

Plans get ratings from 1 to 5 – with 5 being excellent. CMS uses a variety of data to adjudge the quality of plans and determine the star ratings. Health services cover 36 different topics while drug services cover 17[ii]. The key processes that determine the ratings include member satisfaction surveys, how often members are screened for certain conditions, etc.

A critical path to improved ratings is the effective management of MA Appeals and Grievances. The good news is that improving Appeals and Grievances is

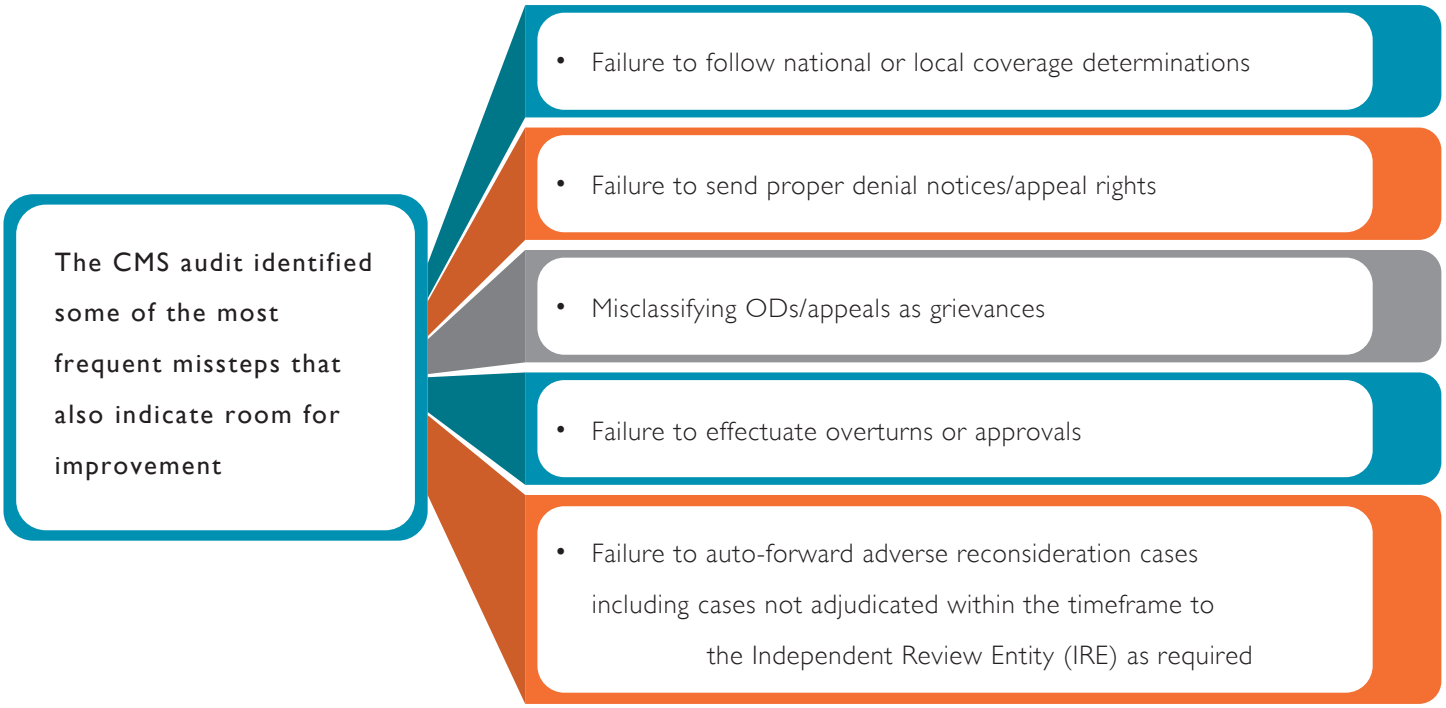
completely in the control of the payer. Payers have understood this and are creating strategies to manage Appeals and Grievances with the goal of improving star ratings.

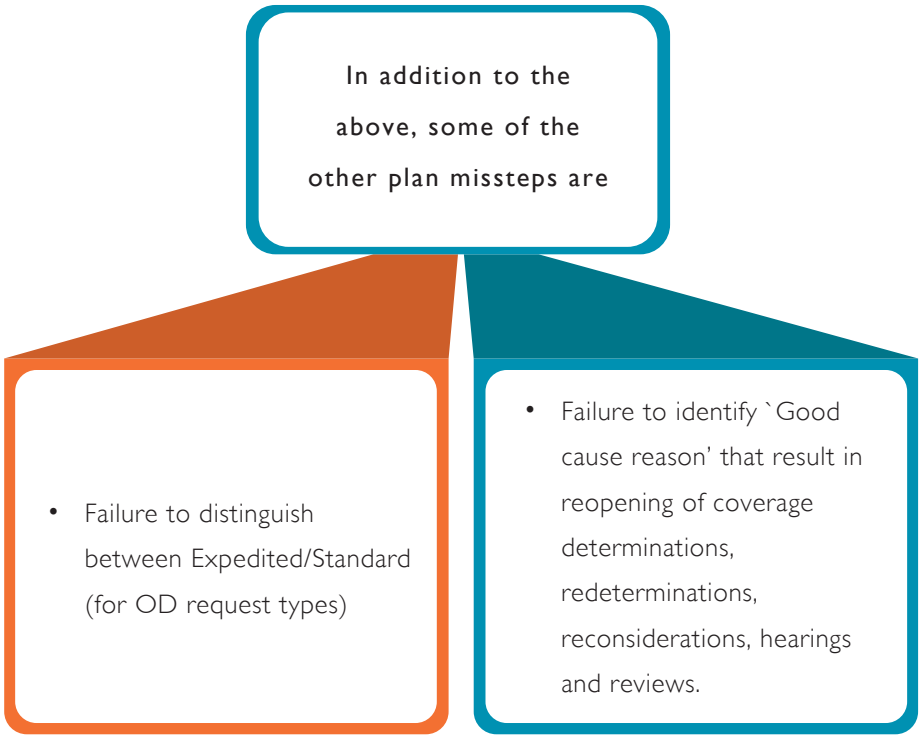
It is possible to comply with CMS norms and improve the management of Appeals and Grievances using technology, analytics and robust process management. However, first it is necessary to examine the timelines that affect the management process. Star ratings are published annually. There is a significant lag time between the measurement of performance and the bonus payment which accrues with good star ratings. Annual star ratings are not a reflection of a one-year cycle. This is how ratings work: Assuming that the performance year is 2014, data for the year will be collected in 2015, ratings will be given based on the data in 2016 and the bonus payment year will be 2017.

Missteps that Need Prognosis

Managing Appeals and Grievances for an MA plan is a critical aspect in improving customer satisfaction and bettering customer ratings. A 2012 CMS Audit placed Complaints (Grievances), Organization Determinations (OD or Coverage determinations) and Appeals processes as the most significant customer-related issues before MA plans. It is more than apparent that plans must bring more attention to and reduce the complexity of processing Appeals and Grievances.

Complaints would be related to the quality of care, privacy concerns, poor or questionable service, inconvenient wait times, hygiene and cleanliness, transparency in plan information, etc. Organization Determination or OD would be related to the amount a payer will pay for medical care, treatment and services and the amount a patient will bear. OD decisions and reviews must be expedited because delays can be detrimental to the health of the patient.





How do payers get in front of these issues related to Appeals and Grievances? Addressing these missteps should be a priority for plans as they are linked back to member satisfaction and CMS performance standards which in turn directly impact star ratings and revenues.

Prescribing Technology as the Cure

Tracking each case closely against fulfilment timeframes, denied service or payment, notifying beneficiaries of appeal rights, etc., and streamlining the processes related to Appeals and Grievances is central to improving performance standards. Improved standards can be expected to translate into a positive member satisfaction metric.

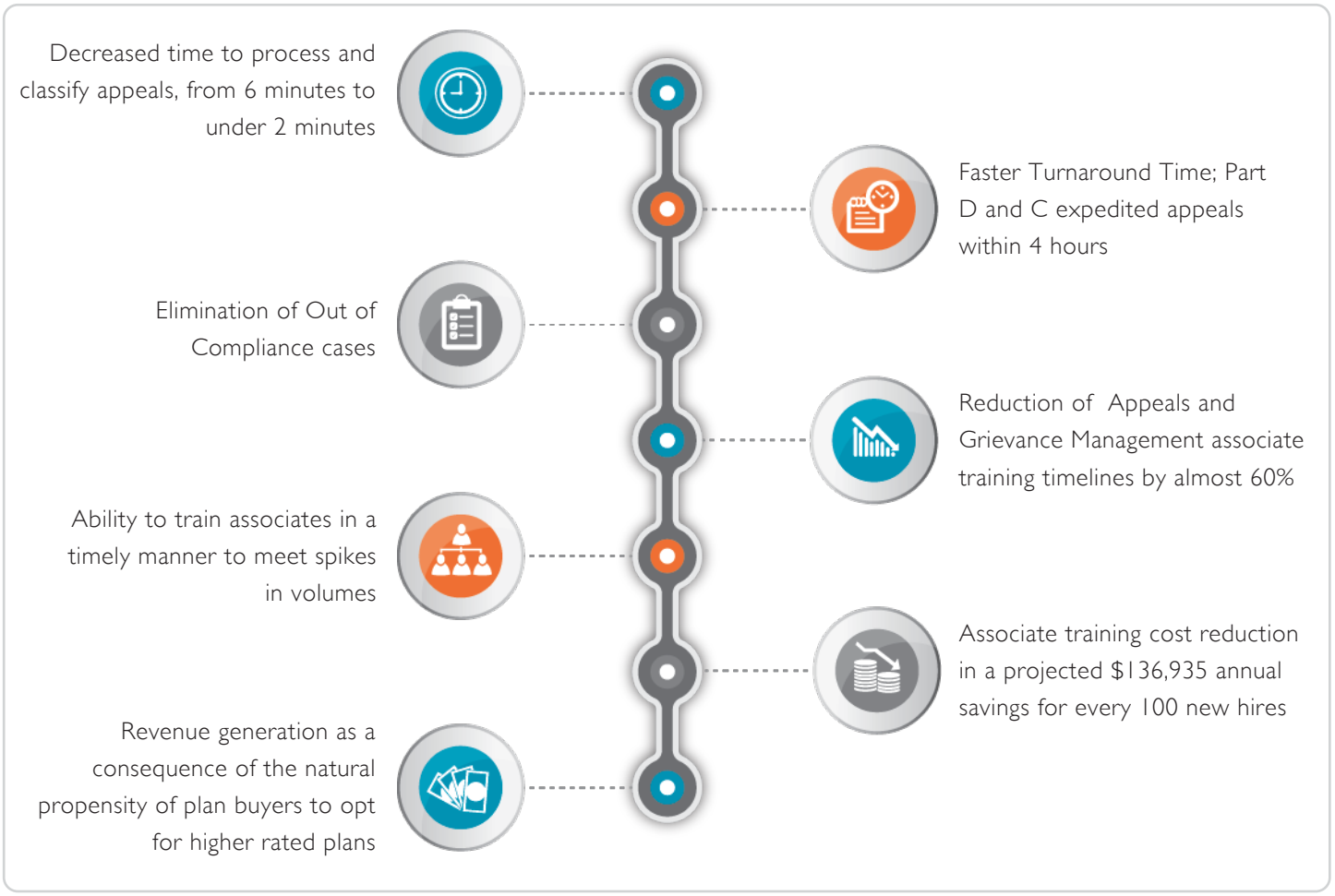
Providing a structured workflow that captures case data, call center reports, patient history, etc. aligned with CMS best practices is the first step to identifying cases that present a risk to ratings and bringing them up for immediate corrective action. A layer of technology and analytics combined with Six Sigma quality tenets, process standardization and expertise can quickly and accurately mitigate the risks for payers.

The advantage of deploying technology and process standards is that the solution also presents a complete audit trail with reliable and readily available documentation in a single repository. The advantages of such a system are undeniable. Payers are using these to intelligently and pro-actively identify triggers for Appeals and Grievances. Analytics is providing them the insights that not only raise timely red flags but also present appropriate strategies at the first pass.

The Future: Getting Rid of Chronic Inefficiencies

Technology-led solutions that combine process standardization and rigor have a direct bearing on star ratings. They can also accurately predict outcomes that payer organizations can prepare for in terms of ratings and bonus payments in subsequent years. On a secondary level, such systems improve turnaround time, improve efficiency, accuracy (in response to appeals, etc.) and reduce administrative and legal costs.

More specifically, some of the measurable outcomes include:



Compliance with CMS regulations is unavoidable. The upside with implementing accurate Appeals and Grievance Management is improved star ratings and enhanced business performance. The bottom line is that payers must quickly seek out technology partners who have domain expertise and understand the business to implement genuinely cost-effective and dependable solutions.

[i] Medicare Advantage factsheet: http://kff.org/medicare/fact-sheet/medicare-advantage-fact-sheet/

[ii] 5-Star Plan Ratings:
http://www.cms.gov/Outreach-and-Education/Training/CMSNationalTrainingProgram/Downloads/2013-5-Star-Enrollment-Period-Job-Aid.pdf

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