Humana, Medicare at Top of Payer Ranking

Regional insurers were shown to be more efficient than their national counterparts.

BY ALICIA AULT
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In an assessment of performance by one of the nation's largest physician revenue management companies, Humana and Medicare were rated highest when it came to issuing payment quickly and being easy to work with.

The performance data were tabulated and made public by AthenaHealth, a Watertown, Mass.–based company that manages $2 billion in revenues for 7,000 physicians, nurses, and other health care providers practicing in 33 states.

In explaining why the company decided to make the data available—free of charge—Jeremy Delinsky, director of process innovation at AthenaHealth, said, "We were a little skittish about making it public, but we found the story was too compelling to sit on." And, physicians who know more about their insurers will have more leverage in contracting and a better opportunity to improve their bottom line, he said.

The company assessed 5 million "charge lines" worth of claims data from the fourth quarter of 2005. To be a part of the ranking, national payers had to have at least 10,000 "charge lines," or line items, and regional payers at least 3,000.

Insurers were ranked according to an overall index that gave the most weight to financial performance. That performance included days in accounts receivable, percentage of claims paid and closed on the first pass, and percentage of charges transferred to the patient.

In addition to financial performance, the index included an administrative measure encompassing the claims denial rate, the percentage requiring a phone call to clarify a response from the insurer, and the percentage of claims lost. Finally, a small amount of weight was given to the difficulty of working within the payer's rules.

Nationally, Humana ranked No. 1, followed by Medicare, United Health Group, Aetna, Cigna, Champus Tricare, and Wellpoint. According to AthenaHealth, Aetna denies claims twice as often as Humana, and the reasons are so unclear that 17% of claims need follow-up calls.

Wellpoint tended to take the longest to pay, and more than any other payer, the company aggressively shifts responsibility to physicians to get payment from the patient.

For all payers, claims stay in accounts receivable for an average of 38 days. On the regional level, there was a wide variation in performance.

In the northeast, for example, BlueCross BlueShield of Pennsylvania/Independence BlueCross was the top-ranked plan, followed by Tufts Health Plan and Fallon Health Plan. In the west, PacifiCare was first, followed by Medicare B in Texas and United Health Group.

The largest regional payers mostly provided clear reasons for denials, rarely shifted the responsibility to physicians to secure payment, and paid most claims upon first submission and within 30 days.

Regional payers appeared to be more efficient and perhaps even more powerful than the national insurers, said Mr. Delinsky. National payers have been growing in size, but "it's unclear to us whether consolidation has resulted in the scale they hoped for," he said.

AthenaHealth did not assess payers' relative reimbursement rates because it would not be legal to publicize those rates, Mr. Delinsky said. However, he suggested that physicians could use his company's rankings to negotiate for a higher fee if the payer is hard to work with, or potentially accept a lower payment rate if the insurer pays more quickly and imposes less of an administrative burden.

The insurance industry did not respond directly to the rankings, but America's Health Insurance Plans, a national trade association, completed a study recently showing that 98% of claims submitted electronically are processed within a month of receipt. The study, based on aggregated data from 25 million claims processed by a sample of 26 health insurers, found that 75% of all claims are submitted electronically, up from 24% in 1995.

If there is a delay in payment, it's often because the claim has not been received in a timely manner from the physician's office, according to AHIP. ■

The rankings are posted at www.athenapayerview.com.

CMS Targets Efficiency of Care For Patients With Chronic Illnesses

BY JOYCE FRIEDEN
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WASHINGTON — Medicare has a number of demonstration projects underway to help chronically ill beneficiaries get better care, and is developing more, Linda Magno said at a meeting of the Practicing Physicians Advisory Council.

Beneficiaries with chronic illnesses are a significant part of the program's budget, said Ms. Magno, director of Medicare demonstrations for the Centers for Medicare and Medicaid Services (CMS). Although beneficiaries with five or more chronic conditions make up only 20% of all beneficiaries, they account for two-thirds of Medicare spending, she noted.

Patients at the end of life often undergo needless and costly 'ping-ponging' from nursing home to the emergency department and back again.

With all of the spending on this population, opportunities exist for making sure the money is spent more efficiently, Ms. Magno said. Currently, CMS has three demonstration projects going in chronic care:

▶ **Medicare Coordinated Care Demonstration.** In this project, which was mandated by the Balanced Budget Act of 1997, the agency is examining various care coordination models that "improve quality of services to chronically ill beneficiaries and reduce Medicare expenditures." The Health and Human Services secretary has discretion to continue or expand projects, Ms. Magno said, adding that currently 11 sites—a mix of urban and rural hospitals and long-term care facilities—are involved in this demonstration. Interventions include patient and provider education, prescription drug management, case management, and disease management.

▶ **Care Management for High-Cost Beneficiaries.** This 3-year, six-site project began last October; the last site was launched in June, Ms. Magno said. The provider groups in the demonstration put their Medicare reimbursement at risk in exchange for guaranteeing a 5% cost savings in caring for the high-cost beneficiaries involved. Services provided include physician and nurse home visits, in-home monitoring devices, electronic medical records, caregiver support, patient education, preventive care reminders, transportation services, and 24-hour nurse telephone lines.

▶ **Physician Group Practice Demonstration.** This demonstration was mandated in the Benefits Improvement and Protection Act of 2000, and involves giving additional payments to providers based on practice efficiency and improved management of chronically ill patients. Participants include 10 very large multispecialty group practices nationwide with a total of more than 5,000 physicians, who care for more than 200,000 Medicare beneficiaries. The project focuses on patients with diabetes, heart failure, coronary artery disease, and hypertension. Enrollment in this project has been "very slow," Ms. Magno said.

Two more chronic disease management demonstrations are in various stages of development. The Medicare Care Management Performance Demonstration, for example, is a pay-for-performance program that will reward physicians financially for achieving quality benchmarks for chronically ill patients and for using health information technology, including using it to report quality measures electronically. This project, which is in final review, will be implemented in Arkansas, California, Massachusetts, and Utah, Ms. Magno said.

Also in development is the Medicare Health Care Quality Demonstration. This involves using payment models that give incentives for improving the quality, safety, and efficiency of care, and incorporating things like best practice guidelines, shared decision making, and cultural competence into the practice. "This [project] is really a provider-driven opportunity to redesign the delivery system, as opposed to something externally imposed through insurers and other payers," she said. "The goal is to achieve projects designed to implement Institute of Medicine aims for improvement" known as the STEEEP principles—safety, timeliness, effectiveness, efficiency, equity, and patient-centeredness.

PPAC member Dr. Carlos Hamilton said that the demonstration projects "raise issues so profound that they go to the very core of our health care system." He suggested that many of the beneficiaries on whom Medicare spends more than $25,000 per year are probably in the last year of their lives, and that needless "ping-ponging" occurs when they are sent from the nursing home to the emergency department to the intensive care unit for, say, a case of sepsis.

"Addressing concerns about palliative care and end-of-life issues is critical if you're ever going to address the cost factors in terms of the overall health care system. If you can keep people from being transferred from the nursing home to the emergency [department] and the ICU in the middle of the night, you'll probably save a billion dollars right there."

Ms. Magno agreed and noted that CMS is developing a separate demonstration project dealing with beneficiaries who are nursing home residents. The goal of the project would be "to avoid 'avoidable' hospitalizations, and to reward nursing homes for better managing care," she said.

The other issue, said Dr. Hamilton, an endocrinologist who is executive vice president for external affairs at the University of Texas, Houston, has to do with lack of coordination of care for chronically ill patients.

"The primary care physician has been reduced to such a role in the system that nobody wants to [coordinate care] any more, and those that do quickly find out they can't afford to do that very effectively. So the system needs to strengthen the role of primary care physicians."

PPAC member Dr. Jeffrey Ross, a Houston physician and podiatrist, asked why CMS was not looking more at preventive measures. "Why aren't we looking at preventive means [when patients are] in their 50s or when they just become beneficiaries before we do major interventional treatment later on, in the last year, when it's costing millions and millions of dollars?" he said.

For patients with diabetes, "maybe before they are diagnosed as diabetics or develop heart failure, we should be looking at exercise, looking at diet, and looking at primary care as a means to intervene before major intervention takes place." ■