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AMERICAN HEALTHCARE OUTSOURCING

The U.S. Healthcare segment is on the move when it comes to outsourcing of healthcare insurance processes. Post reform, an upward trend is observed in the market. The development of information technology has only eased the process of outsourcing for Healthcare industry. Some of the major technology outsourced by US companies are computerized physician order entry (CPOE), electronic medical records (EMRs), inbound voice response systems (IVRs), network and data management, automated claims processing, regulated compliance monitoring, application maintenance, system integration, application development, product reengineering/maintenance, HIPAA consulting, and e-business initiatives. In the BPO segment, common work includes insurance claims processing, adjudication, receivables management, billing and coding services, radiology reporting, and transcription services.

India is miles ahead of other countries when it comes to its popularity as an offshoring destination. Around 75 percent of US healthcare companies outsource some work or the other to other nations. Medical transcription (which involves electronic capturing of patient information and converting it to a useable format) is mostly outsourced in Healthcare insurance sector. There are various reasons why U.S. healthcare organizations are looking to outsource. The most important being shortage of qualified staff in key positions such as nurses and coders.

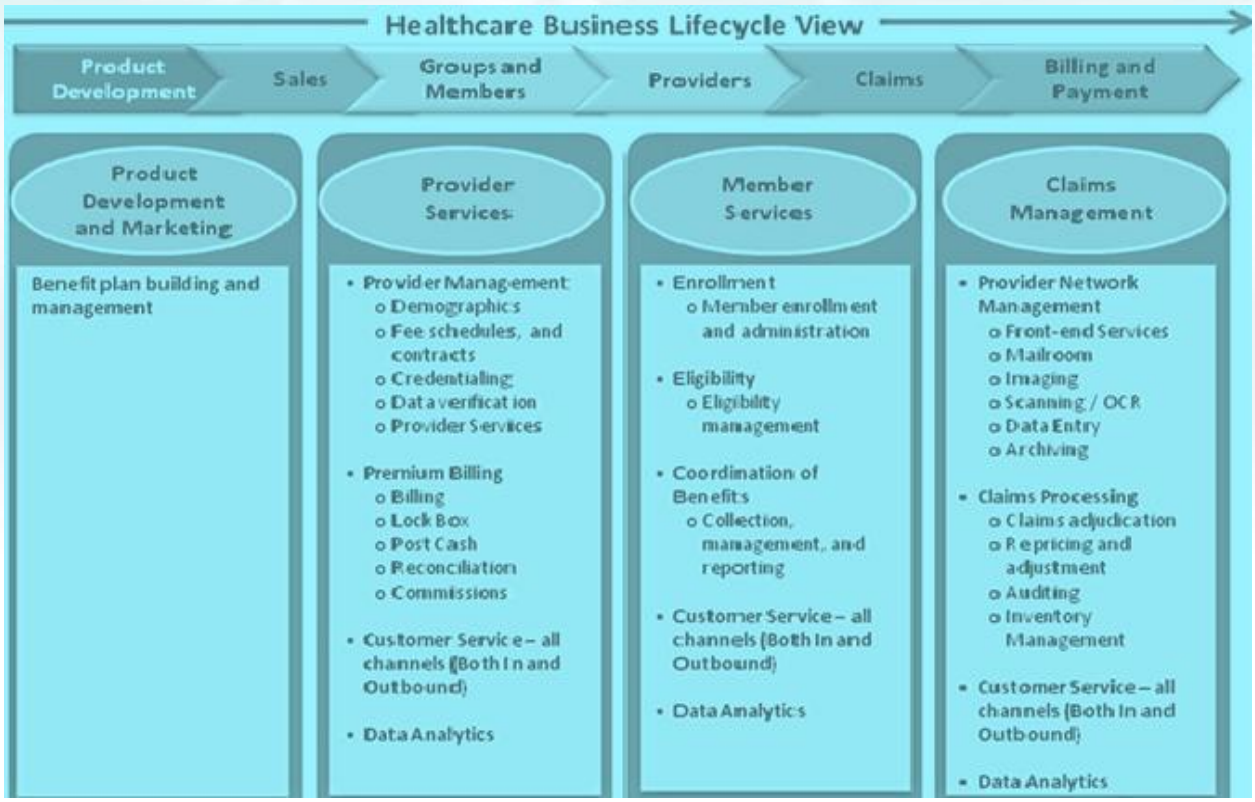
We generally come across three types of outsourcing model:

- ✓ Cost-based model where the entire functions or projects are given to vendor based in another country or location. Here the main aim is to cut labor cost. Healthcare providers generally follow this model of outsourcing.
- ✓ Business Transformation Outsourcing where the outsourcer is more involved with the business as opposed to merely few specific functions. Here, the involvement is much greater in easing the business operation. In other word, the outsourcer becomes an integral component of the entire business.
- ✓ Business Process Outsourcing where the entire business unit, process, sales, or production function is outsourced to a foreign player. These models helps in maintaining a continuous work schedule by having teams in various time zones and expand sales or services into a different geographic location.

The diagram below illustrates the BPO process in Healthcare sector:*

*Source: MphasiS Website

A number of services are provided to outsourcing company in healthcare industry for BPO, technology and professional service. Some of them are given below: *



*Source: MphasiS Website

Healthcare Payer and Insurance:

- *Life BPO:* Here, the main focus is on BPO activities within life, annuities, and pensions (LA&P) policy processing. It does not involve any outbound voice based activities generally leading to selling and marketing of LA&P products.

The Life BPO market is divided into four categories:

- ✓ Cost-focused policy administration, which focuses on policy administration, policy exit and regulatory BPO services of closed life blocks. Here, the main aim is cost reduction keeping in mind that the quality of service levels to policy holders is not deteriorated.
- ✓ Service-focused policy administration, which focuses on extended range of BPO services including policy acquisition, policy administration, policy exit, and distribution management of both open and closed life blocks. Here, the main task is improving customer service levels to policy holders and distributors.
- ✓ Support based product introduction covers life insurers operating in mature markets and introducing new products. Here, the main objective is cutting down on capital investment requirements and reduced time-to-market around new product introduction.
- ✓ Support for new market entry, services in support of life insurers developing presence in emerging markets of China, India, Eastern Europe, Middle East and Latin America.

- *Property & Casualty BPO (P&C BPO):* Here, the main focus is on BPO activities within property and casualty (P&C) products such as home, auto, flood, pet etc., and commercial general insurance in the spectrum of marine, aviation and transportation. It does not include coverage for health, worker compensation or life insurance.

The P&C BPO market is divided into four categories:

- ✓ Claims management which covers management of whole or part of the claims process. The main activities in this line include first notice of loss (FNOL), loss adjusting, subrogation, investigation, settlement. Here, the main objective is to reduce settlement and operational costs alongside improving customer experience of a claim to drive retention.
- ✓ Policy acquisition and administration which supports in-force policy administration and activities associated with new business generation like policy renewal, retention or acquisition directly to customers or via brokers.
- ✓ Comprehensive policy servicing which covers management of the majority of P&C insurance activities for existing product lines within current geographic markets. This includes the service elements encompassed within the claims management and policy acquisition and administration segments which is described above.
- ✓ Virtual insurance company which is known as the outsourcing of all IT infrastructure and operational activities requires offering new insurance product either in support of affinity groups and brand assurers or within a new geographic region.

Health Insurance BPO or Healthcare Payer BPO:

In this segment, the service line includes outsourcing of member management, claims management, provider management, and member care management in support of healthcare payers in both the public sector and private sector.

The Healthcare Insurance BPO market has two main segments:

- **Public Sector/ Govt. Health BPO**: The main task carried out in this segment are claims, eligibility/enrollment, HIPAA compliance, managed care and oversight, early/periodic screening, EHR/HIE, drug benefits/reviews, immunizations, fraud/abuse, ePrescribing, healthcare portals and other related functions. The main activities according to the type of organizations are:

  - State & local government covers services like outsourcing of child support services, employment/welfare-to-work services, revenues & benefits, and housing administration.
  - Federal/central government covers services like outsourcing of departmental application & case management and associated processing.
  - Defense covers services like outsourcing of supply chain management in support of army, navy, or air force facilities.
  - Education covers services like outsourcing the processing of student applications.

The main sub-segments within public sector health insurance are:

- ✓ *Medicare BPO:* BPO activities funded through the Center for Medicaid and Medicare Services (CMS) in support of the federal Medicare program. Some of the important functional areas in this line of specialization are Enrollment, Claims Payment, Member Services, Providers Services, Medical Management, Appeals and Grievances, Provider contracting and relations, Information Systems, Vendors, Billing/Finance, Fulfillment Materials, System Integration, Reporting and Compliance.

- ✓ *Medicaid BPO*: BPO activities funded both by federal and state level government in support of Medicare program. As the Medicaid program adapts to the changes and challenges of the 21st century & HealthCare

reforms, the Medicaid industry that supports it, is changing as well. States are moving to create an integrated care management program where medical services, clinical reviews, and care coordination programs are united into one comprehensive managed care program. In addition to integrated programming, states are also looking at the use of systems to facilitate and streamline the administrative and clinical processes for providers.

- ✓ *Other publically funded BPO*: These are special BPO programs funded by the Federal and State government for Veterans Association (VA), Children's Health Insurance Program (CHIP), American Indian/Alaska Natives and State Children's Health Insurance Program (SCHIP).

- ❖ **Private Sector/ Commercial Health BPO**: This covers healthcare payer related BPO activities carried out on behalf of private commercial healthcare insurers, not-for-profit (NFP) health plan providers and self-insured organizations such as employers, unions or trade associations. The main sub-segments within private sector health insurance are:

  - ✓ National healthcare payer: These are big healthcare payers which operate on national scale or multi-state basis. It includes commercial insurers, BCBS association members and NFP organizations offering FFS, HMO, PPO, CDH or hybrid plans. Some of the leading examples of national healthcare payers are Aetna Health, CIGNA, Humana & United Healthcare.

  - ✓ Regional healthcare payer: These healthcare payers operates on a regional or single state basis and can include commercial insurers, BCBS association members and NFP organizations offering FFS, HMO, PPO, CDH or hybrid plans. Some of the main regional healthcare payers are Dean Health Plan (Wis), FirstCare (Abilene, Amarillo, Lubbock, Waco) Grand Valley Health Plan (Mich.), Vermont Health Plan, Presbyterian Health Plan (Mich).

Enrollment & Dis-enrollment:

Enrollment is basically registering oneself for health insurance policy. Different policies have different clauses and guidelines for enrollment. For joining a Medicare Advantage (MA) plan, one must have Medicare Parts A and B. The Part B premium will continue to be taken out of Social Security or Railroad Retirement benefits check, unless one is enrolled in a Medicare Savings Program (MSP) or have full Medi-Cal or Medi-Cal with a share of cost (SOC) under $500. People cannot be denied enrollment in an MA plan due to a pre-existing condition, unless someone has an end-stage renal disease (ESRD) i.e. permanent kidney failure.

Enrollment for MA plans takes place during certain periods:

- ✓ Initial Coverage Election Period (ICEP): The 7-month period when you are first eligible for Medicare
- ✓ Annual Election Period (AEP): October 15 - December 7 each year

In addition, there are Special Election Periods (SEPs) during which you may be able to enroll in or disenroll from your MA plan, depending on your situation.

Disenrollment means ending ones membership from a health insurance plan. Disenrollment can be voluntary or involuntary depending upon the situation.

- ✓ *Voluntary Disenrollment*: This arises out of own willingness to quit a certain policy. If one enrolls in a different policy, disenrollment happens automatically with the old policy. Disenrollment is effective on the first day of the month following the month your written request is received. If someone chooses to enroll in a stand-alone Prescription Drug Plan, a prescription drug plan without medical coverage, disenrollment from your Medicare Advantage plan will happen automatically.

- ✓ *Involuntary Disenrollment*: There may be situations where membership is cancelled by the company in certain circumstances. For examples if someone do not stay continuously enrolled in Medicare A and B.

Eligibility:

In general, people aged 65 years or older and are legal residents of the United States for at least 5 years are eligible for Medicare. People with disabilities under 65 may also be eligible if they receive Social Security Disability Insurance (SSDI) benefits. Specific medical conditions may also help people become eligible to enroll in Medicare. People who are 65 and older must pay a monthly premium to remain enrolled in Medicare if they or their spouse have not paid Medicare taxes over the course of 10 years while working.

People with disabilities who receive SSDI are also eligible for Medicare while they continue to receive SSDI payments; they lose eligibility for Medicare based on disability if they stop receiving SSDI. The 24 month exclusion means that people who become disabled must wait 2 years before receiving government medical insurance, unless they have one of the listed diseases or they are eligible for Medicaid.

Many beneficiaries are dual-eligible. This means they qualify for both Medicare and Medicaid. In some states for those making below a certain income, Medicaid will pay the beneficiaries' Part B premium for them (most beneficiaries have worked long enough and have no Part A premium), and also pay for any drugs that are not covered by Part D.

HealthCare Claims:

Medicare Advantage claim is the actual application for benefits provided by the health insurance company. Policy holders must first file a claim before any money or service deemed in the policy document is availed. It can be disbursed to the hospital. The insurance company may or may not approve the claim based on their own assessment of the circumstances.

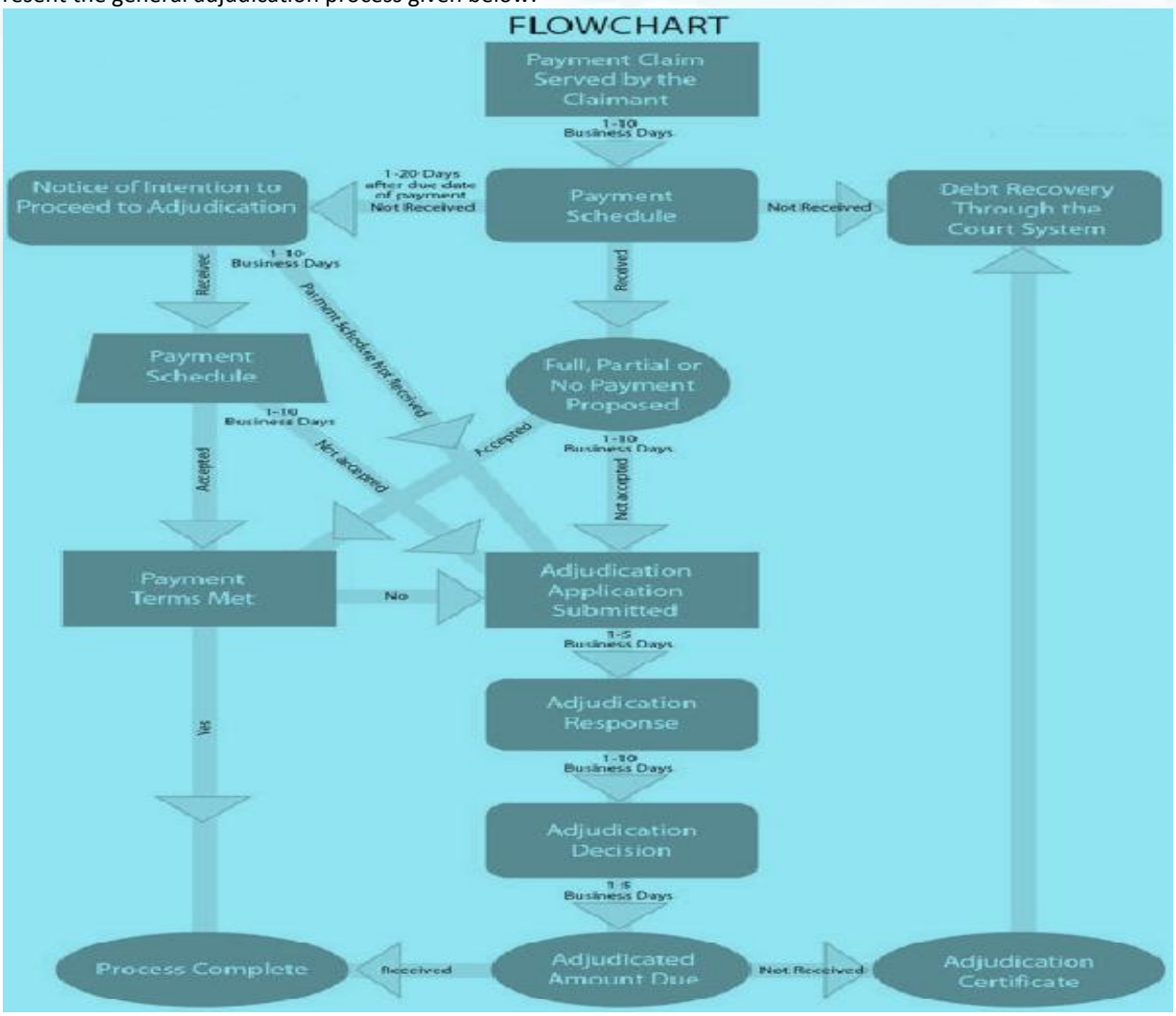
- *Claims Adjudication*: This refers to the determination of the insurer's payment or financial responsibility, after the member's insurance benefits are applied to a medical claim. Some of the claims administration includes Medical, Prescription, Dental, Vision and Disability. Claims adjudication provides management of transactional back office services. Also performs high-end services for the insurance, finance & accounting, banking, mortgage and healthcare industries. The adjudication process consists of receiving a claim from an insured person and then utilizing software to process the claims and make a decision or doing so manually. If it's done automatically using software or a web-based subscription, the claim process is called auto-adjudication. Automating claims often improves efficiency and reduces expenses required for manual claims adjudication. Many claims are submitted on paper and are processed manually by insurance workers.

  Many insurance companies take advantage of auto-adjudication as a method of managing the large number of claims that has to be processed on a regular basis. Claims are submitted electronically in most cases, although paper claims are still an option, and the information is entered into software that reviews the claims. The software checks for errors, eligibility requirements, and deductible payments, and some software programs will even check for fraud. If the claim meets the insurance requirements, then it will be paid. When the claim fails the auto-adjudication process, then it can be denied or sent to an insurance examiner to review the claim manually.
  After the claims adjudication process is complete, the insurance company often sends a letter to the person filing the claim describing the outcome. The letter, which is sometimes referred to as remittance advice, includes a statement as to whether the claim was denied or approved. If the company denied the claim, it has to provide an explanation for the reason why under regional laws. The company also often sends an explanation of benefits that includes detailed information about how each service included in the claim was settled. Insurance companies will then send out payments to the providers if the claims are approved or to the provider's billing service.

  The insurance company might only make a partial payment to the provider as a result of claims adjudication. Insurance companies are often required by law to provide an explanation as to the reason why only partial payment was made. Another possible outcome is a request made by the insurance company for the person to resubmit the

claim. The reason is often to obtain additional information or to provide information that was missing in the original claim. If the claim is denied, then the entity or person filing the claim can file an appeal.*
*Source: wisegeek

We present the general adjudication process given below: *



*Source: Buildingpaymentsolution

- *Claims Audit:* In Medicare Advantage, claims audit is necessary for evaluating the entire claim process. The performance audit can be done by:

  - ✓ evaluating the independence, objectivity, and qualifications of the auditors;
  - ✓ reviewing the approach and planning of the audit
  - ✓ attending key meetings with auditors and CMS officials;
  - ✓ monitoring the progress of the audit; and
  - ✓ reviewing the auditors' reports.

- *HealthCare Claims Payment/Remittance*: After claim process, either an ERA or an SPR is sent with claim adjudication and payment information. One ERA or SPR usually includes adjudication decisions about multiple claims. It gives the guidelines for each claim and adjudication decisions with those claims/lines as submitted by the provider. The ERA or SPR reports the reason for each adjustment, and the value of each adjustment. Adjustments can happen at line, claim or provider level. In case of ERA, the adjustment reasons are reported through standard codes. For any line or claim level adjustment, 3 sets of codes may be used:

    a) Group Code
    b) Claim Adjustment Reason Code
    c) Remittance Advice Remark Code

    Group Codes assign financial responsibility e.g., CO would mean contractual obligation or provider responsibility and PR would mean patient responsibility. Medicare beneficiaries may be billed only when PR Group Code is used with an adjustment. Claim Adjustment Reason Codes provide an overall explanation for the financial adjustment, and may be supplemented by more specific explanation using Remittance Advice Remark Codes. Medicare beneficiaries are sent Medicare Summary Notice that indicates how much financial responsibility the beneficiary has.

    At the provider level, adjustments are usually not related to any specific claim in the remittance advice, and PLB reason codes are used to explain the reason for the adjustment Some examples of provider level adjustment would be: a) an increase in payment for interest due as result of late payment of a clean claim by Medicare; b) a deduction from payment as result of a prior overpayment; c) an increase in payment for any provider incentive plan. SPR also report these standard codes, and provide the code text as well. One check or electronic funds transfer (EFT) is issued when payment is due; representing all benefits due from Medicare for the claims itemized in that ERA or SPR.

    There are a number of advantages of ERA over SPR. The amount payable for each line and/or claim as well as each adjustment applied to a line or claim can be automatically posted from an ERA, eliminating the time and cost for staff to post this information manually from an SPR. ERAs generally contain more detailed information than SPR. Please see the separate page in this EDI section for further information on the benefits of acceptance of EFT for Medicare claim payments.

    All ERAs sent by Medicare contractors are currently in the X12N 835 version 4010A1 format adopted as the national HIPAA ERA standard. There is a link below to this version of the ERA. Medicare is currently working on implementing the new HIPAA standard that has been adopted, and will be ready on January 1, 2011 to start testing with any partner willing to receive ERA in the new HIPAA standard format – ASC X12 versions 5010.

    Medicare provides free software to read the ERA and print an equivalent of an SPR using the software. Institutional and professional providers can get PC Print and Medicare Easy Print (MREP) respectively from their contractors. These software products enable providers to view and print remittance advice when they're needed, thus eliminating the need to request or await mail delivery of SPRs. The MREP software also enables providers to view, print, and export special reports to Excel and other application programs they may have.

Health Analytics:

This provides clients with optimized solutions for achieving goals within the healthcare industries. It also helps to ensure a commitment to compliance, efficiency, audit initiatives and waste management.

Claims handling is one of the most critical areas in the insurance business, especially when it comes to provision of various kinds of reports and analysis of claims data and trends within the data. In today's world of globalization and convergence, a conscious effort to harmonize random claims data, sifted from various discrete sources, into a form of reporting that is crisp and easily accessible. The main task is to identify fraud and duplicity in claims and adjust loss reserves accordingly. Apart from

identifying duplicity in claims and fraud, high standard of care in terms of maintenance of client confidentiality is utmost important. A positive claim experience always results from the efficiency and steadfastness of claims handlers and is bound to enhance customer satisfaction and sales of clients. Proper strategic planning and business modeling also boost the launch of new product plans, pertaining to comprehensive health coverage, crisis cover and hospital care.

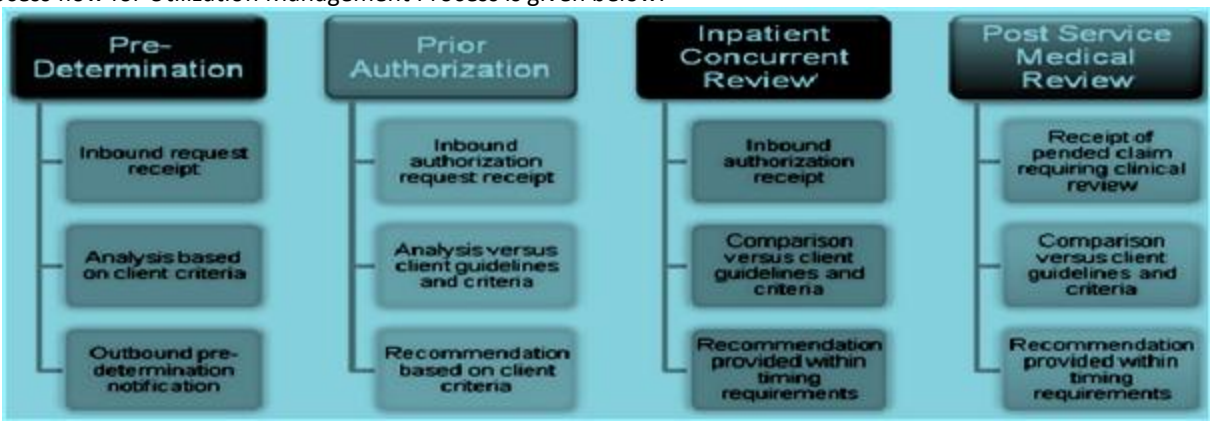
Some of the popular services related to claims reporting, analysis and data are:

- ✓ Fraud Analytics
- ✓ Claims Analytics
- ✓ Enterprise data model
- ✓ Architecture assessment reporting
- ✓ Report design, development and testing
- ✓ Operations support reporting
- ✓ Decision support
- ✓ Fraud detection

Prior Authorization (PA) and Utilization Management:

Utilization Management is the evaluation of the appropriateness, medical need and efficiency of health care services procedures and facilities according to established criteria or guidelines and under the provisions of an applicable health benefits plan. Typically it includes new activities or decisions based upon the analysis of a case.

The process flow for Utilization Management Process is given below:



A prior authorization is a process of reviewing certain medical health services to ensure medical necessity and appropriateness of care prior to services being rendered. In other words, PA refers to meeting certain criteria in order to receive benefits for certain prescribed medication. Medications are selected for prior authorization due to clinical, efficacy, and safety concerns.

Salient features of Prior Authorization (PA):

- ✓ Two level authorization process
- ✓ First level request review and recommendation are made by qualified Radiologists
- ✓ Final decision making process involves qualified Radiologists from the US
- ✓ Prior authorization is required for outpatient advanced imaging services only
- ✓ Prior authorization is based on clinical evidences related to the procedure advised

- ✓ The authorization policies conform to state and federal law, specialty-specific guidelines for utilization management like ACR practice guidelines and technical standards & ACR appropriateness criteria
- ✓ The standard Authorization Request Forms ensures that adequate and necessary clinical information is supplied by the provider when raising an authorization request
- ✓ Authorization outcomes are properly updated in claims adjudication system

Some of the key steps involved in Prior Authorization (PA) are as follows:

- ✓ Prior Authorization can be obtained over fax, phone and online
- ✓ Authorization process should take 24-48 hours
- ✓ If an urgent clinical situation arises, the ordering physician may request a prior authorization on an urgent basis for which a prior authorization number will be issued within three hours from the receipt of all required information during business hours
- ✓ After the final decision is taken, the decision outcome is communicated to the ordering and rendering physicians via mail or fax
- ✓ In case of a denial, the decision outcome is communicated to the ordering and rendering physicians via mail or fax

Regulatory Compliance:

The healthcare industry faces various challenges that it has never seen before. The industry is at the receiving end from various angles like cost containment, HIPAA compliance, lack of stability, etc. The regulatory compliance is becoming more demanding as well. The major cause of concern is security and protection of electronic data. The two major US healthcare regulatory compliance mandates are HIPAA migration from 4010 to 5010 electronic transaction set and conversion of ICD-9 code set to ICD-10 code set. This compliance will affect every player associated with healthcare industry. In fact it will have impact on every core process, system and interface across the industry.

The Health Insurance Portability and Accountability Act (HIPAA) represent the most significant standards healthcare providers face. HIPAA was enacted by the U.S. Congress and signed by President Bill Clinton in 1996 to cover three specific areas:

1. Insurance portability or the ability to move to another employer and be certain that your insurance will not be denied
2. Fraud enforcement and accountability
3. Administrative simplification

The first two areas have been active since 1996, but it took until April of 2003 to enact administrative simplification. The US government has given specific deadlines for implementation of regulatory compliance and if not followed, action will be taken against the concerned party. HIPAA 5010 Compliance is to be completed by January 1, 2012. All electronic claims provided after this date must use Version 5010 and Version 4010 claims will no longer be accepted. ICD-10 Compliance is to be completed by October 1, 2013. Claims for services provided on or after this date must use ICD-10 codes for medical diagnosis and inpatient procedures.

The possible benefits of migrating to advanced regulatory standards are likely to be:*

- ✓ Facilitating interoperability of stakeholder systems and drives efficiencies.
- ✓ Enhancing usability and effectiveness of transactions such as claims, eligibility inquiries, referral authorizations, remittance advices and other transactions.
- ✓ Enabling integration of codes of different versions across systems in the industry.
- ✓ Providing standardization of interoperability guides between systems across the industry.
- ✓ Increasing protection of personal medical information (PMI) through limiting ways in which information is shared.
- ✓ Assisting healthcare consumers in purchasing appropriate health insurance coverage.
- ✓ Enabling easier accessibility of individual records by patients

*Source: GSS Infotech

HIPAA migration from 4010 to 5010 electronic transaction set and conversion of ICD-9 code set to ICD-10 code has set up new challenges for payer's as well medical practitioners. The change has already been accepted by company: strategies and planning are made taking into consideration the latest compliance. In fact, healthcare providers can best control their own destiny by developing and deploying a comprehensive compliance program. The possible course of action can be:

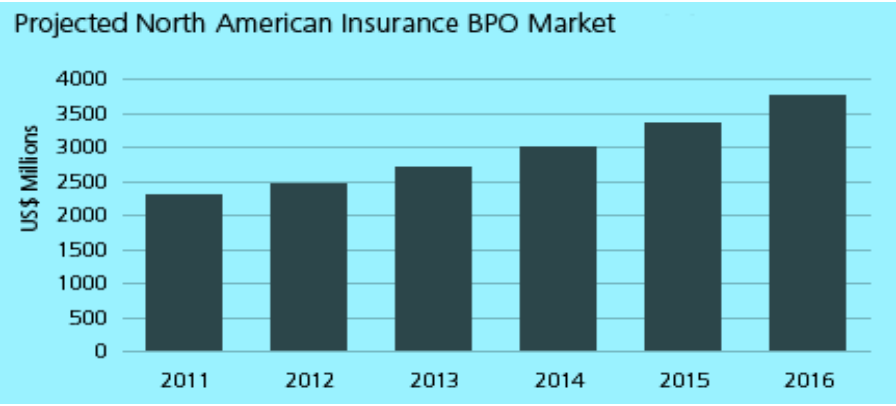
- ✓ Defining or identifying the parameters of the compliance program, including regulations requiring compliance, provider's risk categories and policies it must implement.
- ✓ Automating compliance by mapping policies to multiple frameworks, standards, and regulations.
- ✓ Self-auditing, automatic generation of enterprise-wide metrics, and comprehensive reporting to appropriate authorities.

Top HealthCare BPO firms:

Some of the biggest player in Healthcare BPO market worldwide is as follows:

Accenture	FirstSource	MphasiS
Acclaris	GeBBS	Promantra
ACS-Xerox	Genpact	Royal Health Care
Aegis	HCL	Sparsh
Allsec Technologies Limited	IBM	SUN Knowledge
Apollo Health Street	iGatePatni	Syntel
Cognizant	IMS	Tata Consultancy Services
Convergys	Infosys	TMG Health
Copley Global	iProjects	Trizetto-Facet
Dynamic HealthCare Systems	iSoftStone	Wipro
EXL Service	Mahindra Satyam	WNS

With recent economic events taking a toll on world economy, once again cost containment is the top priority for the insurer. The development of technology, great improvement in networking facility and unrelenting pressure on expenses with an increased appreciation for highly flexible business models, all insurance carriers are looking at outsourcing model for running their businesses. A recent study by Deal Analysis provides a North American perspective on the insurance BPO sector.



The above diagram clearly states Insurance BPO market will grow considerably in the coming years and India stand to gain the most from this. The future will continue to experience growth in Healthcare Insurance outsourcing from US. But the Indian companies should be ready to face stiff challenges from emerging markets, labor attrition rate which is always on the rise and rising real estate and infrastructure cost.

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