



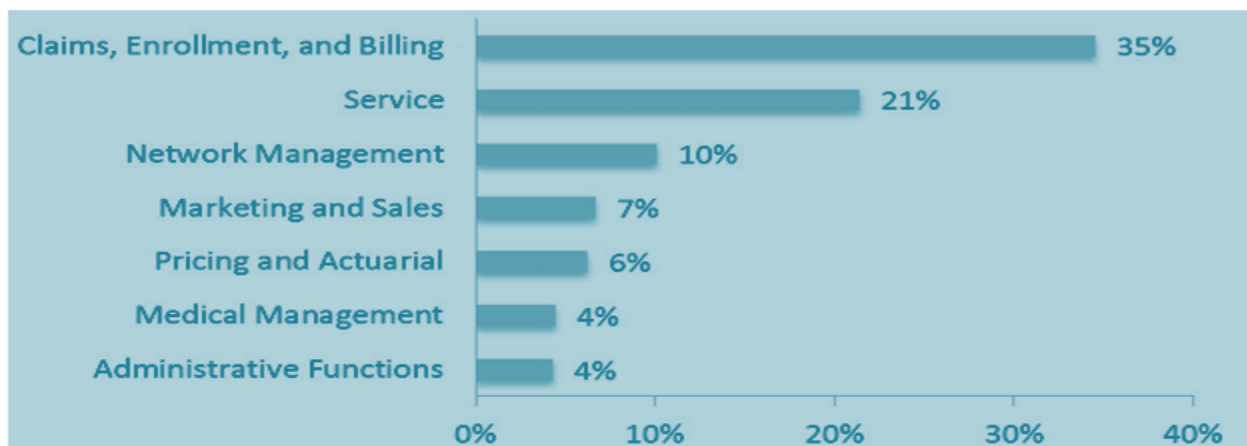
MEDICARE ADVANTAGE OUTSOURCING

A Medicare Advantage (MA) Plan is offered by private health insurance companies that are approved by Medicare. It is a social insurance program administered by the US government. They have a contract to provide Medicare benefits to people who are aged 65 and over and to those who suffer from permanent physical disability. MA Plans are also sometimes called Medicare Health Plans, Medicare Part C Plans, and MAs/MA-PDs (and originally, MA Plans were called Medicare+Choice plans). MA Plan combines Medicare Hospitalization (or Medicare Part A) and Medical insurance or Doctor's visit coverage (or Medicare Part B) into one Health Plan that provides the same Medically-Necessary Services as Original Medicare. Some MA Plans also offer Prescription Drug Coverage (or Medicare Part A and Medicare Part B and Medicare Part D) at no additional cost and are known as MA-PDs.

The current state of Medicare outsourcing is on the high and some of the biggest private players of the market are on move to stamp their authority in the market. It has also been observed that there is a great flow in outsourcing of process in healthcare domain. Outsourcing of business process work at this juncture is huge. Earlier, outsourcing was perceived to be a risky affair but now it has become an integral part of hundreds of US companies. The dependence on outsourcing has been on a high and companies are investing more than ever to achieve strategic and financial goals. But, outsourcing in healthcare is relatively untapped compared other industries. This is changing of late, but before getting into outsourcing, healthcare organizations should undertake a comprehensive review of the risks, including performance, reputation, security, legal, financial, and competitive factors associated with offshore outsourcing. Some of the major reasons for outsourcing are as follows:

- ✓ Reduce/control cost
- ✓ Gain access to IT resources unavailable internally
- ✓ Free up internal resources
- ✓ Improve business or customer focus
- ✓ Accelerate company reorganization/transformation
- ✓ Accelerate projects
- ✓ Gain access to management expertise unavailable internally
- ✓ Reduce time to market

We have seen drastic increase in US spending since 2002. Infact, it is second highest next to National debt. In order to curb down on healthcare expenditure, most insurance companies have accepted the importance and advantages of outsourcing. India is ranked first when it comes to percentage of work outsourced. Some of the popular work outsourced in healthcare industry is as follows: *



* Source: HFS Research 2011

Top MA Insurance Companies:

Some of the major players in the market which are listed below accounts for nearly two-thirds of the total premium collected. The ranking is based on market share for which data is provided by National Association of Insurance Commissioners, whose members direct the state agencies that license insurance companies.*

Rank	Insurer	Rank	Insurer	Rank	Insurer
1	Unitedhealth Group	10	Blue Shield of CA Group	19	Wellcare Group
2	Wellpoint Inc. Group	11	Cigna Health Group	20	HIP Ins. Group
3	Kaiser Foundation Group	12	BCBS of MI Group	21	Metropolitan Group
4	Aetna Group	13	Health Net of California, Inc.	22	Unumprovident Corp. Group
5	Humana Group	14	BCBS of NJ Group	23	Universal Amer Fin Corp. Group
6	HCSC Group	15	BCBS of FL Group	24	Lifetime Healthcare Group
7	Coventry Corp. Group	16	Regence Group	25	BCBS of NC Group
8	Highmark Group	17	BCBS of MA Group		
9	Independence Blue Cross Group	18	Carefirst Inc. Group		

*Source: Health US News

MA Operations:

In today's world, for any business the greatest challenge is to cut down on cost which leads to increase in profit. This requires a systematic operation and work flow. The healthcare sector is no different where multiple problem arises due to rising operating costs, increased cost per member/policy holder and higher loss ratios, fragmented and broken processes resulting in duplicate & missing records, use of legacy systems increasing manual interventions, lack of skilled resources to manage and handle seasonal fluctuations for any spikes in new business inflows and increasing pressure and strictures from the regulatory & compliance authorities. The diagram below is a typical example of how the operation should be:*



*Source: iGATE Patni website

MA Claims:

A 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. In claims audit, the major services that are provided by outsourcing companies are as follows:

- **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.
- **Risk Adjustment Data Validation Audit (RADV)** - The CMS reinstate (RADV) audits for Part D Medicare Advantage (MA) plans to the extent necessary for CMS to have visibility to assess the level of inaccurate diagnosis data and its affect on the tabulation of risk factors and payments to Part D plan sponsors. Medicare Advantage organizations (MAOs) submit risk adjustment data to CMS on which CMS calculates risk scores. Part D risk scores are largely based on Medicare fee-for-service data and Part D risk seems have a smaller impact on final payment is said that audit on Part D will be less effective.
- **Claims Audit – Pre & Post Claims-** Pre audit and post audit differs in the sense that the former occurs prior to payment and later occurs after payment is made. Pre audit errors are identified and corrected before payment is made and post audit errors are identified after payment. No cash is tied up in case of pre audit and client gets 100% of recovered revenue but in case of post audit, client gets 50% of recovered revenue and auditor gets 50% of recovered revenue.
- **PDE Audit-** On November 15, 2005, Medicare Part D, the prescription drug coverage program for seniors and other disabled citizens, went into effect. Under this program, private health insurance companies and organizations (plan sponsors) offer insurance coverage for prescription drugs in which Medicare recipients can enroll. A PDE record is created every time a Medicare Part D beneficiary (i.e., an individual enrolled in a qualified Part D plan) fills a prescription covered under Part D. Thus, we can say PDE record is a summary record of all the transactions that occurred surrounding the dispensing event.

A PDE record consists of 39 data fields. PDE records contain actual costs incurred by beneficiaries at the point of sale. PDE records include separate payment fields to distinguish between payments made by plans and payments made by beneficiaries or by others on behalf of beneficiaries. Both TrOOP-eligible and non-TrOOP-eligible payments are reported on PDE records.

PDE Audit allows a plan to calculate an internal view of PDE transactions based on actual Drug Claim, formulary, benefits design and membership data. This allows the plan to identify covered drug claims that should have been

reported and were missed and verify the accuracy of the cost and payment fields. PDE audit include the following steps:

- ✓ Monitor PDE Content Errors — Need to identify PDE calculation errors in cost and payment fields
- ✓ Verify Paid Drug Claims— Identification of covered drug claims that have not been reported to CMS and should have been reported to be correctly reimbursed by CMS
- ✓ Identify MIS-Reported Values— The next step is to find PDE transactions that have not been retroactively processed for changes in Member Data like retroactive LICs changes
- ✓ Verify Claims are adjudicated in the Correct Benefit Phase — The internal view of PDE transactions provides a discrepancy where PDEs have been processed in the wrong benefit phase because of incorrect TrOOP or Gross Covered Drug Cost Tracking.

Claims Processing & Claims Adjudication:

This again is a very important issue in MA outsourcing. Claim Processing includes processing of outpatient and inpatient claims. The basic claims processing guidelines are given below:

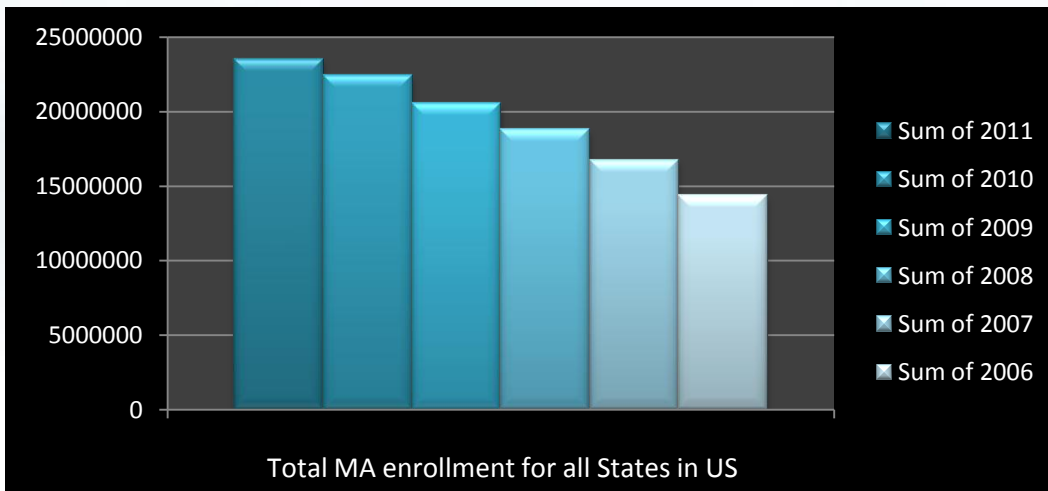
- Verification of all keyed fields in case of claims that are not submitted electronically
- Determination of member eligibility and coverage
- Determination of primary insurance when member is covered by 2 or more health plans
- Determination of Timely Filing Limit of claims
- Confirmation of provider status (Participating / Non-participating)
- Checking of authorization notes for instructions & applying authorization status to the claims
- Checking for CCI edits where applicable
- Apply capitation to services within the purview of the capitated contract
- Determination of correct allowable (RBRVS, Medicare/Medicaid Fee Schedule, APC and DRG)
- Ensuring application of multiple procedure reduction
- Ensuring that modifiers have been taken into consideration while determining the allowable
- Ensuring that Copay, Coinsurance, Deductible and OOP are accurately calculated and applied as per the members' benefit plan
- Use of appropriate Remark / Adjustment codes which will be printed in the EOB

When it comes to Claims Adjudication the general process is explained with the help of a diagram given below:

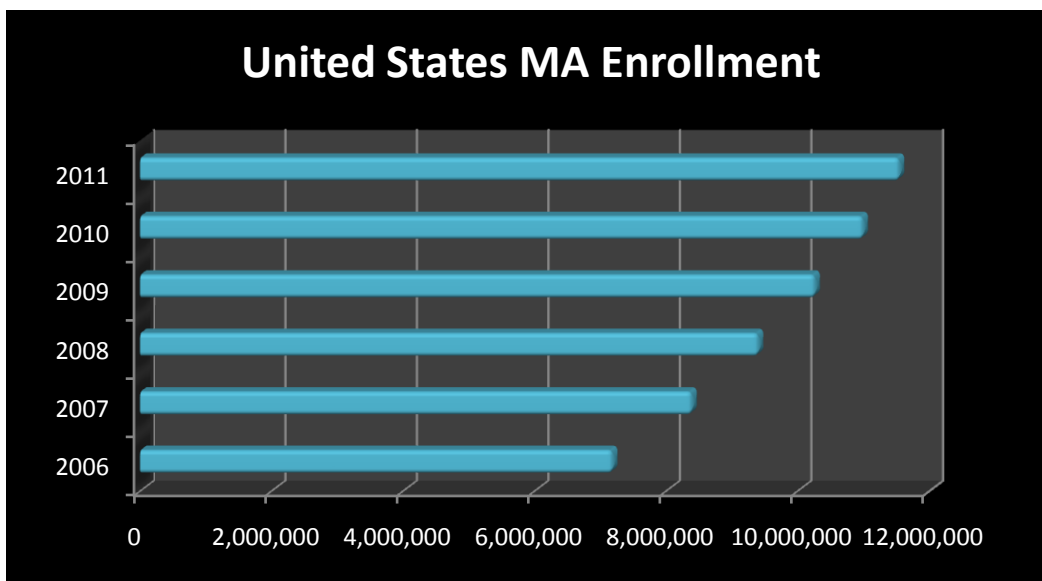


MA Enrollment:

MA Plan participation and enrollment have fluctuated over the past decade. The number of Medicare enrollees in private health plans increased from 8.7 million in 2007 to 11.6 million as of 2011. The growth is largely attributed to higher plan payments. The enrollment in MA plans for the elderly and disabled is estimated to climb up by 10 percent in 2012. The enrollment cannot be denied unless under certain specified extreme cases. The diagram below states the Total MA enrollment for all States in US from 2006 to 2011. Data is taken from CMS website.



The diagram below states the MA enrollment for US State only from 2006 to 2011. Data is taken from CMS website.

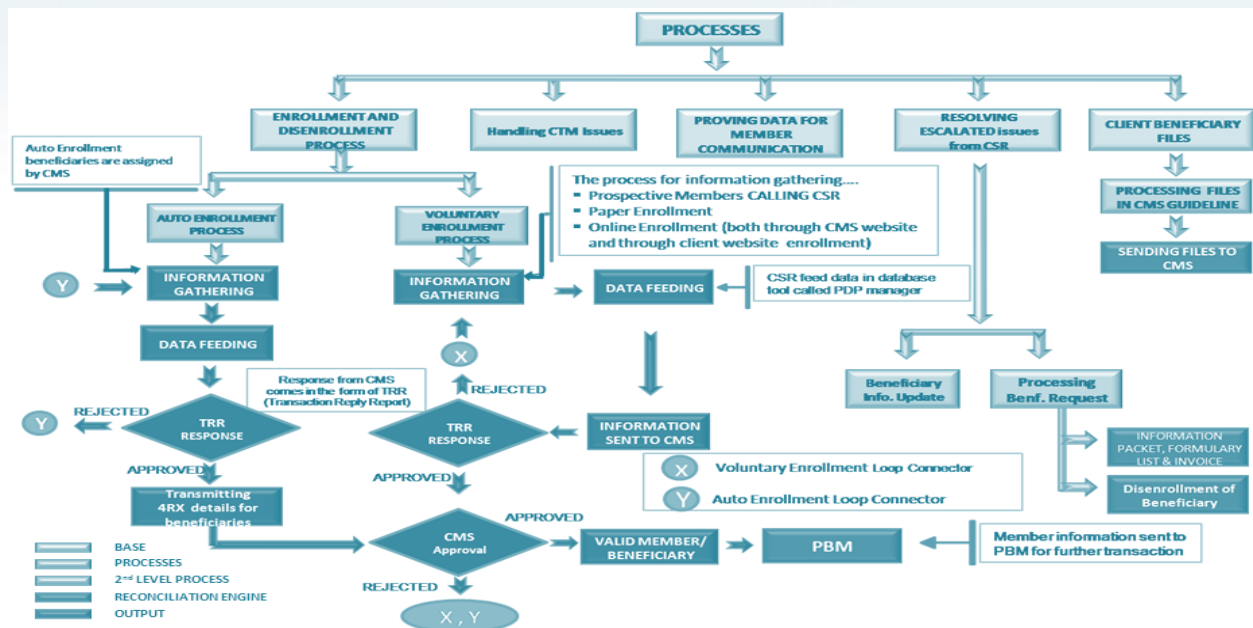


- **BEQ & TRR Processing:** This is an automated action based business rules for processing BEQ and TRR transactions. The Batch Eligibility Query (BEQ) provides beneficiary eligibility verification to support the enrollment process. When the health plan receives an enrollment application, its first step should be to validate, and if necessary repair, the application to ensure it efficiently passes through the BEQ process. The Transaction Reply Report (TRR) provides

eligibility information about beneficiaries through a weekly file that covers the processing week and a monthly file that covers the payment processing month.

- ✓ Correspondence Management- Here, manual and automatic letter creation and retrieval of historical letters is done.
- ✓ Data Validations- This is done by using online data validation rules and real time US Postal Service address validations.
- ✓ Reporting- By having a reporting process, standard and custom reporting provides unlimited view of the entire business process.

The diagram below explains the general enrollment process flow:



MA Premium Billing & Collection:

The expectations of healthcare consumers and group purchasers are placing pressure on plans and carriers and their billing processes. The traditional process must be transformed into latest technology driven processes. This can lead to increase in revenue. The services which outsourcing companies can help are as follows:

✓ 3 rd Party Payouts	✓ Enrollment / Disenrollment	✓ Lockbox remittances
✓ Age outstanding balances	✓ Invoices, Statements and Coupons	✓ SSA Premium Reconciliation
✓ Calculate member Premium & Refunds	✓ Late Enrollment Penalties	✓ Trial bills

MA Member Management:*

This is nothing but the best way to manage organization efficiently and productively in an easy and safe manner.

- **ECRS & COB Processing:** Here, it requires creating ECRS submission files and then processing COB files to ensure accurate Part C and D COB data.
- **Member Information:** This means storing and maintaining complete member demographic and special status information with start and end dates.
- **Integrated Reconciliation:** This is important in the sense that Member data is shared with the Reconciliation module providing a direct view of the impact of plan data changes and corrections
- **Reconciliation:** Medicare Advantage health plans are required to attest that CMS payment reports (MMR) are correct and accurate with their internal records. Dynamic's reconciliation module allows a plan to easily load their bid information and MMR and quickly identify member, special status and payment discrepancies.

*Source: Dynamic Healthcare Systems

MA Clinical Services:

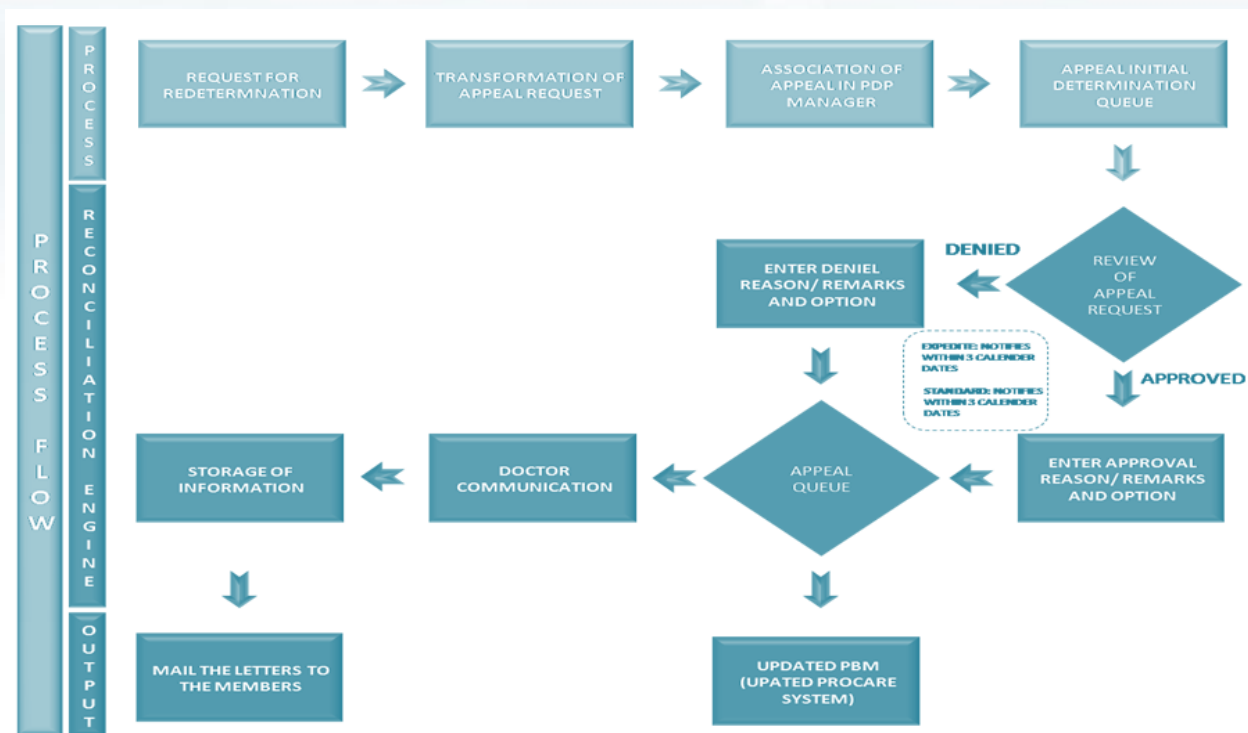
The clinical services offered today comprises of an extensive range of value added benefits for clients. The clinical services mainly focuses on the maintenance of the rationality of prescriptions so as to provide a better health outcome and maximum end-customer satisfaction. In this area, major service includes the following:

- **Prior Authorization (PA)** - 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. Prior authorization is required for:
 - ✓ Automatic Implanted Cardioverter Defibrillator (AICD)
 - ✓ Dental surgery related to an accident
 - ✓ Joint replacement surgery
 - ✓ Nasal and sinus surgery
 - ✓ Cosmetic surgery
 - ✓ Spinal surgery
 - ✓ Surgical treatment of obesity
 - ✓ Transplants (organ, tissue, etc)
 - ✓ Experimental or investigational procedures
 - ✓ Blepharoplasty
 - ✓ Cochlear implants
- **Appeals-** There are two types of appeals processes that a Medicare Advantage plan enrollee can make use of to assure Medicare health insurance coverage. The first type of appeal is called coverage and payment appeal. This may be used by an enrollee in two circumstances- first; it can be used to appeal the MA plan's decision to deny coverage and payment for health care services that the enrollee has already received and second; it may be used to appeal the MA plan's decision to deny coverage and payment for services that the enrollee has not yet received, but that he or his physician are seeking pre-approval of.

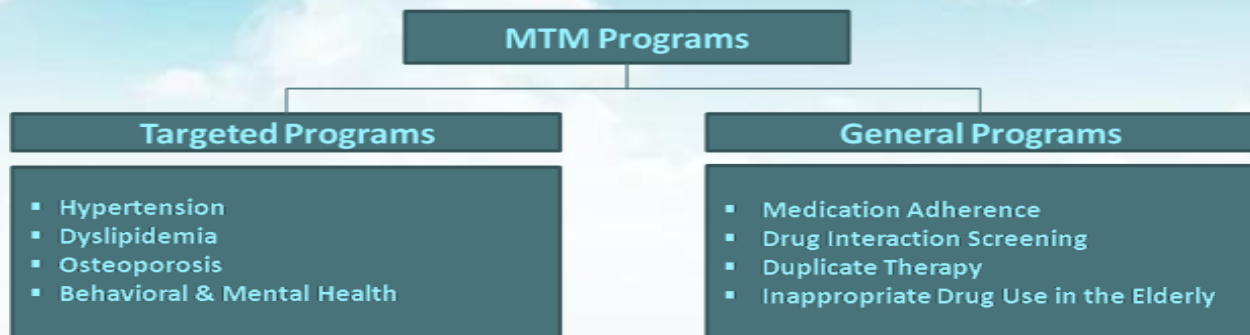
The second type of appeals process is called fast-track appeals. This can be used by enrollees who are receiving hospital care, skilled nursing facility care, outpatient rehabilitation facility care, hospice, or home health care, and who are notified by their MA plan that these services are coming to an end. The enrollee may appeal this denial of coverage and termination of services through the fast-track appeals process.

In both the cases, the appeal process may progress through a number of stages. The general appeal process is diagrammatically explained.

The appeal process:



- **Step Therapy-** This guides plan participants to utilize the most effective and appropriate drug therapy while progressing to other more costly or risky therapy. The aim of step therapy is to control costs and minimize risks. It is sometimes also called step protocol. In other words, Step Therapy refers to guiding plan participants to use effective alternative medications prior to receiving approval for specified medications. When a medication has a step therapy check applied, it means that good alternatives are available. When patients have tried the alternatives without a successful outcome, the medication that requires an override may be approved for coverage.
- **Medication Therapy Management (MTM)-** This program were significantly enhanced for the 2010 contract year, and expanded requirements were put into place in order to increase the number of beneficiaries eligible for MTM services and the intensity of interventions and to provide for the collection of more robust plan-reported data for outcomes analysis. Each Part D sponsor is required to incorporate a MTM program into their Plan’s benefit structure. MTMP is considered an administrative cost (component of the plan bid) by CMS. Part D Sponsors are required to explain how their fees account for the time and resources associated with their MTM program. The diagram below illustrates the MTM program from targeted and general perspective.



Again, the basics of MTM is briefly given below:



As Per CMS guidelines:

- * Annual Drug cost of the beneficiary needs to be more than \$ 3000
- ** The beneficiary should be suffering from at least four chronic diseases

MA Analytics:

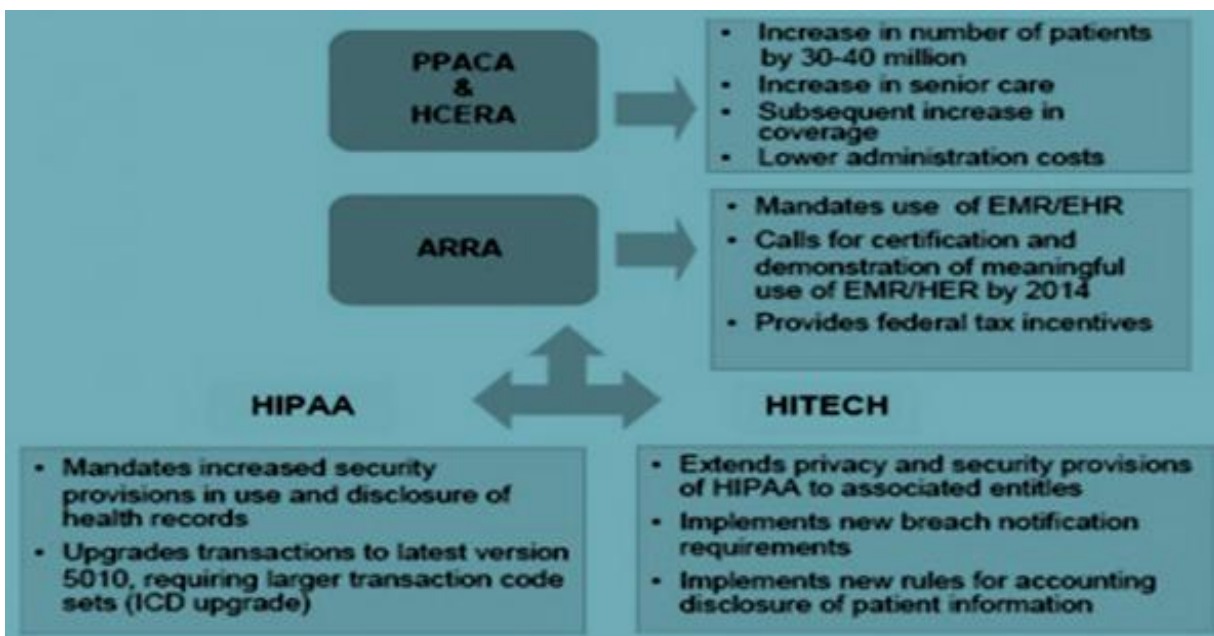
Analytics is the buzz word in the market today. Basically, analyzing data in a structured manner and making valid inference and conclusion is analytics. Also, the knowledge advantage is critical for organizations to succeed in today’s business environment. Broad areas in Healthcare Analytics can be in the form of:

- ✓ Audit Quality Process Documentation
 - ✓ Customized Management / Analytical Reports
 - ✓ CMS Compliance Reporting
 - ✓ Customized Data Management Programs
- **PDE Management-** PDE files are generated on the basis of the daily claims of the beneficiaries. The purpose of creation of this file is to submit the claims to CMS in order to get the payment for the beneficiaries. Each time a beneficiary fills a prescription under Medicare Part D, a prescription drug plan sponsor must submit a summary record, called the Prescription Drug Event (PDE) to CMS. Every PDE record contains prescription drug cost and payment data that enables CMS to make payments to plans and otherwise administer the Part D benefit. The PDE records are classified as below:

- ✓ Monitor PDE Errors- Monitoring is important which means reporting and tracking PDE errors on PDE transactions by error code and group by type of error.
- ✓ Correct Errors- This includes creating corrective action tasks to resolve PDE errors and ensure acceptance of PDE transactions.
- ✓ Identify Error Causes- With simultaneous view of PDE and Drug Claim data allows for quick identification of differences and discrepancies.
- ✓ Work Flow- If proper work flow is carried out by proper channel, tracking error resolution for PDE transactions that have been rejected becomes easy.
- ✓ PDE History- PDE history are created for showing PDE transactions that have been created, stored, submitted and deleted.

Future of MA Outsourcing:

A number of reforms like PPACA, HCERA and ARRA have been passed by the current US government affecting healthcare system. The likely impact on the healthcare industry is outlined below:*



*Source: Market Publishers

Every party associated with the healthcare industry stands to be affected by these changes. Major players will seek outsourcing as the way to go about business operations because there is a shortage of healthcare professionals in the US, and this includes lack of coding professionals. Also, an outsourced coding job is done at a third the cost for providers outside US. With the adoption of EMR/EHR systems, coding is a function that can be easily facilitated remotely;

The fact that around 30-40 million citizens is expected to be added into the country's healthcare systems and with not enough facilities available, companies will look at outsourcing major work. Healthcare providers in the US too, are accepting this fact and using both technology and outsourcing as solutions to meet this challenge is expected. Some of the works likely to be outsourced are concentrated towards the following five broad service areas:

- ✓ RCM services: Base to high end services;
- ✓ KPO Analytics and benchmarking;
- ✓ Code set upgrading, compliance and conversions;
- ✓ EMR/EHR implementation, testing and beyond;
- ✓ IT Advisory and consultancy for providers;

So, this is a great opportunity for players to cash in as the Healthcare Outsourcing market looks bright and positive. In fact, big market players have already started making a mark in the market but the opportunity still persists. In this scenario, large BPO vendors with significant healthcare operations, RCM vendors, Healthcare KPO and IT vendors can make the most of the given situation.

For Details, Please contact:

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