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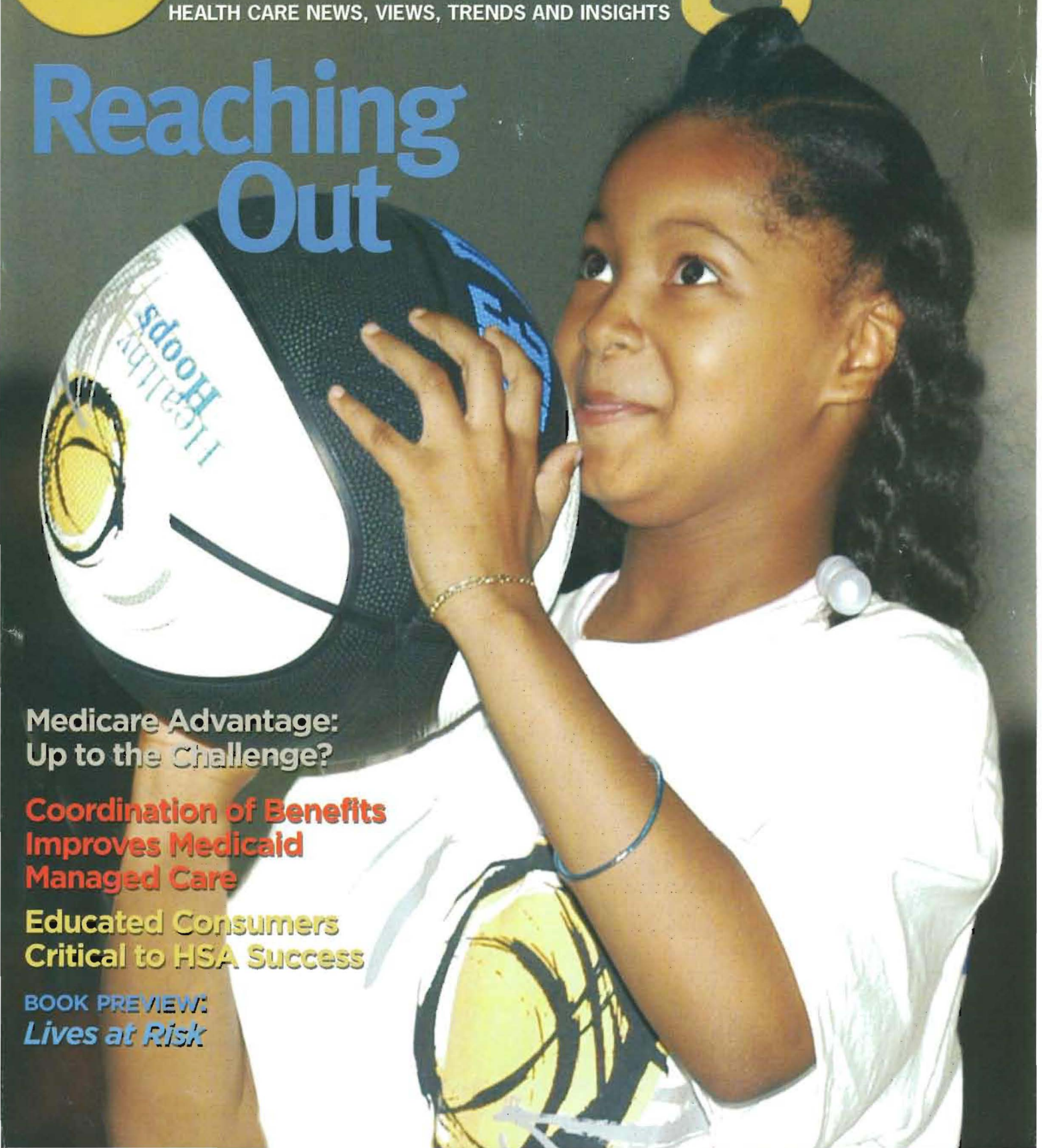
Reaching Out



Medicare Advantage: Up to the Challenge?

Coordination of Benefits Improves Medicaid Managed Care

Educated Consumers Critical to HSA Success

BOOK PREVIEW: *Lives at Risk*

Climbing the Medicaid Mountain: Coordination of Benefits Brings Success

BY WILLIAM C. LUCIA

FOR MANAGED CARE PLANS, doing business in the Medicaid market can be a little like climbing Mount Everest. Hardy adventurers find the rewards of success are great, but perils along the way are treacherous and leave even experienced climbers gasping for breath.

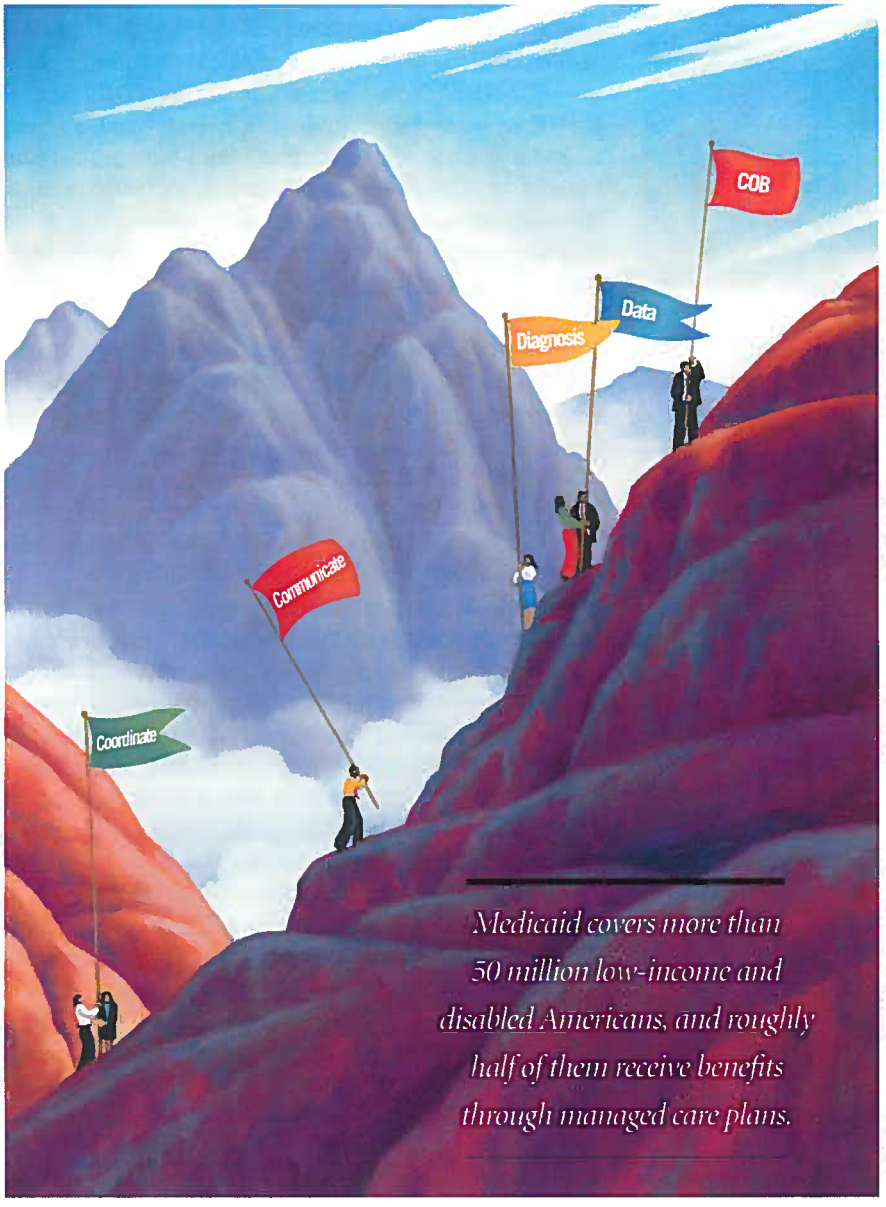
However, with the right gear—and an experienced climbing partner—plans can increase their chances of topping the summit. One of the most important pieces of gear is a robust, efficient, and accurate coordination of benefits (COB) program.

A Look at the Terrain

Collectively, Medicaid programs represent the nation's largest health care payer, with total federal and state expenditures estimated to reach $304 billion this year, according to the Centers for Medicare & Medicaid Services. Medicaid covers more than 50 million low-income and disabled Americans, and roughly half of them receive benefits through managed care plans contracted with state Medicaid agencies.

But after growing dramatically in the '90s, Medicaid plans now confront uphill challenges. Faced with a growing fiscal crisis over the last several years, many states have slashed the capitation rates they pay plans. Medicaid's increasing administrative requirements have added a layer of red tape that plans can ill afford, and managing care of the Medicaid population has proven difficult. As a result, many plans have exited the Medicaid market or consolidated with larger competitors. Those remaining in the market have had to develop new capabilities and seek out new sources of revenue. For these plans, coordination of benefits has proven to be a strategic advantage.

Traditionally, some health plans have viewed Medicaid COB as little more than a contractual requirement. Like the agencies they serve, Medicaid plans are usually required to recover health care expenditures when members have other sources of health insurance. Despite capitation rates



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STEVE KROPP / SIS

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that assume a baseline of third-party recoveries—penalizing plans that do not pursue them—COB often has been viewed as a back-office, noncore function.

Forward-thinking Medicaid plans, however, have discovered that COB represents a revenue opportunity, and the size of the opportunity is significant. Federal officials estimate that more than five percent of a Medicaid program's expenditures can be recovered from third parties. In most states, plans are entitled to retain these monies. What's more, the new insurance eligibility data obtained through COB can alert a plan to other payers on future claims and achieve savings worth several times the value of the original recoveries.

Consider the experience of one client, a midwestern plan with approximately 100,000 Medicaid members. Like many Medicaid plans, the health plan performed COB using a small staff and limited sources of third-party coverage information, such as data supplied by the state Medicaid agency. In July 2003, the plan began supplementing its internal COB efforts with Health Management Systems (HMS).

Just a year later, the health plan's third-party recoveries from Medicare and private insurers had increased by nearly $1 million. That's equivalent to $0.80 per member per month—or an even higher figure if one considers that benefits were coordinated for only a portion of the plan's membership—with 85 percent of the initial billings submitted to third parties representing new, previously undiscovered sources of health insurance.

Mapping Your Path

Clearly, COB offers the potential of untapped revenue for Medicaid plans. Why aren't more plans taking advantage of it? The answer is simple: too few allocate the resources and expertise necessary to pursue COB aggressively.

Health plans, after all, are in the business of keeping members healthy. The complex work of identifying third-party coverage and seeking payment is not the focus of daily operations. When it comes to reimbursement, plans are more accustomed to functioning as "adjudicators" that pay claims, rather than "billers" that submit them.

Despite these obstacles, plans can learn from the experience of others to improve the effectiveness of their COB functions. Some of these lessons are summarized below.

1 Recognize the unique information needs of COB.

Fully coordinating Medicaid benefits requires the ability to retrospectively analyze vast amounts of member data. In order to identify potential recoveries, plans must be able to data-mine paid claims at a transactional level. Plans need to pick out fine threads of billing and clinical information that can determine whether or not expenditures are covered by other insurance. To submit certain pharmacy claims to Medicare Part B, for instance, a plan may need details about a member's diagnosis and care setting—information that can be difficult to obtain from Medicaid data. Various forms of member identification data must be carefully compared and matched, using tiered logic systems that take into account missing or inaccurate information.

The sheer volume of data can, at first blush, seem overwhelming. Medicaid members, like other insured Americans, often receive benefits through an intricate, overlapping web of health coverage. Increasingly, this web extends far beyond the borders of an individual state; it is no longer enough for a Medicaid plan to rely on a state's records of third-party coverage. To accurately identify members' coverage, plans need to match eligibility and claims information with data from major health insurance entities throughout the nation—including insurers, other managed care plans, third-party administrators, and public payers such as Medicare and TRICARE. In fact, some revenue recovery companies are equipped with data-match networks containing more than 100 current carriers.

This information is constantly changing, as a result of life events (for example, changes in job, income, marital status, residence, age, and dependents) or changes made by an insurer (such as a change in its pharmacy benefits manager or a new benefit carve-out). So a comprehensive COB program should obtain eligibility information regularly and frequently, through automated eligibility interfaces with the carriers. The information must then be validated, integrated, and mined.

Coordinating benefits for the "dual-eligible" population—individuals covered by both Medicaid and Medicare—is especially challenging. Roughly 10 percent of the nation's six million dual eligibles are enrolled in Medicaid plans, and the group accounts for a disproportionate share of plan costs. However, identifying Medicaid plan members who are also eligible for Medicare benefits can prove a complex task. No single data resource provides a complete picture of Medicare coverage, so an accurate determination of Medicare benefits requires analyzing a host of data files, including the Medicare Common Working File, "buy-in" files for Medicare Part A and Part B, and the BENDEX File.

2 Communicate even more closely with providers.

Maintaining strong relationships with providers has always been a priority of health plans. But an aggressive COB program runs the risk of alienating these critical stakeholders, as they are forced to deal with the paperwork and the perceived revenue impact of additional claim reversals. Medicaid plans can minimize this risk through proactive communication and an understanding of providers' concerns.

The midwestern health plan mentioned earlier is particularly sensitive to the concerns of physicians. In response, a dedicated provider relations team works closely with the plan's physicians to lighten the burden created by the new COB efforts. For example, within days of notifying a physician of a potential claim reversal, the revenue recovery company contacts that physician by telephone to address questions about the reversal process. The provider relations team also makes it clear that claim reversals ultimately do not affect the physician's revenue stream; in fact, usually a third party will pay more than the amount being reversed. Follow-up continues over a six-week period, with communication and correspondence managed online, until the reversal is completed.

The result: the health plans' network of physicians have largely accepted the claim reversals, and averted any "backlash". In fact, of more than 200 physician groups that recently received claim reversals, nearly every one of them cooperated fully. The increase in reversals also was partially offset by the revenue recovery company's ability to bill many types of claims directly to third parties—a task our client previously had not performed and a time-saving convenience for providers.

3 Decide if outsourcing Medicaid COB services makes sense.

Once the decision is made to more aggressively pursue coordination of benefits, a health insurance plan needs to look at the most cost-effective way of implementing the task. With so many challenges for Medicaid plans, more and more of them are turning to vendors who provide specialized COB services. The advantages can be numerous.

By centralizing data and technology tools, a COB firm allows plans to draw on resources that exceed their individual capabilities. For example, rather than maintaining its own storehouse of eligibility information, and the in-house expertise necessary to analyze it, a plan can rely on those of a vendor such as HMS—and avoid much of the overhead costs associated with COB. A COB firm also can dedicate specialized resources to satisfying stakeholders, such as a round-the-clock call center a revenue recovery vendor can use to communicate with providers.

Working with a COB firm also allows a Medicaid plan to benefit from the experience and knowledge of others. Because they interact with a variety of Medicaid plans and agencies, COB firms are able to share best practices and innovative approaches to revenue recovery. The result benefits both the plan and the vendor. In the case of the midwestern health plan, for example, the COB firm found that the plan's internal COB efforts have become more effective over the course of the vendor/health plan's work together, and the health plan has made use of new cost avoidance information and techniques. With the client taking on more responsibility for COB success, the vendor will be able to tackle new revenue-producing opportunities for the plan.

For many plans, however, the most important reason to work with a COB firm is a matter of dollars and cents. COB firms that work on a contingency-fee basis offer health insurance plans revenue opportunities with zero risk. Because fees are only deducted from actual recoveries, the plan incurs no up-front costs, and revenue recovered goes directly to the bottom line.

Reaching the Peak

Ultimately, Medicaid plans may discover that the most efficient way to coordinate benefits is to turn the function over to a partner. In doing so, they will follow the path of their clients, which are increasingly privatizing COB. Most Medicaid agencies already employ COB firms to supplement their internal efforts, and today are relying more and more on these firms' specialized capabilities to capture the maximum possible third-party recoveries. One Medicaid client, the Florida Agency for Health Care Administration, has even outsourced its entire COB function to a revenue recovery firm.

But whether they outsource the function, hire a vendor to supplement their efforts, or develop new internal capabilities, Medicaid plans can no longer afford to take COB for granted. Succeeding in the Medicaid market is too difficult, and the stakes are too great, for COB to remain a back-office function. On the long climb to the top, plans need to use all their revenue-producing tools wisely. C

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