AGILITY

TMG Health *white paper series*

Perspectives on Agility

in the BUSINESS PROCESS OUTSOURCING *discussion*

TMG Health

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TMG HEALTH – BUSINESS AGILITY

As government health programs have grown, so too have the expectations placed on participating health plans. With ever-increasing oversight experience, the Centers for Medicare & Medicaid Services (CMS) have continued to raise the bar with respect to statutory requirements, regulations and guidance governing programs.

Illustrative of the agency's increasing focus is its most recent Medicare Call Letter providing ground rules for participation to health plans. The 2010 Letter represents of 108 pages of guidance necessary for the coming year.

Specific activities CMS undertakes in its oversight capacity for Medicare Advantage Organizations (MAOs) and Medicare Part D programs include contracting; account management and day-to-day monitoring; data monitoring, performance assessment and surveillance; auditing; and progressive enforcement.[1] Reflective of its maturing expectations, for 2010 CMS announced a fundamental shift in its oversight approach from routine audits to more targeted audits. [2]

For many health plans, the internal controls, time and energy needed to address increased compliance requirements from CMS are colliding with other business pressures, including rising costs and reduced reimbursement. Because of these diverse factors, contention for limited plan resources is a dilemma being faced by more any more organizations.

At the same time, government health plans are facing reduced reimbursement, rising costs and intense regulatory scrutiny. To succeed and prosper in the face of these challenges will require new levels of business agility as plans maneuver to expand market share in highly competitive arenas.

DATA DRIVEN, PROACTIVE AND FOCUSED OVERSIGHT

Among the latest changes implemented by CMS for 2010 is the mandatory use of the Online Enrollment Center (OEC). In previous years, organizations were encouraged, but not required to participate in the OEC. As of 2010, all MAOs and Part D sponsors must accept enrollment made via the OEC.

At least once every business day, MAOs and Part D sponsors must log into the Administrative Console of the OEC and download pending enrollments. MAOs and Part D sponsors failing to download enrollments every business day are subject to compliance actions including, but not limited to, a request for a corrective action plan.

CMS will produce a performance profile of MAOs and Part D sponsors and will target organizations that demonstrate poor performance. CMS warns that it will focus on high-risk areas that have the greatest potential for beneficiary harm (e.g. enrollment operations, appeals and grievances). In addition to this risk-based approach, there will be some degree of random selection.

CMS continues to enhance its analytical tools to provide the steps to identify potential errors, unusual variances, system weaknesses, or inappropriate patterns for financial data accumulation. [3]

While the rate of change can be dizzying, against this backdrop of uncertainty there exists even greater opportunity for health plans that are effectively positioned.

MORE CHANGES ON DECK

CMS is not the only external audience demanding agility from health plans. Organizations must concurrently satisfy the continuing escalation of claim payment timeliness requirements and expectations of participating providers.

Providers and health plans are anticipating another, significant, forthcoming wave of change, as ICD-10 diagnosis and procedure codes must be implemented by Oct. 1, 2013. Experts say that improvements over ICD-9 — including less ambiguity, more specificity, standardized terminology and combination codes — will help hospitals improve their compliance. But at the same time, fraud investigators may also benefit from ICD-10 (which is essential to adoption of electronic medical records) when it's deployed with electronic anti-fraud tools.[4]

"This is a boon for compliance," said Rita Scichilone, director of practice leadership at the American Health Information Management Assn. (AHIMA). With 35% of overpayments identified during the recovery audit contractor (RAC) pilot related to coding errors, the new system could have a huge ripple effect, says Scichilone.[4]

A PERFECT STORM OF CHANGE

A "Perfect Storm" of change and evolution exists with health plans participating in Medicare Advantage programs at the end of the century's first decade.

CMS continues to increase demands on participating entities, a landscape that will only intensify as beneficiary protections are likely to be part of any forthcoming reform legislation. As the bar of expectation gets raised, organizational resource contention issues continue to accelerate.

At the same time, sizeable populations of Private Fee For Service (PFFS) members will see the elimination of their plans, creating even more growth opportunity for MA programs.

While MA health plans are well positioned to welcome PFFS enrollees, they must do so while concurrently addressing the first-ever payment cuts in the history of the program in 2010, and aggressively consider benefit design changes and premium adjustments.

While the rate of change can be dizzying, against this backdrop of uncertainty there exists even greater opportunity for health plans that are effectively positioned. Organizations that can quickly evaluate and re-evaluate the changing landscape, and take the steps needed with their business processes to respond (including seasonal staffing adjustments), will succeed.

In meeting these challenges and optimizing the opportunities, reduction of waste and efficiency of operations will become even more crucial for health plans.

TMG Health employs quality and audit programs that result in best practice work flows that yield maximum performance.

LOGICAL RESOURCE ALLOCATION BECOMES A NECESSITY

"Production is not the application of tools and materials, but logic to work."

Peter F. Drucker

Entities that succeed in government health programs moving forward will share many characteristics. Key among them will be a logical approach to their business processes, and the ability to quickly alter processes and adapt to the ongoing waves of program changes … both known and unknown at this time. Business agility has always been important, but will become even more so with the emerging landscape.

As demands increase, more and more executives are emphasizing a logical evolution: the emergence of business process outsourcing (BPO) and related solutions such as business process utility (BPU) "shared" approaches.

When it comes to agility of operation, there's a simple formula health plan executives can keep in mind: Activity ≠ Productivity. Health plans need to realize productivity with their processes, not just activity.

TMG HEALTH = PRODUCTIVITY

With more than a decade of successful government plan experience TMG Health brings a depth of understanding and broad perspective to the unique requirements of the government market. TMG has leveraged this experience to develop a rapid response model to the myriad of changes enacted each year by CMS. Experience has also given us the ability to ensure continued compliance with CMS regulations through careful, conservative interpretation and constant communication by our compliance staff with CMS. Relieved of the burden of responding to constantly changing requirements, TMG Health clients can refocus their resources on creating differentiated products and services that help them thrive in today's increasingly competitive market.

TMG Health employs quality and audit programs that result in best practice work flows that yield maximum performance. In addition, our unique home-shoring staffing model, flex staffing programs and employee cross-training provide both scalability and elasticity to deal with unexpected volume fluctuations. Because TMG Health specializes in government health plan markets there is no resource contention as so often happens when commercial and government interests clash. Our single focus yields resource optimization for both TMG Health and our clients.

A third contributor to business agility is TMG Health's specialized technology. By surrounding our MCIS with purpose-built applications for the government sector we are able to enhance and expand the effectiveness of our systems. Over the past 10 years we have developed and honed our proprietary software applications and integrated them with our workflows to yield the optimum levels of scalability and flexibility to react to change at a moment's notice. An added benefit to TMG Health's technology investment is that it saves our clients millions of dollars in capital investment that can be redirected elsewhere while providing leading edge technology in a risk-free environment.

All TMG Health staff work in a managed care-centric environment focused on government program requirements, processes and systems.

TMG HEALTH = BUSINESS AGILITY

TMG Health is also uniquely positioned to help its clients gain greater flexibility to enter, expand in or exit markets in response to changing competitive opportunities or economic conditions.

Clients have access to systems that are fully configured for Medicare and Medicaid process requirements without capital outlay or the burdensome, operationally distracting and costly task of implementing new systems, departments, staff and workflows for this purpose. With our complete claims processing and payment functionality, we are able to correctly and rapidly process any Medicare or Medicaid claim form from any provider, anywhere across the country.

All TMG Health staff work in a managed care-centric environment focused on government program requirements, processes and systems. All remain current on operations through the support of TMG's Compliance Department which intakes and distributes all program Guidance and Transmittals. TMG Health personnel represent an agile, highly interactive (non-siloed) group producing a steady stream of enhancements to processes, system capability and performance.

The management staff for each client plan is assembled upon conclusion of contracting with new clients and includes seasoned managers, reassigned or newly promoted supervisors, experienced and newly-hired front-line staff. All individuals are trained on the specific policy, procedure, benefits and workflows of the plan to which they are assigned.

TMG Health utilizes the TriZetto Facets® managed care information system, selected specifically for its Medicare configuration capability. The system's highly advanced; state-of-the-art plan/server technology delivers performance, flexibility, speed, and robust scalability. Its open systems architecture facilitates integration with existing and external systems, while its extensive relational database offers a comprehensive reporting capability.

In addition to delivering leading edge technology, Facets contains integrated Medical Management applications and extensive Medicare and Medicaid managed care functionality. The Facets system is integrated with numerous TMG Health proprietary software applications specifically designed to meet all CMS and state regulations and all contracted functional requirements. In addition to being compliant, TMG Health proprietary systems are specifically designed around optimizing performance and monitoring of Medicare and Medicaid product operations.

TMG Health's proprietary Enrollment automation and processing system, TMG Enroll, allows for the application of up to 1,000 CMS, Plan and TMG-specific business rules and edits for applicant data and verifies each applicant against the Common Working File before certifying the application for submission to CMS.

SOURCE ATTRIBUTIONS

[1] – *Medicare Advantage and Part D Contract Compliance & Oversight Overview presentation; Michael Kavouras, Part C Compliance Lead, Center for Drug and Health Plan Choice (CPC).*

[2] – *CMS: Issuance of the 2010 Call Letter, Jonathan Blum, Acting Director, Center for Drug and Health Plan Choice – March 30, 2009*

[3] – *CMS Financial Report, Fiscal Year 2008*

[4] – *Health Business Daily, July 2, 2009, ICD-10 Will Reduce Payment Errors and Claims Denials, but Will Also Help Fraud Investigators*