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## Beneficiary Eligibility Information: The Medicare Plan Challenge

In recent years, private Medicare plans have faced increasing scrutiny around cost and compliance, leading some beneficiaries to question the value of their private health plans and increasing the number and intensity of health plan audits. Recent analysis predicting near-term bankruptcy for the entire Medicare program and research demonstrating that private Medicare plans are more costly than traditional Medicare suggest that continued pressure on rates for private Medicare plans is a virtual certainty.<sup>1,2</sup> These forces challenge Medicare Advantage and Medicare Part D plan profitability, and make operational efficiency and revenue optimization more critical than ever.

Maintaining accurate eligibility information is a critical success factor for the Medicare plan. Errors and inconsistencies in beneficiary information lead to costly mistakes — eroding financial performance, undermining beneficiary satisfaction and exposing the plan to the risk of serious regulatory compliance errors. A typical Medicare plan that takes steps to optimize its enrollment, eligibility update and reconciliation processes can expect financial performance to improve by two to five percent through cost reductions and increased payments.

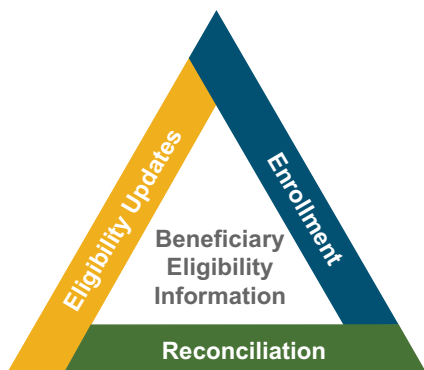
**A Medicare Part D plan with 1.3 million beneficiaries realized savings of \$20 to \$30 million simply by ensuring that its internal systems were updated with the most accurate beneficiary eligibility information.**

*What does your Medicare plan stand to gain?*

Medicare plans face unique challenges in maintaining beneficiary eligibility information because of the complexity of the requirements and coordination of enrollment, eligibility updates and reconciliation imposed by the Centers for Medicare and Medicaid Services (CMS). Fortunately, the steps a plan must take to meet these challenges are straightforward ones:

- Identify and fix problems as early in the process as possible — and as often as updated information becomes available;
- Use the most appropriate and current CMS source for the data element being updated;
- Employ automation to reduce errors and improve throughput; and
- Conduct root cause analysis on recurring problems to eliminate internal sources of errors.

This paper examines enrollment, eligibility updates and reconciliation activities — identifying best practices for each of these critical steps in maintaining accurate and consistent beneficiary eligibility information.



## Best Practices: An End-to-End Strategy to Meet the Challenge

Maintaining accurate up-to-the-minute eligibility information is critical to efficient and effective operations in any health plan, because eligibility information determines both the payment the plan is entitled to and the expenses for which it is responsible. Eligibility maintenance is especially challenging for Medicare plans because of the data coordination requirements with CMS and because CMS continuously updates and communicates eligibility information to Medicare plans.

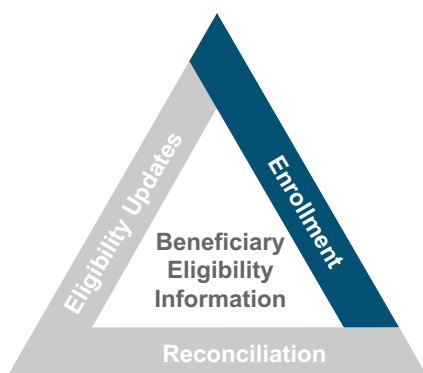
To ensure that all health plan systems and processes that rely on eligibility information are synchronized with the most accurate data available, a Medicare plan needs to coordinate core data elements with CMS through its enrollment processes, seek eligibility updates from CMS on a regular basis and implement reconciliation against CMS' data. There are some straightforward steps that private Medicare plans can take to optimize these processes.

- ★ **Identify and resolve problems as early in the process as possible — and as often as updated information becomes available** — to acknowledge that the need for eligibility information is time sensitive. Accurate eligibility information early in the process ensures the health plan pays for the right benefits only for eligible subscribers. Providing beneficiaries with the services they expect and billing them accurately improves beneficiary satisfaction and reduces exposure to costly audits.
- ★ **Identify the most appropriate and current CMS source** to use for each validation element, to ensure the health plan is referencing the most accurate eligibility information. CMS issues many files and reports with overlapping content and different reporting dates, rather than a single comprehensive source for beneficiary information.
- ★ **Automate updates** based on the large quantity of eligibility data that must be reviewed to reduce errors and improve throughput — reducing the need for rework. Cost and time constraints make it impossible to thoroughly complete this process manually. The large number of steps and great deal of repetition make Medicare enrollment, eligibility updates and reconciliation processing natural candidates for simplification and automation.
- ★ **Conduct root cause analysis** to identify and fix recurring errors that the health plan can control. This will limit the number of discrepancies that must be dealt with during reconciliation and ensure accurate eligibility information as early in the process as possible.

### Pre-Enrollment Processing: Improving Eligibility Information from the Start

CMS maintains the system of record for Medicare beneficiary eligibility information, so a Medicare plan must work not only with beneficiaries but also with CMS to validate information contained on enrollment applications. Through the Beneficiary Eligibility Query (BEQ) process, CMS conveys preliminary information about applicant eligibility that enables the health plan to update its internal system of record as early as possible — minimizing errors that result when health plan records do not reflect the most current CMS information. These early updates, along with data that the health plan can gather through preliminary application validation work prior to the BEQ, help the health plan to maintain correct information in its internal system of record, which serves as the basis for proper reconciliation, billing and claims functions. Automating these processes will reduce administrative costs and increase accuracy and consistency.

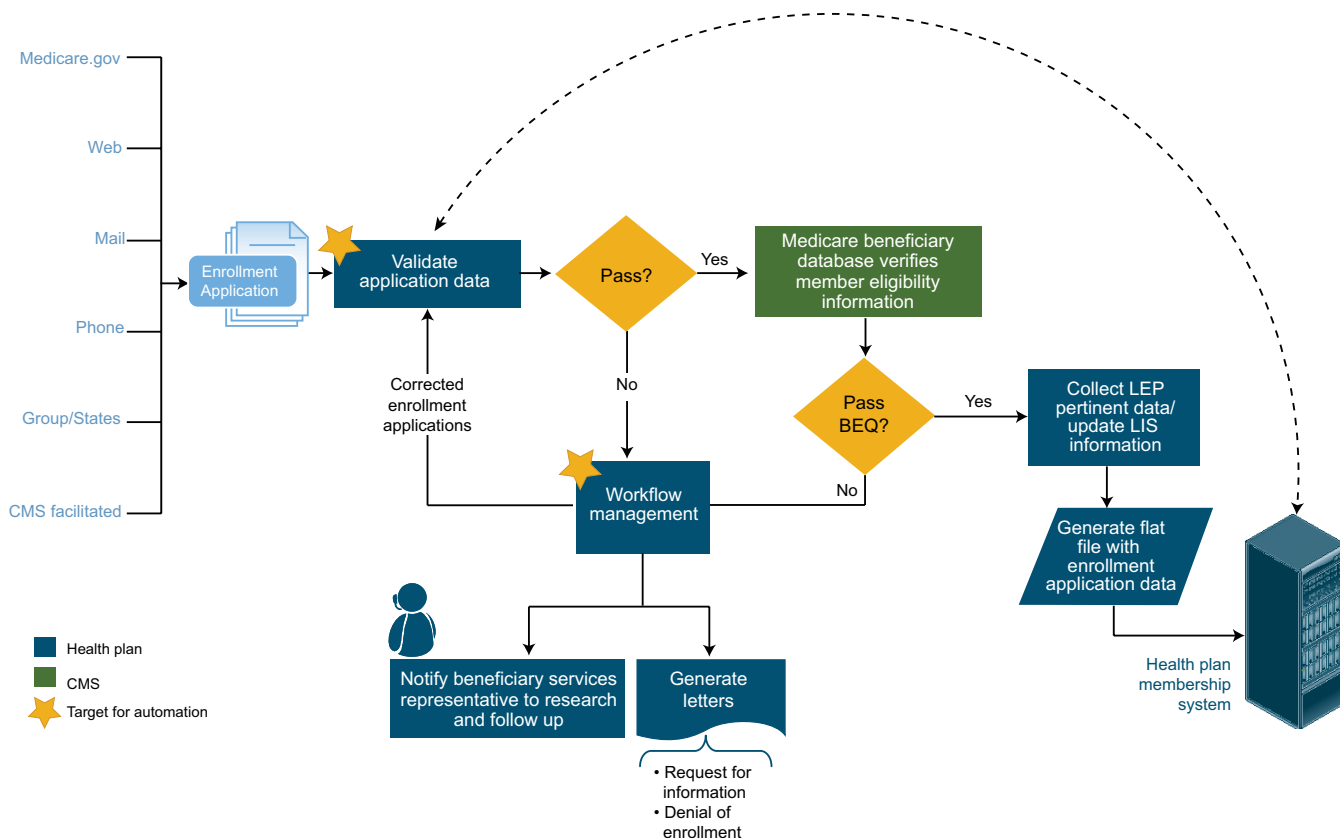
**Validate application data and repair errors to maximize successful BEQ processing.** When the health plan receives an enrollment application, its first step should be to validate, and if necessary repair, the application to ensure it efficiently passes through the BEQ process. By conducting pre-enrollment processing to fix applications and duplicate enrollments, a health plan avoids the rework required when a BEQ submission is rejected. Addressing beneficiary information inaccuracies and omissions early also helps the health plan maintain correct information in its internal system of record as early in the process as possible.

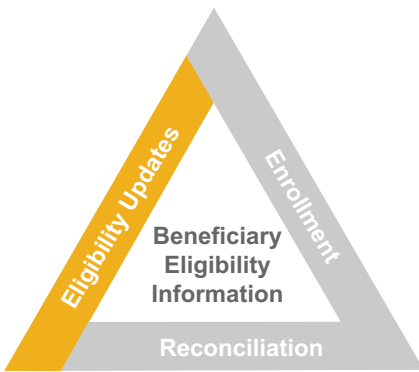


**Automate processes and use workflow management tools where manual intervention is necessary.** Validation of the standard elements in the application is a logical candidate for automation in which business rules can be applied to screen the data for missing elements or other variances. Automated workflow or work routing software, often an existing feature in core administrative systems, can further improve process efficiency by directing a “problem” application to the appropriate work queue for follow up and resolution.

**Update internal beneficiary information with BEQ response data.** CMS sends a batch response to the health plan’s regular BEQ submission that serves as preliminary confirmation of applicant eligibility. The health plan should use the BEQ information about eligibility dates and Part D Low Income Subsidy (LIS) status to update its internal records to reflect the more accurate data in CMS’ system of record as early as possible. These early updates will help the health plan minimize errors that result when its records do not reflect the most current CMS information, and will improve the accuracy of health plan functions that rely on beneficiary eligibility data.

**Identify late enrollment penalty (LEP) assessments for Part D subscribers and ensure that they are reflected in related financial operations.** Medicare Part D plans should establish specific procedures in the BEQ response process to identify LEP assessments that have been applied by CMS. LEP assessments are an addition to the monthly Part D premium that is due from beneficiaries who enroll after their initial open enrollment period without maintaining “creditable” coverage as defined by CMS regulations. The LEP assessment that is reported on the BEQ response is an early and important trigger for a health plan to confirm the accuracy of the assessed penalty with the beneficiary, and to incorporate the assessment into the premium that will be billed to the beneficiary (or, if the assessment is incorrect, to work with the beneficiary to correct it). These are lengthy administrative procedures, and the early indicator provided by the BEQ response is an important tool that health plans can leverage to ensure that assessments are accurate and reflected in monthly payments, billings and collections.





## Eligibility Updates: Capturing Dynamic Data

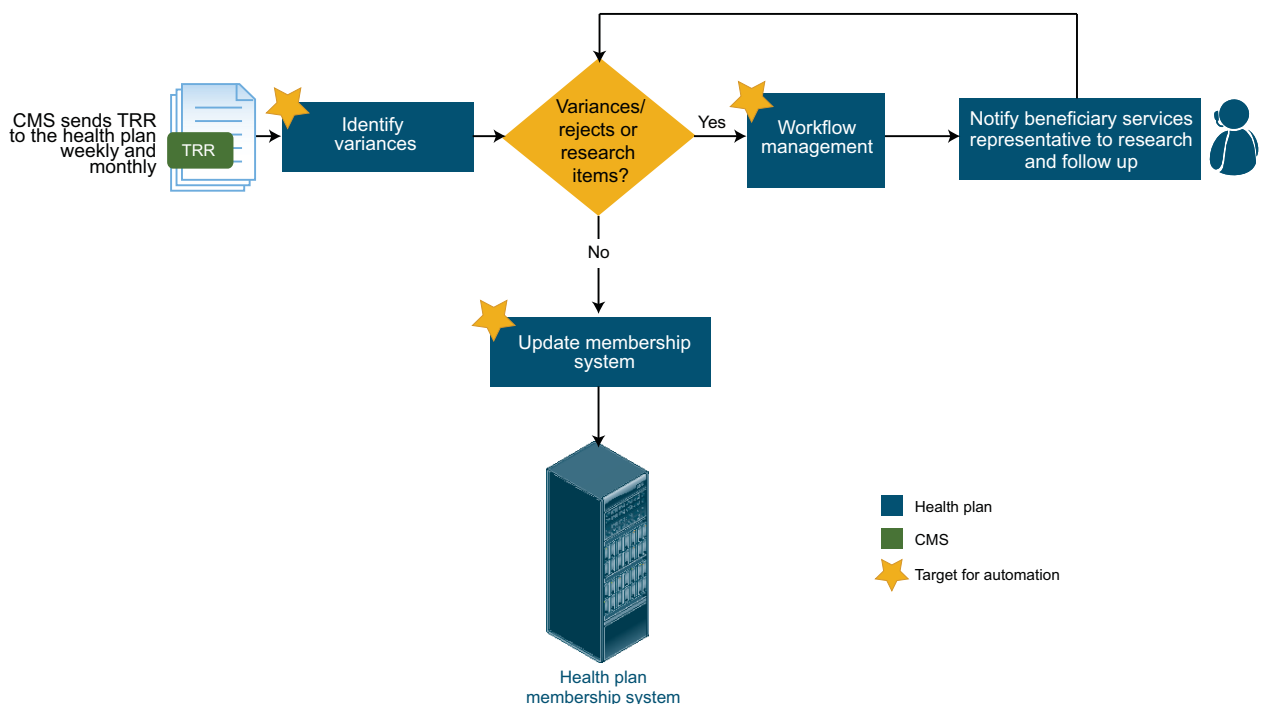
While CMS' BEQ batch response offers preliminary validation of beneficiary eligibility information, updating beneficiary records based on information in the BEQ alone is not sufficient. CMS communicates a more comprehensive report of all eligibility changes through a weekly Transaction Reply Report (TRR) that covers the processing week and a monthly TRR that covers the payment processing month. The TRR is an important tool for health plans to capture changes to beneficiary data as early as possible to ensure the updates from CMS are reflected in the health plan's business and financial operations.

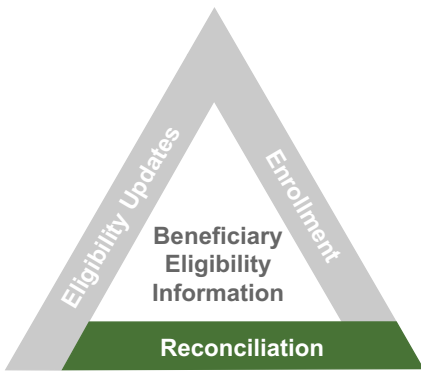
**Work the TRR files aggressively and completely as they come in.** Updating beneficiary eligibility data as soon it becomes available minimizes the health plan's exposure to the risk of basing coverage and invoicing decisions on inaccurate data, which creates rework, costs the health plan money and interrupts beneficiary service.

**Identify and prioritize TRR codes that impact operational and financial processes at the health plan.** CMS uses the TRR to capture many different elements of beneficiary information, not all of which are relevant to health plan business operations. For this reason, best practice suggests that the health plan prioritize those codes that affect eligibility and payment in order to ensure that the most important updates are made accurately and consistently. Once the relevant TRR codes are identified, the health plan should also identify business process impacts of eligibility file changes and establish standards and processes for adjustments and corrections that may be required. Maintaining a continuous evaluation procedure to update the processing parameters as new TRR codes are added to the file by CMS is a key element of this best practice.

**Automate the evaluation of the TRR file and updates to the internal membership system.** The high volume of TRR codes in each report and the dynamic quality of eligibility updates for Medicare beneficiaries make TRR evaluation a logical target for applying automation. Many TRR transactions and updates to the health plan's internal systems can be processed automatically to reduce administrative costs and increase process accuracy and consistency.

**Use workflow management tools for updates that require manual intervention.** For processes that cannot be automated, greater efficiency can be achieved with automated workflow or work routing software, often an existing feature in core administrative systems, which directs the case to the appropriate person on queue for follow-up and resolution.





## Key CMS Sources of Eligibility Information

**The Batch Eligibility Query (BEQ)** provides beneficiary eligibility verification to support the enrollment process.

**The Full Enrollment File (FEF)** provides a monthly snapshot of beneficiaries' eligibility and premium information from the CMS database.

**The Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) data file** provides beneficiaries' LIS statuses and premium amounts and their LEP amounts (applies to Medicare Part D only).

**The Monthly Premium Withhold Report (MPWR)** provides information about premiums withheld from SSA checks for beneficiaries who elect to have premiums withheld.

**The Monthly Membership Report (MMR)** provides beneficiary information used to calculate risk scores and financial transactions.

**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.

## Reconciliation: Closing the Eligibility Information Loop

Even if the health plan updates its systems based on the TRR file, it needs to also draw on information contained in other CMS reports to capture the most complete and accurate beneficiary eligibility information. Reconciling CMS data with the health plan's internal record each month ensures that correct information is used for eligibility determinations and invoicing, and validates the accuracy of payment amounts from CMS and beneficiaries. Reconciliation is a labor intensive and complex process that should be automated as much as possible to reduce administrative costs and increase accuracy and consistency.

**Conduct reconciliation monthly.** Medicare eligibility and payment reconciliation should be conducted monthly to align with CMS' monthly payment cycle. The reconciliation process is resource intensive and lengthy, and the data on which the process draws is only made available monthly – making more frequent reconciliation processes impossible.

**Reference the CMS report that provides the most accurate version of the data in question.** No single file from CMS reliably captures all the data required for reconciliation. To validate the data contained in its internal membership records, a health plan should first apply information on the Monthly Membership Report (MMR), which is most relevant because it contains pertinent payment information from CMS, including the beneficiary risk adjustment score for Medicare Advantage beneficiaries. To reconcile the premium withhold amount, which is not contained on the MMR, the health plan should reference the Monthly Premium Withhold Report (MPWR), and to reconcile other data elements not contained in the MMR the health plan should look to the Part D Low Income Subsidy/Late Enrollment Penalty (LIS/LEP) data file and other CMS sources. If different CMS files contain conflicting values for the data in question, the health plan should use the report that reflects the most recent transaction date.

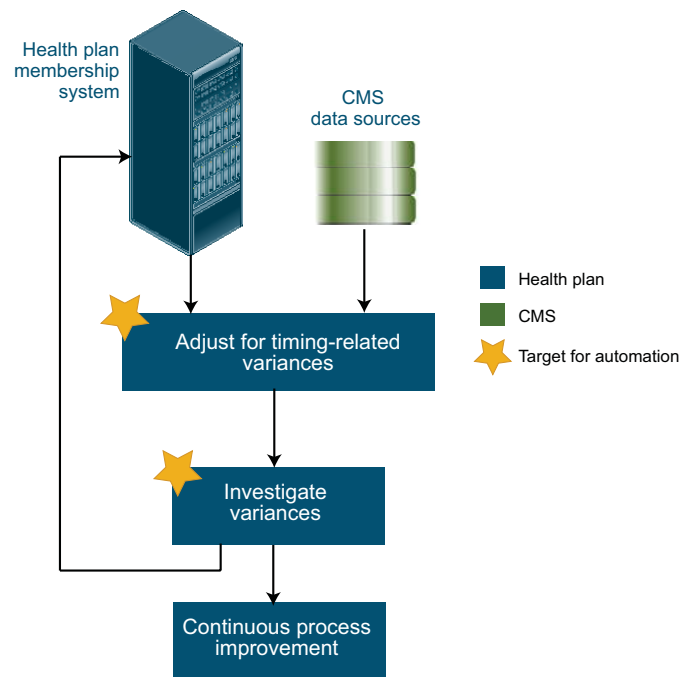
**Filter variances that do not require investigation.** To increase the efficiency of reconciliation, a health plan needs to identify and filter out variances that are related to timing discrepancies and do not require investigation. A health plan should look for variances that occur when it has received information directly from a beneficiary that makes its own record more up-to-date, or when information on multiple CMS reports conflict due to different dates on which the reports were created.

**Apply automation to update internal systems.** For variance types with a high volume of cases, the cost of developing an automated solution may be justified to reduce administrative expenses and improve accuracy. The health plan should evaluate samples from high volume variance types to determine whether the CMS data is generally accurate; if so, then the health plan should create an automated approach to override health plan data with CMS data.

**Use workflow tools to manage the correction of variances that require manual investigation.** For processes that require manual methods, greater efficiency can be achieved with automated workflow or work routing software that helps the health plan manage the process of directing work to the right place to correct the problem, and then to ensure that it is resolved. The development of standardized work processes will also contribute consistency and add to efficiency. Manual approaches will be necessary to resolve variance types with a high volume of cases in which a sample review finds that CMS data is frequently inaccurate. Manual investigation is also appropriate where the volume and frequency of the variance is too low to warrant investment in automation.

**Review and update processes to ensure continuous improvement.** Health plans should evaluate variance types that recur month after month to determine whether developing an automated solution for reconciliation may be the most cost-effective and consistent approach. Health plans should also conduct root cause analysis on variances that recur with high frequency and volume in order to uncover areas for improvement within the health plan's enrollment and eligibility update work processes and procedures. Addressing the earlier procedures will enable the health plan to attain more accurate beneficiary eligibility information as early as possible.

**Notify CMS in cases where the health plan's record is more accurate than CMS data.** While in most cases CMS' database is accurate, there are incidences where a health plan has received information directly from a beneficiary that brings its own record more up-to-date. In these cases, the health plan should notify CMS so the agency can update its system of record as early as possible to improve beneficiary service.



### Overcoming the Challenge

The cost and compliance pressures faced by Medicare Advantage and Medicare Part D plans today create more incentive than ever to lower costs, maximize revenue, improve beneficiary service and ensure regulatory compliance. Private Medicare plans can achieve these ends by optimizing the key enrollment, eligibility update and reconciliation functions to maintain accurate and consistent beneficiary eligibility information. Applying best practices to these most administratively complex process areas will help a Medicare plan be successful and thrive during this time of challenge and change.

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