The definitive guide to maximizing Medicare Advantage premium revenue:

Tips to boost revenue now
Contents

Introduction
Understand the impact of MSP on your premium revenue 3

Best practice #1
Recognize and challenge organizational barriers 8

Best practice #2
Improve process to overcome obstacles 10

Best practice #3
Empower your team with the right technology 20

Conclusion
23

About Discovery Health Partners
24

Appendix
Understanding MSP files 25
Introduction
Understand the impact of MSP on your premium revenue

Premium loss due to Medicare Secondary Payer (MSP) has more impact on the financial bottom line of a Medicare Advantage (MA) plan than many people realize. By our calculations, MA plans collectively are underpaid by more than $2 billion because of Part C eligibility issues related to MSP. Though most plans attempt to validate MSP records and correct eligibility errors, a variety of organizational and operational obstacles prevent many of them from identifying and restoring incorrect premiums. In this eBook, you’ll learn how organizational and process changes may help your plan restore millions of dollars within a few months.

Most MA plans experience some level of revenue reduction from underpaid premiums due to MSP. At the core, it’s a problem with eligibility data. Member information that changes hands between commercial payers, CMS, and Medicare Advantage plans is often inconsistent. The result is that for many members, who mistakenly are thought to have other primary commercial coverage, MA plans receive lower secondary premiums when they should be getting paid more as the primary payer.

Though most MA plans have processes to validate MSP records and correct errors, many are still missing millions of dollars. A variety of roadblocks—some subtle, some not so subtle—can stand in the way of thoroughly identifying and restoring underpaid premiums. Whether a long-standing MA plan or one that is new to the Medicare market, any plan can benefit from a review of its MSP validation process to find areas for improvement. It’s an opportunity too big to ignore. Read on to learn best practices that can help everyone—from health plan executives to business analysts—discover potential opportunities to improve premium restoration results now.
Why premiums go underpaid (and the “MSP Factor”)

Underpaid premiums cost MA plans more than most realize. When the MA plan is secondary for a member, it receives a premium from CMS that is 82% lower for that member than if it were the primary payer. This is known as the MSP Factor. According to our experience at Discovery Health Partners, an average of 4% of MA membership has open records that may have premium restoration opportunities. Though this may seem like a small percentage, keep in mind that each member may have more than a dozen open MSP records and you can restore premiums up to 72 months. It adds up quickly.

Why does this happen? To help determine payer primacy, CMS gathers other insurance information from a variety of sources, primarily member enrollment and commercial health plan Section 111 reporting. If these or other sources of eligibility information indicate commercial health coverage for a member, then CMS assumes that information is correct and that the MA coverage is secondary. It reduces the premium to secondary.

It’s important to note that while CMS does some quality checks on the data to validate that the right fields are filled in or that the layout is correct, it does not validate accuracy of the other health insurance information included in your Monthly Membership Detail Data File. MA plans must validate other insurance for members with open MSP records to ensure it is correct and does not negatively affect the plan’s premiums.
Cycle of revenue reduction resulting from the reporting of other coverage to CMS

Eligibility inputs
CMS receives member eligibility information from a variety of sources.

Primacy determination
CMS aggregates other insurance information, which indicates payer primacy.

Premium payments
Inaccurate eligibility information leads CMS to incorrectly pay secondary premiums—premiums that are 82% lower—for some members. An average of 4% of MA membership has other insurance that is primary.
Millions of dollars restored in a short period of time

MA plans of all sizes restore millions

MA plans of all sizes benefit from a look at their MSP files. By identifying gaps and implementing process improvements, they more easily and thoroughly identify and validate records, and successfully correct eligibility with CMS. As a result, they find and restore millions of dollars in underpaid premiums.

Typically, when a MA plan does a “lookback” across its full MSP file, it can expect to see a spike in premium restorations over an initial validation period of about 4 to 6 months. Restorations will then taper off as the plan maintains a best practices MSP program.

To the right are examples of what MA plans restored within an initial validation phase. Originally, some of these plans were less than aggressive about MSP and needed to kickstart their program. Others were diligent about MSP, but still missed opportunities to restore premiums.

It’s a challenging process wrought with nuances that can elude even the strongest teams. At Discovery Health Partners, with years of experience and a large team of experts, we still find new ways to improve our processes and restore more premiums to our clients faster.

Some plans see a revenue spike even faster. By prioritizing high-value records, these plans saw significant results within 30 days with even more to follow.
**Calculate your plan’s potential to restore premiums**

Based on our work with more than 20 MA plans to validate MSP records and restore underpaid premiums, Discovery Health Partners has devised a formula to estimate how much a plan can restore on average. Try it out at the link below: Just enter the state or territory where your plan is headquartered and the number of MA members in your plan.

[Discovery Health Partners MSP Estimator](#)

![MSP estimator to help MA plans estimate premium restoration potential](#)

Results may vary slightly based on plan size and location. But if your plan is already seeing similar results, that’s great! If you’re not achieving these results, it’s probably because of hidden challenges inherent in the MSP process, which can stand in the way of maximizing revenue from MSP. Read on to learn how to further assess your plan’s performance.
Best practice #1
Recognize and challenge organizational barriers

Align eligibility across commercial and Medicare Advantage business units

This guidance is for health plans that operate commercial and Medicare Advantage business lines. One of the quickest ways to improve accuracy of Medicare premiums for these health plans is to communicate across business lines to ensure commercial enrollment doesn’t overlap with Medicare enrollment.

Very often, in their reporting to CMS, commercial health plans report coverage for members who have transitioned to the same plan’s Medicare business. As a result, the MA business receives lower premiums for those members, at the same time it pays claims as the primary payer. It’s a double financial hit for MA plans, so make sure the commercial side of your plan communicates termination dates to CMS. Frequently, this problem alone is responsible for millions of dollars in underpaid premiums.
Improve coordination across MA organization

While MSP validation is typically “owned” by a group within Claims, Enrollment or Finance, it’s important to recognize that many areas of the MA organization touch MSP and vice versa. Eligibility information comes from CMS in the form of the MSP files, but it also exists and can be updated within Enrollment, Claims, Customer Care, and other areas of the health plan. And because MSP involves financial reimbursement, the Finance department has a role, too.

When these groups operate too independently of one another, eligibility problems persist and the plan continues to be vulnerable to reduced premiums. As eligibility information is collected, updated, and validated in various areas of the organization, how is that information communicated to other groups that use it? Do they know or trust the information that is coming from other areas of the company?

For example, if the group in charge of MSP doesn’t know or trust how Enrollment determines member eligibility, it may duplicate efforts to verify eligibility on its own. Likewise, if the MSP group validates other health insurance for a member, how does that information reach other areas that need it, such as COB?

As a best practice, MA plans should empower one group (preferably a cost containment or payment integrity group) with oversight of the MSP validation and premium restoration process overall—with cross-functional responsibilities in Enrollment, Coordination of Benefits, and Finance. All of these areas should understand how they impact the MSP process, and likewise how information gathered during the MSP validation process can benefit their areas.

To the right is a diagram that provides an example of the steps involved in MSP validation and premium restoration process, including dependencies and interactions with other departments and processes. In upcoming best practices, we’ll talk about the importance of updating eligibility information to protect future premiums and improve accuracy of claims payments.
Best practice #2
Improve process to overcome obstacles

In addition to organizational challenges, many process challenges stand in the way of identifying all instances of incorrect eligibility and fully restoring premiums.

Here, you’ll see the high-level process we follow at Discovery Health Partners to validate open MSP records, correct inaccurate records, and restore premiums. At this level, it looks fairly simple and maybe even very similar to the process your plan follows. But challenges throughout this process can obstruct even the most diligent efforts and skilled teams. If you’ve been frustrated by dead ends in the validation process, CMS denials, or inaccurate eligibility data, you may find some useful tips embedded within this process.

The approaches you’ll read about have helped our team at Discovery Health Partners restore $120 million in underpaid premiums for more than 20 MA plans. They can work for your plan, too.
Identify and prioritize open records

Identify records to validate for other insurance

One of the first obstacles to successful MSP validation is identifying the records to be validated for other primary insurance. MA plans receive a Monthly Medicare Secondary Payer Information Data File from CMS. This file contains other insurances that CMS believes are primary to Medicare, and provides the justification for reduced premiums.

Though CMS subjects this information to quality checks, other insurance information changes frequently for Medicare beneficiaries. It’s in the plan’s best interest to double check this information. As we cited before, our experience shows that an average of 4% of MA members have open records that may inaccurately list MA as the secondary payer. This small percentage translates into many millions of dollars for health plans of all sizes. It’s worth getting this step right.

Account for all records

In order to maximize premium revenue, it’s important that MA plans have a process that examines all MSP occurrences on this monthly file. Many plans focus only on active members. This neglects MSP occurrences for terminated members, which could have significant premium potential that is being missed. Remember that CMS allows a plan to go back up to 72 months to have premiums credited, and a single member can have multiple MSP occurrences. Grouping these together for examination and creating a snapshot of coverage will provide a clear and accurate way to determine primacy. Ensure that all records are accounted for.

Prioritize records appropriately

You only have so many resources and so much time to devote to this process. To help you work smarter (not harder), we recommend that you prioritize the records with the highest potential for premium impact.
When the CMS lookback period was 36 months, it was considered best practice to prioritize the oldest records to the top to avoid missing out on months of restored premiums. Now that CMS extended this “look back period” to 72 months, the time-based prioritization, while still useful, isn’t as critical.

It is now considered best practice to prioritize work based on the potential premium value to the plan. To that end, plans should assign a dollar value to each record that needs to be validated by looking at MMR history. For some members, a plan may have lost $100K, and for others, a plan may have lost $500K. We’ve been able to improve the efficiency of our own staff so that we get more significant value quicker without adding equivalent resources.

To learn more about the CMS files that are related to MSP, and how to use them, click here.

Current challenges

- Focus only on actively enrolled members
- Examining a portion of MSP records per member
- Data matching process misses potential opportunities to restore premiums

Best practices

- Examine ALL open records for each member, including terminated members
- For ongoing maintenance, know when to re-examine records
- Prioritize records according to their potential value
Once you have identified MSP occurrences that show Medicare as the secondary payer, it’s time to validate what was reported to CMS and gather appropriate information to determine primacy.

**Direct contact with other insurer**

Many plans reach out to members to validate other coverage. We recommend reaching out to the other insurers directly. Too often, member contact results in dead ends or inaccurate or incomplete information, and may even contribute to member abrasion. By reaching out to the other insurer directly, you’re more likely to make contact and get the information you need. Be sure to maintain accurate records of the conversations. You’ll need this information in the next step, when you communicate corrections to CMS.

**Other insurer contact database**

We also recommend maintaining a contact database of other insurers. This is a simple way to improve your team’s efficiency and increase validation success. Over time, you can build a list of other insurers, including their phone numbers and the correct menu options to reach the department that handles eligibility verification. This helps your team reach the right person faster every time. In addition, if an insurer will allow multiple verifications in a single call, be sure that this is noted in the contact database and that records for validation are queued accordingly. This is a key to efficiency, eliminating hold times for your team members and multiple navigations through the other plan’s phone system.

**Validate for primacy**

Even though it’s the most effective approach, working directly with the other insurers isn’t fool proof. Avoid asking the contact whether Medicare is or is not primary for the member. Ask specific questions that help determine primacy. Some of the most important determinants of primacy are member’s
employer size and whether the member is actively working or retired.

Ultimately, we recommend that you settle for nothing less than 100% success on every validation record. It’s possible, so aim high.

**Current challenges**

- Can’t reach the right person
- Too many calls required
- Increased risk of member abrasion
- High “give up” factor

**Best practices**

- Capture and maintain contact
- Validate primacy criteria
- Group validations by insurer
- 100% validation success
Submit updates to CMS

During the validation step, you’ll identify open records that inaccurately show Medicare as the secondary payer. To restore premiums, you’ll need to update the eligibility information with CMS. CMS offers two methods to accomplish this. The first is through a batch file process, in which multiple corrections are uploaded at once. The second is through ECRS Web, in which each correction is entered individually.

In our experience, batch file submissions yield only a 60%-70% success rate. They are filled with errors that can be difficult to understand. If information on the record has changed since it was created, and you submitted a batch file, there’s a high likelihood that won’t match the information in ECRS. It can take 10 days to get a response, plus time spent on the exception process and waiting for further responses.

We recommend using ECRS Web to submit corrections. It provides a real-time, updated view into a member’s eligibility with CMS. It shows you the record you’re attempting to update and any other records on file with CMS, so you can see if there is another record that conflicts with your effort or if a change has happened since you validated the file. With ECRS Web, you spend more time up front, but a 99% or higher success rate is possible for first submittals, which means revenue gets back to the plan faster.

Success factor: diligence and follow-through are key

Perhaps the key factors of success in restoring MSP premiums are properly training and dedicating resources to execute these steps and to track progress. MSP is not a “one and done” activity.

At Discovery Health Partners, our team ruthlessly tracks ECRS responses and premium adjustments. We immediately follow up on denials and exceptions to ensure our clients receive the full premium adjustments as quickly as possible. Likewise, we recommend that you dedicate focused, skilled resources to execute this process thoroughly and consistently.
Current challenges

- Submit batch files
- Inherent issues with CMS system
- 60%-70% acceptance
- Time-consuming re-submittals

Best practices

- ECRS web has a higher success rate on first submittal
- Focused staff – master the nuances of CMS communication
- 99% success the first time
The same information you have corrected with CMS needs to be corrected within your internal eligibility system as well. Ensure you close the loop across the organization so this information is in sync. As we’ve stated before, the focus of a good MSP process should be balanced between maximizing premiums and cost avoiding when paying claims.

Often, these processes are out of sync, resulting in reductions in premium payments, but claims still being paid as primary. A balanced approach is required. Ensure you have established a solid process of requiring that the validated information is corrected both in the plan’s eligibility system as well as with CMS. These two sources should remain in sync with validated information.

Eligibility data errors are the root cause of an estimated 20%–30% of all payment integrity issues, including reduced premiums due to MSP. By sharing with the organization the information you’ve gathered about your members, you may help reduce inaccurate payments in other areas of the organization as well.

**Current challenges**

- Eligibility misaligned between health plan and CMS
- Double loss: reduces premiums, but claims are paid as primary

**Best practices**

- Correct the source information to maximize premiums and minimize claims
- Prevent costly repetitious efforts
Track, monitor and reconcile financial impact

This is a critical step that can easily be overlooked when recovery teams are stretched thin. All the effort that your MSP team put into validating and updating eligibility can be for nothing if you don’t realize the financial impact of their efforts. You must capture all the information required to track your corrections and premium adjustments through to financial reimbursement.

This is a step in which organizational boundaries may have to be crossed, so you’ll have to determine which group is responsible for various actions and build that into your process. For example, a Claims organization may receive the MSP file used to identify and validate open records, but Finance receives the MMR file, which reports premium adjustments. Even if one group receives both files, these areas of the organization will have to communicate with each other so your plan can:

- Forecast how many dollars will be added to your premium check each month as a result of MSP
- Know if you have received every month of restored premium that you were expecting, once the MMR file is received
- Maintain an audit trail to validate the outcome and the steps that you took to correct the inaccuracies

Tracking begins with the MSP file. Every record should be tracked, and a status assigned. Some of the questions you might ask yourself in this tracking are: has the record been validated? Has the record been submitted to CMS? As of what date was it accepted? Did you capture the ECRS tracking number for easy reference? Has CMS accepted the record? This date will correlate to the date your plan will see the restored premium.

Have you captured sufficient detail in case CMS audits your efforts around MSP? Who did you validate the information with? At what phone number? On what day? When did you submit the corrections to ECRS? What’s the DCN number for that submittal? Did you capture the response back from CMS?
Be sure that you make transparent tracking and monitoring a priority and you will definitely reap the benefits in terms of premium restoration. Tracking is particularly critical in large organizations, where there are multiple hand-offs throughout the process. This ensures that no opportunity is lost or falls through the cracks.

**Current challenges**

- Limited insight past CMS submittal
- Minimal audit trail
- Hand-off to other departments: Eligibility, Enrollment, IT, Finance
- Was the full expected amount received?

**Best practices**

- Track status at every step
- Forecast monthly projections
- Measure future financial impact
- Establish an audit trail to simplify CMS compliance
Best practice #3
Empower your team with the right technology

Much of the MSP validation and premium restoration process is and always will be manual and time-intensive. But the right technology and tools can help improve the efficiency of your resources, expedite the process, and enable information sharing and tracking, leading to stronger financial results.

In-house technology

Many plans use homegrown technology, including Excel or Access databases and data warehouses or data marts to manage the information associated with MSP. In these cases, the MSP team may be reliant on business analysts or IT resources to help build queries and databases that help load and analyze the records and data needed for MSP. When working with clients in this situation, we find a series of challenges, including IT resource constraints. Frequently, the business group can’t get IT support fast enough to meet their needs.

In addition, we often discover that the MSP business process owners and IT resources understand the process differently, which can impact the effectiveness of the technology solution. Bridging the gap between business and IT is a problem as old as computers. If your plan is in this situation, our recommendation is to challenge each other and not assume that you understand each other’s work. Business people don’t always know what’s happening below the technology’s surface. IT resources may not understand how the technology or information is being used by the business. You need to validate that the technology is working as it should.

Commercially available technology

Payment integrity solutions available today leverage data integration, business intelligence, and case management technologies that can quickly highlight opportunities to restore premiums, while introducing consistency and transparency to the process. Often, these solutions are affordable and minimally disruptive to implement. If your team is relying on spreadsheets
or outdated applications, chances are you’re missing opportunities to restore premiums.

The right technology can help:

- Automate the data load (integration of MSP and eligibility files), which can be one of the most challenging steps in the whole process
- Apply data matching logic when loading MSP files to help you identify updated and changed records as well as new records
- Maintain a contact database of other insurance to make validation easier and faster
- Capture and store all information related to validation to help with CMS corrections and compliance requests
- Automate tracking of ECRS responses and MMR reconciliation
- Improve communication and efficiency across whole process

The following image shows several challenges that can prevent MA plans from maximizing premium restoration. Do you recognize these obstacles in your organization?

*Today’s MSP processes can be wrought with challenges due to insufficient technology resources.*
This image shows how improved technology assets and support can enable dramatic improvements to the MSP process. These capabilities can be built internally or acquired through external vendors.

*Improved technology assets and support enable better validation, staff efficiency, and premium restoration results.*
Conclusion

Without a doubt, MA plans have significant opportunity to optimize plan revenue by applying proven best practices and diligence to the process of validating MSP records, correcting inaccurate records, and restoring underpaid premium dollars. MA plans frequently receive incorrect primacy information from CMS regarding members with other coverage, which quickly can add up to millions of dollars in underpaid premiums. By reviewing their own MSP processes and implementing the best practices outlined here, MA plans can:

• Identify a more complete range of open records that require validation
• Capture complete validation information with 100% success
• Request CMS corrections through ECRS Web with great success
• Protect future premiums and claims payments by updating eligibility information as necessary
• Create an electronic audit trail of each record to simplify compliance and revenue tracking

As we’ve said, it requires diligence and focused resources to execute this process well. If your team needs help evaluating your current process or making changes, bring in some experts. Consider best-practices training for your team or look into outsourcing the process so your team can focus on other high-priority tasks.
About Discovery Health Partners

With our MSP Validation solution, MA plans can optimize premium revenue related to MSP, while correcting eligibility issues with CMS. Proven processes, information-driven technology, and flexible case management tools enable quick and accurate validation of MSP records, correction of inaccurate records, and restoration of underpaid premium dollars.

MA plans that work with Discovery Health Partners benefit from the scale and focus that we bring. They value our keen understanding of CMS processes; team of expert resources; and tools to improve success. Additionally, they are delighted by the level of transparency that all our solutions deliver across all areas of payment integrity. We offer many of our solutions on a contingency basis, so plans assume minimal risk.

Our MSP Validation solution enables clients to:

- Restore millions in underpaid MSP premiums
- Improve efficiency of in-house recovery teams
- Simplify compliance and revenue tracking
- Improve eligibility information for ongoing payment accuracy
Appendix
Understanding MSP files

MA plans receive several files related to MSP. While these files will contain group health plan and non-group health plan records, the process we’re talking about here is related to group health plan coverage. Below is a brief guide to these files.

**Monthly Medicare Secondary Payer (MSP) Information Data File**

This is the file to use for Part C other health insurance validation. It contains other health insurances listed as primary to Medicare and should be used to identify records to be validated. Plans that are just starting to offer Medicare Advantage coverage should initially validate all other coverage listed on this file. After doing this once, you can focus on existing membership only.

File name: “Rxxxxx.MSPCOBMA.Dyymmdd.Thhmmsst”

**Coordination of Benefits (COB); Validated Other Health Insurance Data File**

This file contains other prescription drug coverage listed as primary to Medicare and is used to identify records to be validated for Part D.

File name: “Rxxxxx.MARXCOB. Dyymmdd .Thhmmsst”

**Monthly Membership Detail Data File**

This file contains payment information for a MA plan, including reductions due to MSP and any adjustments that occur for your membership. This file should be used to reconcile premium adjustments due to MSP.

File Name: “Rxxxxx.MONMEMD.Dyymm01.Thhmmsst”

**ECRS Response Files**

These are files provided by the ECRS tool indicating status and disposition of ECRS transactions.

File Name: “Results”