Internship Training

at

MaxBupa Health Insurance Co. Ltd. ,

Bangalore

1-April- 2019 to 20-May-2019

A study on

Assessment of Case Management Process

By

Dr.Nabila Khan

PG/17/034

Under the guidance of

Dr. Nitish Dogra

Post-graduate Diploma in Hospital and Health Management

2017-2019

International Institute of Health Management Research,

New Delhi

Internship Training

at

MaxBupa Health Insurance Co. Ltd. ,

Bangalore

1-April- 2019 to 20-May-2019

A study on

Assessment of Case Management Process

By

Dr.Nabila Khan

PG/17/034

Under the guidance of

Dr. Nitish Dogra

Post-graduate Diploma in Hospital and Health Management

2017-2019

International Institute of Health Management Research,

New Delhi

ABSTRACT

Background:

Health insurance companies are always subjected to challenges of increase in the medical loss ratio, resulting from rising claims costs. It is estimated that crores of rupees are lost annually due to healthcare fraud and abuse. Absence of standard treatment protocols and regulatory mechanism by the insurance company, allows the provider/ hospital to add unnecessary cost to claims, in order to get monetary benefit out of it that is completely unjustifiable.

Common healthcare abuse practices that lead to increased claim expenditure include inappropriate billing for the medicines and services that are not provided, substantial tariff variations between actual bill & tariff (up-coding), addition of unwarranted procedures, consultations, expensive medications, excessive diagnostic tests, extended length of stay etc.

Clinical Quality & Governance (CQG) team of Health Risk Management (HRM) Department of MaxBupa has been working on few processes in order to control fraud and minimize abuse by the provider, and thereby reducing the medical loss ratio. One of such process is Case Management, through which MaxBupa is able to investigate such fraud and abuse, before it costs millions to them. The team mainly focuses on triggers. i.e. live preauthorization requests, that helps in early detection of suspicious cases. These triggers are either managed through online system or on field by personally visiting the hospital, from where the request has been generated. The ultimate purpose of case management is to achieve cost effective quality care.

The present study was conducted to understand the importance and process of case management and to analyze its effectiveness in cost containment.

Aim and objective:

The aim of this study is to understand and analyse the effectiveness of case management by measuring outcomes in terms of cost.

Study area:

A cross-sectional study was carried out for a period of 1 month from 15-April 2019 to 20-May-2019 in Maxbupa Health Insurance Corporation, Bangalore.

Methodology:

This study was a time and motion study; the total sample size of 50 patients was collected. Convenient sampling technique was used and planned to involve all the patients whose triggers were generated. Total number of eligible patients were 50. Data was recorded in a tracker sheet, formulated and entered in an excel spreadsheet and then analysed to measure the outcomes.

Results:

The estimated amount shared by the providers was Rs. 4,448,160, and after case management estimated amount was reduced and final bill paid by insurance company was Rs. 3,518,118 and henceforth the actual savings achieved by the company through the process of case management was Rs. 930,042. In 71% of cases the estimated LOS shared by the hospital was more than actual requirement of the patient

Conclusion:

Case Management plays a vital role in saving cost without compromising on quality of care. Effec--tive case management not only saved cost, but also significantly reduced hospital days.

Keywords:

Case Management, Health Insurance, Cost containment, Clinical quality & governance, Quality care.

ACKNOWLEDGEMENT

I take this opportunity to express my gratitude to everyone who supported me throughout the course of my PGDHM summer internship project. I am thankful for their aspiring guidance, invaluably constructive criticism and friendly advice during the project work. I am sincerely grateful to them for sharing their truthful and illuminating views on a number of issues related to the project.

I am highly obliged to Dr. Akanksha Saxena, Senior Manager, Clinical Quality and Governance, for allowing me to pursue my Summer Training from MaxBupa Health Insurance Co. Ltd., Bangalore. I would sincerely like to thank her for her immense guidance and constant training in providing necessary information regarding the project despite her preoccupation and busy schedule.

I would also like to express my gratitude towards Dr. Chetan S Koilkar, Senior Manager, Mumbai for being helpful and guiding me throughout my training.

I feel privileged to express my heartfelt gratitude and deep appreciation to my esteemed Professor and Mentor Dr. Nitish Dogra without whom this project would have been a distant reality. His tire-less pursuit for perfection and professional approach were constant inspiration for me.

TABLE OF CONTENTS

LIST OF FIGURES

LIST OF ABBREVIATIONS

CQG	Clinical Quality and Governance
HRM	Health Risk Management
TPA	Third Party administrator
LOS	Length of Stay
WIP	Work in Progress
CM	Case Management
OT	Operation Theatre

PART 1: ORGANIZATION PROFILE

INTRODUCTION: MAXBUPA HEALTH INSURANCE CO. LTD.

Max Bupa is a specialist health insurer established in 2010, as a joint venture between Bupa and Max India Limited, a multi-business corporate with expertise in life insurance and healthcare.

As one of the fastest growing private health insurers in India, Max Bupa's core competency lies in its focus in assessing the evolving needs of our customers and fulfilling them through innovative, comprehensive and flexible products and services. Max Bupa offers a comprehensive suite of health insurance products and services to individuals and families through multiple distribution channels, including our agents, telesales, bancassurance partnerships with leading Indian and international banks and online sales channel.

Today, Max Bupa has 27 offices across 16 cities - Delhi, Mumbai, Hyderabad, Chennai, Bangalore, Pune, Ludhiana, Chandigarh, Jaipur, Thane, Surat, Kochi, Kolkata, Patna, Goa and Jodhpur.

Max group has unparalleled expertise in insurance and healthcare. This is exemplified by its strong presence in Life Insurance (Max Life Insurance), Healthcare (Max Hospitals) and Clinical Research (Max Neeman Clinical Research).

Bupa was created on 3 April 1947 with the founding purpose – 'to prevent, relieve and cure sickness and ill-health of every kind' – enshrined in our original constitution, combining a caring ethos with freedom of choice. Originally called the British United Provident Association, Bupa was never actually a provident association itself. Four large associations (the Central Provident Association, the British Provident Association, the Oxford and District Provident Association and the Birmingham Extended Benefit Scheme) and other smaller associations and hospital contributory schemes came together to create Bupa a private company limited by guarantee without shareholders.

By July 1948 we had 38,000 customers and an 80% share of the private health insurance market. Today Bupa serve more than 27 million people across the globe. The historical roots of our business in Australia are also deep – the firm that was to join Bupa in 2002 was originally founded in the 1930s to help people cover the cost of their hospital treatment. Sanitas, our business in Spain was founded in 1956 and joined Bupa in 1989. We have been in Hong Kong for forty years, it being one of the first places outside the UK that Bupa expanded to. Over the past 70 years, Bupa is driven by its passion to provide high quality, affordable healthcare and by its purpose: helping people live longer, healthier, happier lives. Bupa brings to the table, a wealth of experience in serving customers directly in health insurance across the world. In addition to quality health insurance, Bupa runs care homes for elderly people and the young disabled; health assessments & health coaching as well as workplace health programmes for customers.

Bupa strategic framework has three pillars: Customers, People and Performance. In order to deliver these three pillars, Bupa has various priorities:

- Putting our customers front and centre: delivering truly outstanding, personalised customer experiences, ensuring high quality clinical outcomes and value for money.
- Engaging and empowering our people to deliver: our people operate in an environment that enables and inspires them to make a real difference for customers, and are themselves healthier and happier.
- Digital transformation and continuous improvement: making things easier, faster, more personalised and responsive for our customers, employees, providers and partners.
- Maximising value through healthcare co-ordination: a trusted co-ordinator and guide to healthcare services, delivering efficient, seamless experiences with positive health outcomes.
- Expanding into related business lines: targeted expansion in services such as dental and digital which our customers want, and which enhance our brand and deepen our connection with customers.

Bupa's operating approach is to:

- Invest in strength and depth prioritising existing businesses and geographies, with selective expansion into new markets and related business lines.

- Win locally, enabled globally, meeting the individual and local needs of our customers, while leveraging broader capabilities to support these.
- Be ever-focused on quality, efficiency, safety and compliance recognising that we need to uphold the highest standards and enable healthcare that is affordable for customers.
- Integrate corporate responsibility and sustainability, holistic agenda across customers, people, business ethics, community and environmental considerations.

An experienced and talented team of leaders drive the strategic direction of the company. The management team at Max Bupa is focused –on providing our customers with products and services that meet their needs and creating an exemplary work environment for our employees.

MaxBupa offers three types of health insurance plans. First is hospitalisation plans, criticare plans, and accident care plans. Hospitalisation plans are further divided into GoActive, health companion, heartbeat, MaxBupa health recharge, and MaxBupa health pulse.

GoActive goes beyond the coverage of hospitalisation expenses as it takes care of overall health. It gives the flexibility to choose the perfect cover for customer's needs, gives the option to choose from a varied list of benefits and what's more, it rewards customer for being healthy. GoActive not only cares of health but also customer's wealth. It is a pocket-friendly health insurance plan that is designed keeping customer and customer's family (spouse and

up to 4 children) in mind. Some of the key benefits include OPD Consultations, I-Protect, Health Coach and more.

Health Companion is affordable & comprehensive, designed keeping in mind the individual and nuclear family needs. A Direct claim settlement, cashless facility, and assured plan renewal for life are some of the key benefits.

Heartbeat Family Floater Plan to protect family through comprehensive blanket coverage for the medical expenses incurred.

Max Bupa Health Recharge is a pocket-friendly health insurance plan that is designed keeping customer and customer's family in mind. Customer can also opt for Personal Accident and Critical Illness cover along with the base product. With Max Bupa Health Recharge customer have to mandatorily choose an annual aggregate claim deductible amount. Max-Bupa's liability to make payment under the policy in respect of any claim made for that policy year will only commence once the deductible has been exhausted.

Max Bupa Health Pulse plan provides coverage for hospitalization expenses, pre & post hospitalization expenses, day care treatment, organ transplant & alternative treatment like Ayurveda, Unani, Sidhha and Homeopathy. After Customer's first renewal, customer will be able to avail annual health check-up every year on cashless basis at Max Bupa's empanelled diagnostic centers. With other benefits like re-fill, no claim bonus and pharmacy and diag-

-nostic booking services, customer can also boost their coverage with optional benefits like personal accident cover, critical illness cover, hospital cash, e-consultation, enhanced re-fill and enhanced no claim bonus.

VISION AND MISSION

VISION

To become India's most admired Health Insurance Company

MISSION

To help our customers live healthier and more successful lives by providing expertise as health-care partners

VALUES

CARING

We earn trust and respect through personal care. Our customer service is responsive, humane and empathetic.

RESPECTFUL

We respect people's individuality and dignity and try to respond to their individual needs.

ETHICAL

We are committed to conduct ourselves responsibly and strive to work in the best interest of customers and society at large.

ACCOUNTABLE

We are accountable to our customer and ensure quality services, efficient processes and provide long term value.

TRUSTWORTHY

We are capable of being depended upon. We take responsibility for our conduct and obligations.

ENABLING

We empower people with our knowledge and expertise to help them choose the most appropriate solutions.

PART 2: PROJECT REPORT

ASSESSMENT OF CASE MANAGEMENT PROCESS OF MAXBUPA HEALTH INSURANCE COMPANY, BANGALORE

INTRODUCTION

Health insurance companies are always subjected to challenges of increase in the medical loss ratio, resulting from rising claim cost. It is estimated that crores of rupees are lost annually due to health-care fraud and abuse. National Health Care Anti-Fraud Association (USA) has defined healthcare fraud as "The deliberate submittal of false claims to private health insurance plans and/or tax-funded public health insurance programs." Abuse on the other hand can be defined as "Practices that are inconsistent with business ethics or medical practices and result in an unnecessary cost to claims." Absence of standard treatment protocols and regulatory mechanism by the insurance company, allows the provider/ hospital to add unnecessary cost to claims, in order to get monetary benefit out of it that is completely unjustifiable.

Common healthcare abuse practices that lead to increased claim expenditure include inappropriate billing for the medicines and services that are not provided, substantial tariff variations between actual bill & tariff (up-coding), addition of unwarranted procedures, consultations, expensive medications, excessive diagnostic tests, extended length of stay etc.

Clinical Quality & Governance (CQG) team of Health Risk Management (HRM) Department of MaxBupa has been working on few processes in order to control fraud and minimise abuse by the

provider, and thereby reducing the medical loss ratio. One of such process is Case Management, through which MaxBupa is able to investigate such fraud and abuse, before it costs millions to them. Case management for high cost illness is designed to control the health care expenditures for a small proportion of population that accounts for a large share of health expenditures. Main focus of the process is on triggers. i.e. live preauthorisation requests, that helps in early detection of suspicious cases.

Preauthorisation request is generated by the hospital at the time of admission of the patient. Preauthorisation form is shared with the company by the provider or hospital at the time of the request, which contains general information of the patient, clinical condition with which the patient is suffering, treatment required by the patient, expected length of stay, estimated amount of the treatment required and the breakup of the estimated amount. These triggers are either managed through online system or by case manager by personally visiting the hospital, from where the request has been generated. The ultimate purpose of case management is to achieve cost effective quality care.

The present study was conducted to understand the importance and process of case management and to analyse its effectiveness in cost containment.

AIM AND OBJECTIVE

The aim of this study is to understand and analyse the effectiveness of case management by measuring outcomes in terms of savings.

Specific Objectives:

- To calculate savings by comparing the requested amount with the final bill amount.
- To identify the factors that are adding unnecessary cost to claim.

METHODOLOGY:

A cross-sectional study was carried out for a period of 1 month from 15-April 2019 to 20-May-2019 in Maxbupa Health Insurance Corporation, Bangalore. This study was a time and motion study; the total sample size of 50 patients was collected.

Convenient sampling technique was used and planned to involve all the patients whose triggers were generated. Total number of eligible patients were 50.

Data was recorded in a tracker sheet, formulated and entered in an excel spreadsheet and then analysed to measure the outcomes.

Study Criteria:

Inclusion Criteria:

Study population included all the patients with cashless scheme.

Exclusion Criteria:

Patients whose preauthorisation requests were rejected or cancelled.

Data Collection, Tools and Techniques:

Source of data collection was primary and data was extracted from-

1. One to one discussion with the TPA person and doctor
2. Case sheet of the patient

Tools and Techniques

Collected data was entered in excel spreadsheet under the following headings:

1. Preauthorisation Number - This is the unique identification number allotted to patient at the time of admission request.
2. Patient Name
3. Age and Sex
4. Estimated Amount - This is the requested amount shared by the Hospital with the insurance company for the treatment of the patient.
5. Estimated Length of Stay by the Hospital
6. Final Bill
7. Final LOS
8. CM Status - It is divided into 2 categories- WIP (Work in Progress) and Closed.
9. Work in Progress means patient is still admitted and requires rigorous follow up and in Closed Status means patient is discharged from the hospital
10. CM Outcome- It is divided into three categories-
    - Deduct and pay/Successful - This means that case management was successful and saving was achieved

- Failed - This means that case management process failed to save any cost
- Screened and abandoned

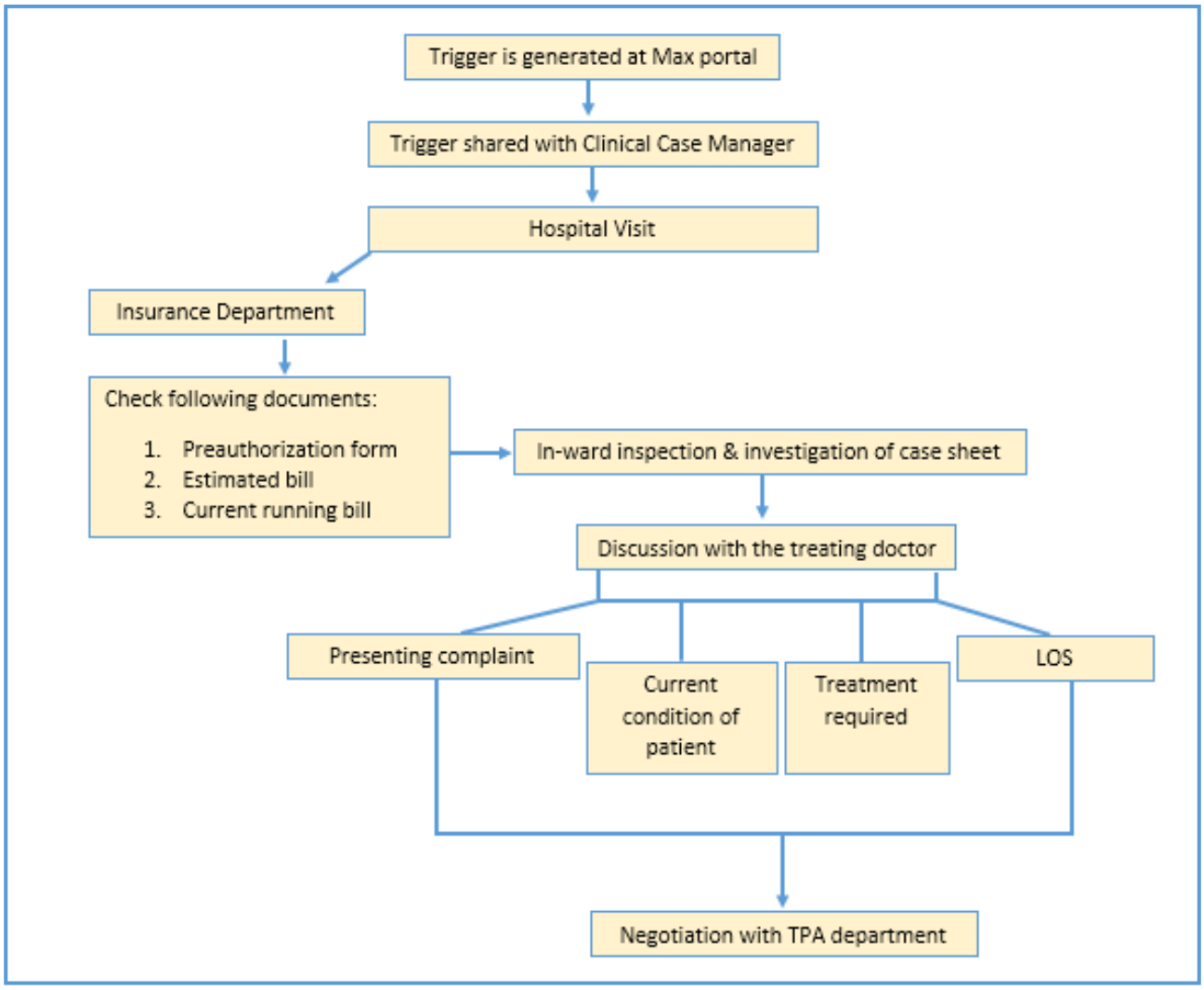
11.Pointer of Negotiation- It includes two factors, that help us achieve savings-

- Excess LOS
- Over-billing

12.Savings

13.Short Summary

PROCESS FLOW



RESULT AND DISCUSSIONS

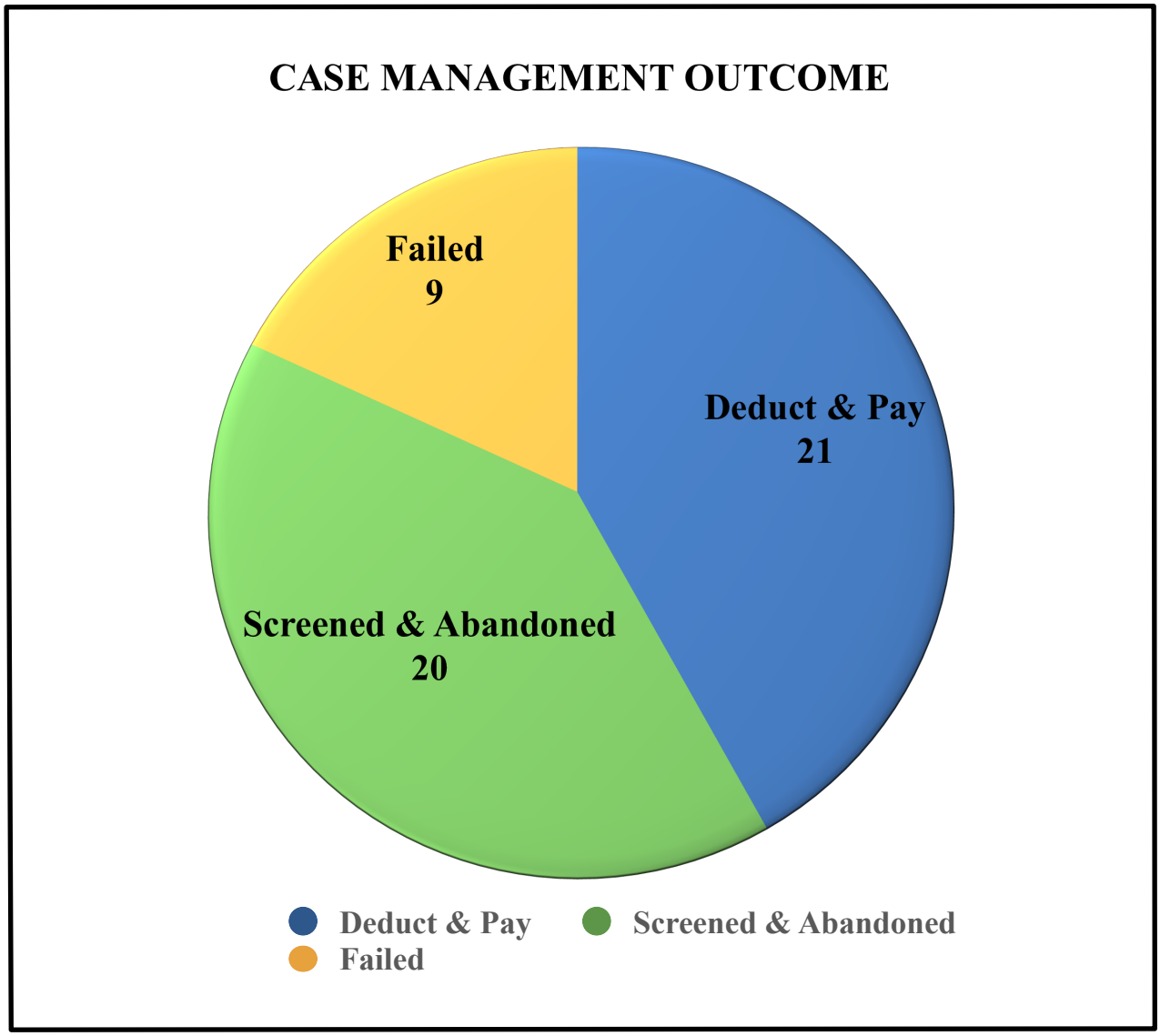


Fig.1. Pie chart depicts Case Management Outcome. Savings were achieved only in 42% of cases, as case management was successful, where as in 18% cases case management failed to contain cost as the final bill crossed the estimated amount requested by the hospital and this happened in cases

where there was lack of rigorous follow up, discrepancy in taking approval for certain specific implants at the time of surgery and in cases wherein final bill shared by hospital was medically appropriate. Rest 40% cases were screened and abandoned, as there was no scope of savings, it included patients with package pricing, patients who were in OT, patients who were on discharge, and patients whose estimated amount given by the hospital was medically justifiable.

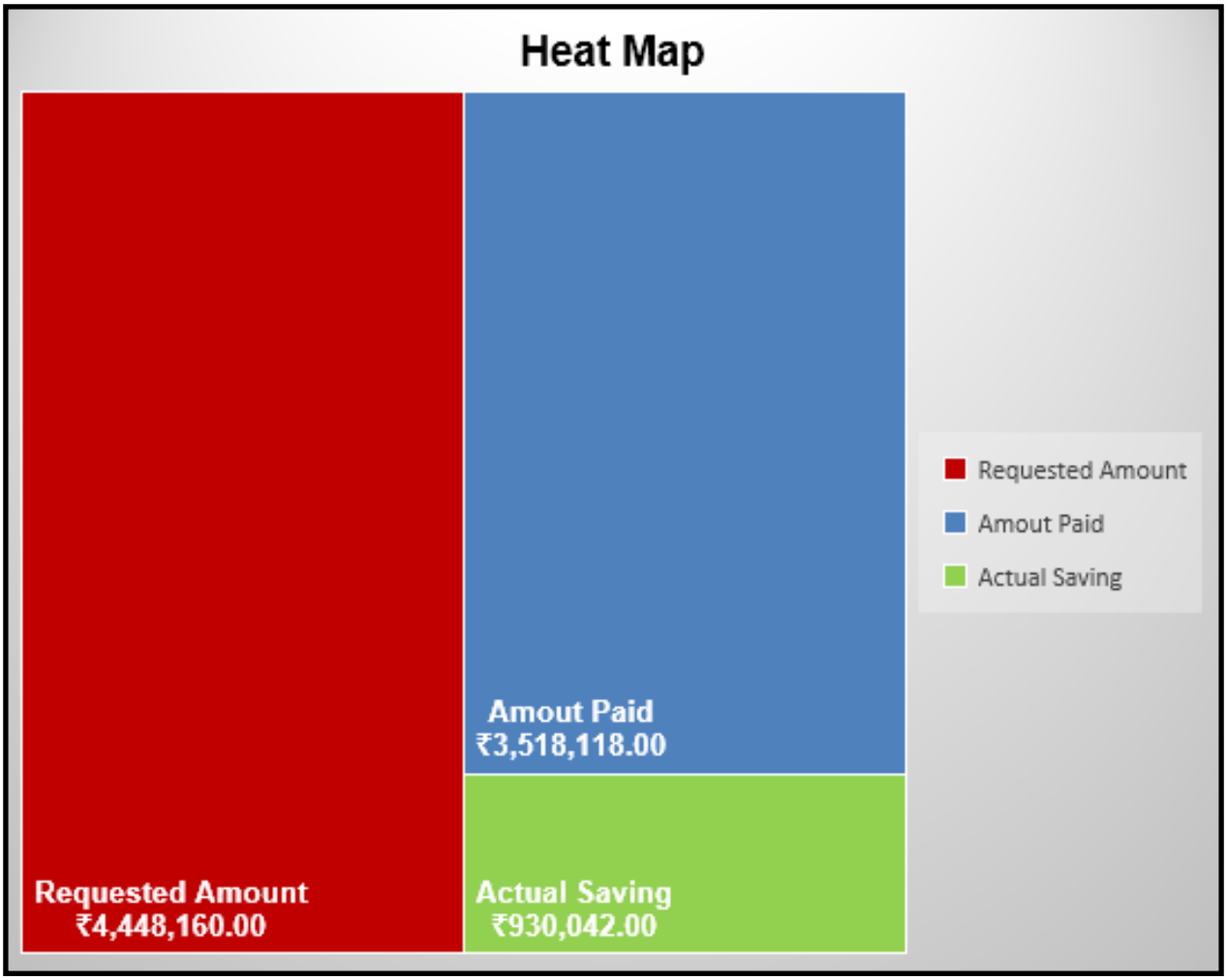


Fig.2. This heat map is a two-dimensional representation of data in which values are represented by colours. It provides immediate visual summary of requested amount by hospital, amount paid by insurance company i.e. the final bill and actual savings achieved through case management process.

The one with the highest value is giving a hot color, where as the one with lower value is relatively giving a cold color and hence forth it is easy to visualise the change and analyze the data quickly. The estimated amount shared by the providers was Rs. 4,448,160, and after case management estimated amount was reduced and final bill paid by insurance company was Rs. 3,518,118 and hence forth the actual savings achieved by the company through the process of case management was Rs. 930,042.

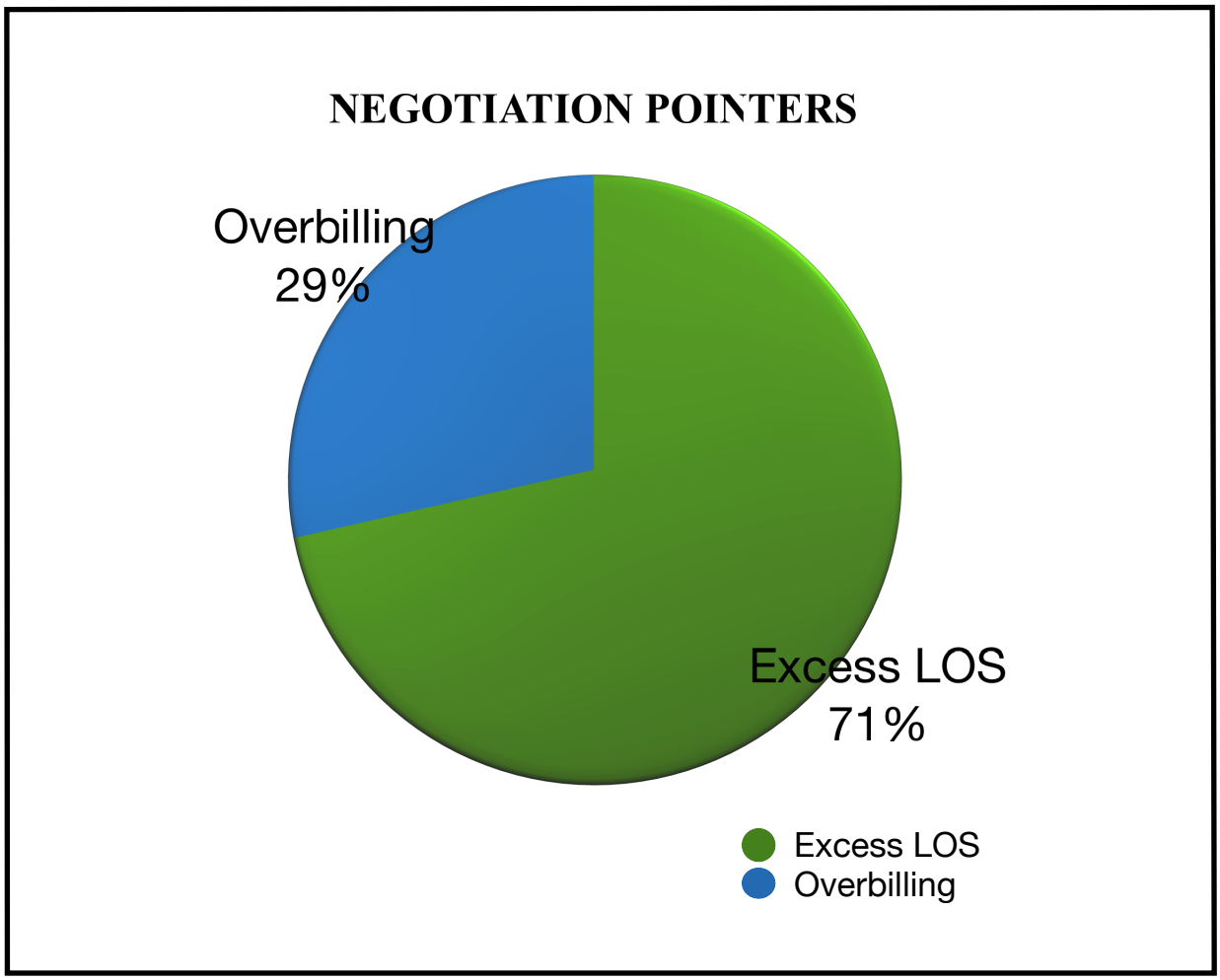


Fig.3. depicts Negotiation pointers. These are the factors that add unnecessary cost to claim. Outcome was successful in cases wherein there was over billing or the estimated LOS shared by hospital was high, since only in these two pointers hospital tries to make maximum profit.

It was observed that in 29% of the cases the estimated amount shared at the time of preauthorisation i.e. admission was very high and after inspection done by case manager the cost reduced drastically. The focus for reduction in cost is made specifically on certain bifurcations that are shared in the preauthorisation form and that are: room charges, nursing charges, consultation fees, pharmacy (medication & consumables) and investigations.

However, in 71% of cases the estimated LOS shared by the hospital was more than actual requirement of the patient. The aim in such cases is to first understand the patient's medical condition and second, to discuss the same with concerned consultant and if it is found to be stable, efforts were made to reduce unjustified length of stay.

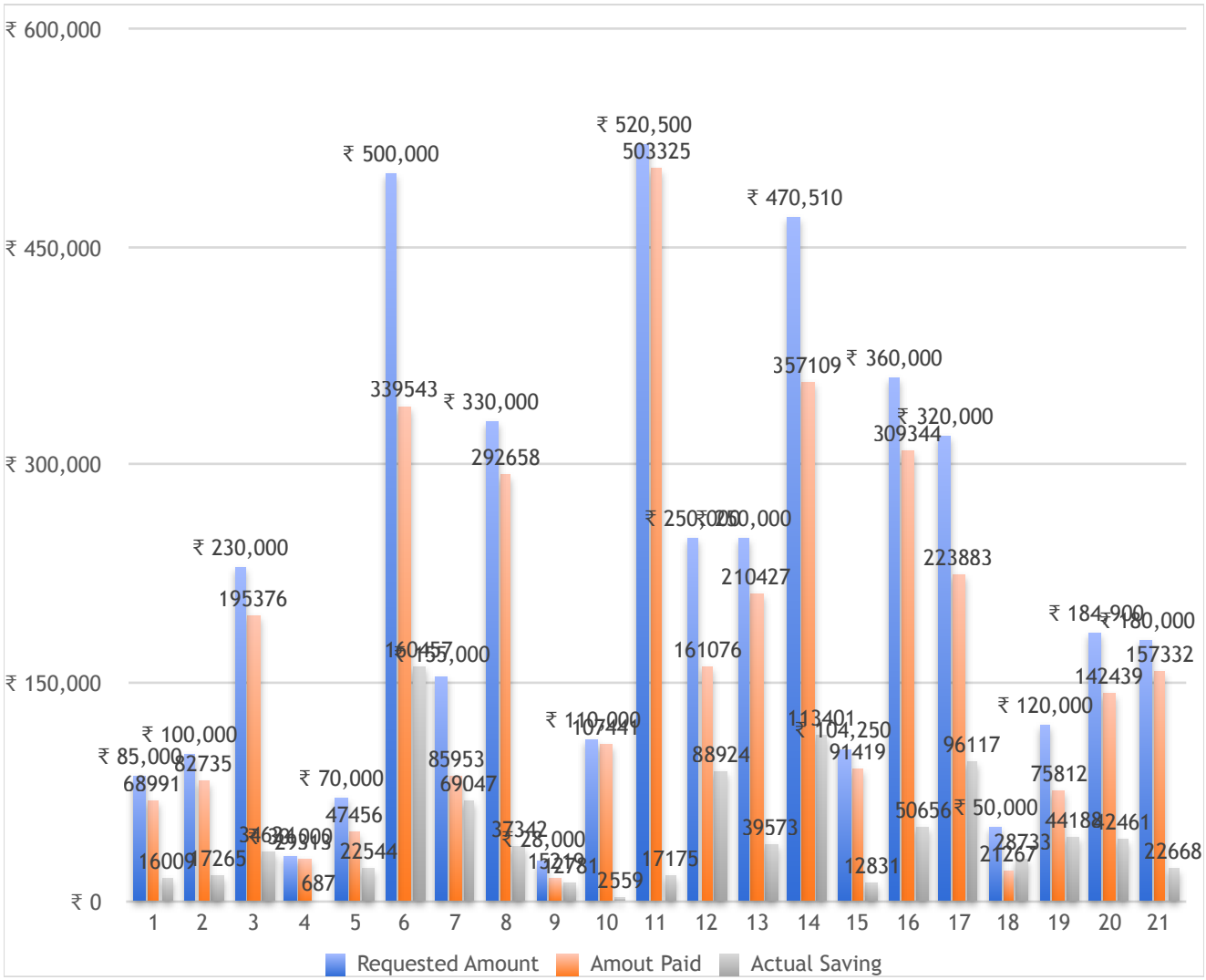


Fig.4. depicts patient wise requested amount, amount paid and actual saving. This bar chart shows the data of patients, where case management was successful, in this blue colour represents the requested amount by the hospital, orange colour represents the final bill and grey colour represents savings that we achieved after comparing requested amount with the amount paid i.e. final bill.

CONCLUSION

It is clearly evident that Case Management plays a vital role in saving cost without compromising on quality of care. Effective case management not only saved cost, but also significantly reduced hospital days i.e. Length of Stay (LOS). Such kind of initiative should be adopted by other health insurance company, in order to control fraud, minimise abuse by the provider, reduce claim expenditure and ultimately save cost.