2013 Program Report Card: Office of the Healthcare Advocate

Quality of Life Result: The third party liability recovery process in the Medicaid program will be more transparent and accountable to Connecticut residents.

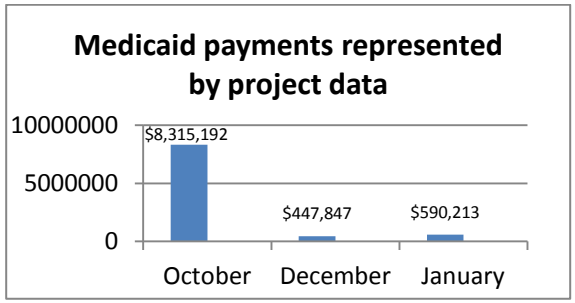
Contribution to the Result: In 2012 the Office of the Healthcare Advocate and the Department of Social Services collaborated on a special project which has resulted in the discovery of needed improvements in the recovery efforts and data processing in the third party liability process.

Program Expenditures	State Funding	Federal Funding	Other Funding	Total Funding
Actual FY 12	$0.00	$		$0.00
Estimated FY 13	$ 447,118.00	$		$ 447,118.00

Partners: Consumers of Connecticut, DSS, health care providers, health insurance companies.

How Much Did We Do?

Potential state savings under the project

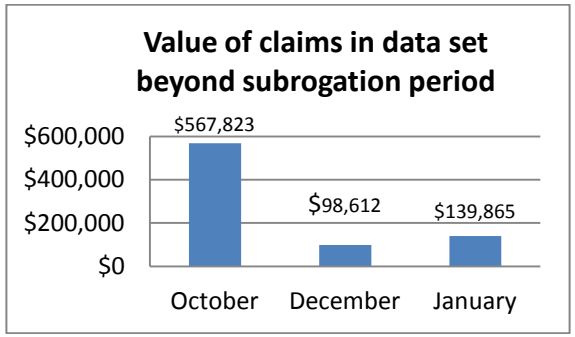


Story behind the baseline: This special project officially began in October 2012 with the goal of identifying and recovering Medicaid payments for members that were also covered by commercial carriers. In 2010, Medicaid paid approximately $78 million in claims that were denied by commercial carriers. HMS recovered $6.8 million through administrative appeals. This project created four positions, three of which were hired by or shortly after the project's start date. The fourth, the Program Manager, began on January 11, 2013. We received our first data set in October 2012, which contained 7,005 claims from 2009 to present representing $8,315,192 in Medicaid payments. The December and January data sets contained 516 claims worth $447,847, and 623 claims worth $590,213, respectively.

Trend: ◄►

How Much Did We Do?

Ability to act on provided data



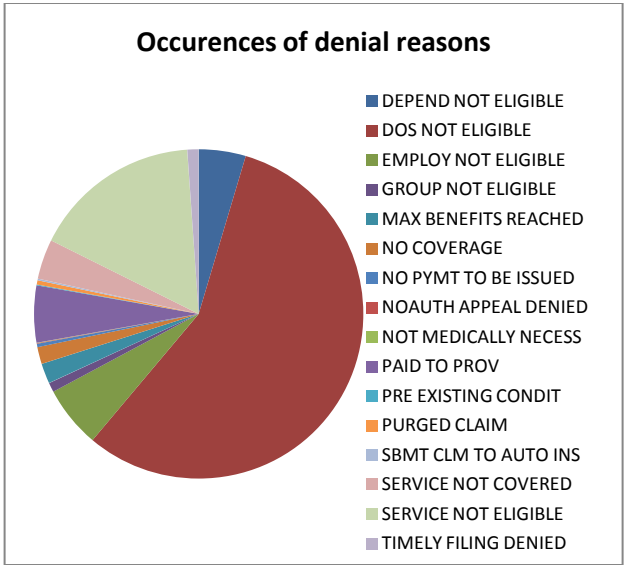
Story behind the baseline: Trend: To date, OHA has received three datasets with 8,144 claims for evaluation. Of those, 773, or 9.5%, of the claims received were beyond the 3 year date range for subrogation. This totaled $806,300, or 8.6%, of the total Medicaid payments OHA could not pursue.

Trend: ◄►

How Well Did We Do It?

Types of claim denials

Story behind the baseline: OHA received data with 17 different denial reasons from 165 different private carriers. 56.5% of the claims received were coded as Date of Service Not Eligible. This classification was found to be inaccurate in many cases. One carrier had 127 claims denied as DOS Not Eligible, but 17 of the dates of service were actually during active enrollment, with $52,644 in Medicaid payments resulting from this erroneous categorization.



Trend: ◄►

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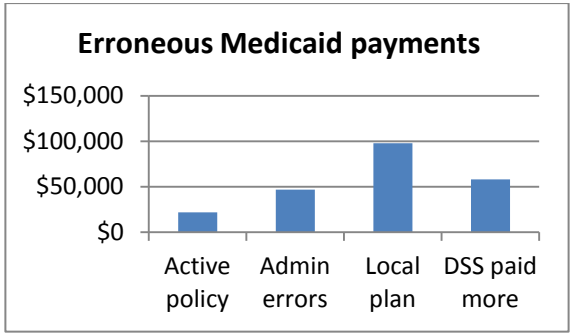
How Well Did We Do It?

Analysis of accuracy of claim data sets

Story behind the baseline: Of the 8,114 claims that OHA has received to date, it has been difficult identifying appropriate contacts for many of the commercial carriers with who to coordinate submission, review and appeal, as indicated, of the claims. Once a contact was identified, project staff was routinely informed that the denial listed in the data set provided by HMS was inconsistent with the actual basis for denial. One recurring theme was that member's eligibility had terminated prior to the claimed date of service. While in many cases this supported the "DOS not eligible" classification provided by HMS, carriers informed project staff that these claims had been submitted to them for processing at least once before, in some cases multiple times. One carrier reported receiving over three thousand claims from HMS in paper form, requiring that they utilize an outside vendor to enter the data for processing, after which it was discovered that, despite the routine dissemination of member eligibility files, over 75% of the claims had previously been addressed by the carrier. Multiple carriers have noted similar trends and are in the process of analyzing the additional administrative costs associated with this unnecessary additional work. Examples include a member with over 133 claims submitted for processing, despite having been terminated in 1999. It is not infrequent to see that a member's policy terminated years prior to the claim date of service; in some cases, the policies had terminated over a decade ago, and yet were submitted in spite of the availability of current eligibility data. Other issues identified with the data or claim management include: denied as "DOS not eligible" despite member having active commercial coverage, failure to correct administrative deficiencies (missing codes, records, FTIN, etc), claims not submitted to local plan for processing, Medicaid paid more than was required as secondary, commercial carrier denied coverage as substantiated fraud and yet Medicaid paid anyway.



The graph above represents analysis of less than 500 claims out of over 800, yet has identified $225,000 in probable unnecessary payments.

Examination of a portion of the total claims provided to OHA to date has identified numerous and significant errors in data aggregation and dissemination, concerns about the accuracy of, justification for and amount of payments made. OHA will continue to contact commercial carriers in order to identify further systemic flaws, as well as seek to find and pursue available appeals, once claim data is confirmed with the carrier.

Trend: ◄►

Proposed Actions to Turn the Curve

Action 1: Collaborate with DSS, HMS and commercial carriers to identify systemic flaws and inefficiency.

Action 2: Follow up with DSS concerning OHA's November memorandum detailing our findings and barriers to date. Despite raising significant concerns, we have yet to receive a response.

Action 3:

Data Development Agenda:

1. OHA will continue to collaborate with stakeholders to refine the project parameters to more accurately represent the universe of available claims and maximize efficiency.

2. Identify discrepancies in claim data and seek to cross reference across carriers.