Claims Accuracy:

Striking a balance between accurate claims decisions and administrative cost

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17th Annual Intercompany Long Term Care Insurance Conference

Session Overview

- Look at accuracy within three areas of the claim process: Claimant Eligibility, Provider Eligibility, and Payments.
- Focus on how to reach the balance of ordering the appropriate and necessary requirements/proof of loss to assure that a claim is legitimate and non-fraudulent, while rendering an accurate decision within a reasonable timeframe and at a manageable cost.
- Discuss the challenges of resource allocation and use of tools and technology to effectively manage claims, exploring some of the best sources of information available to enable accurate decisions within existing constraints [budgetary, cycle time, resource].

Claims & Underwriting

Initial & Continuation Claim Eligibility Decisions

David Dysart, Senior Associate LTC Claims, NY Life

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Introduction

- Review goals of Claim Decision Assessment process
- Consider potential information sources
- Cost / cycle time / quality impact of information sources
- Align potential information sources with claim types

Claims Decision Assessment Methodology Goals

This is the biggest single risk management decision we can make!

Major considerations:

- Quick Turnaround: Are decisions made timely?
- Degree of alignment across documents and sources: If inconsistent, can inconsistencies be resolved?
- Sustainability: Do denials hold up to appeals?
- Legality: Are claims decisions made on solid information?
- Potentially Inappropriate/Fraudulent claims: Does the review process identify possible misrepresentation (e.g., APS reveals a non-insurable DX with a date prior to policy effective date) or questionable claim activity?
- Fair claims practices: Are we requesting only what we need to make an accurate decision?

Potential Information Sources

- Benefit Eligibility Assessment (BEA)
  - Goal is a comprehensive functional and cognitive assessment
    - Combines self-reported history and nursing observation and assessment
  - Different tools and formats available
    - Document disabling diagnosis, medical history, including hospitalizations, specific events, such as falls
    - Current medications
    - Standardized screening for cognitive impairment
    - Detailed assessment /demonstration of ADL's

- Provider Statement
  - Form of tool determined by the LTC company
  - Documents:
    - Level of assistance the insured currently receives with each ADL
    - Diagnoses
    - Degree of cognitive impairment, if any

- Personal Care Questionnaire
  - Form of tool determined by the LTC company
  - A form completed by a licensed or non-licensed caregiver
  - Requests information such as:
    - SOC date
    - Care provided
    - Caregiver details (including address, credentials, training, etc.)

Potential Information Sources (continued)

- MDS (Minimum Data Set)
  - Reliable, CMS-designed assessment tool
  - Used by Nursing Homes (NH's) to bill Medicare and provide reports to the state

- APS (Attending Physician Statement)
  - Proprietary document created by the LTC company.
  - Should be specific to ask for disabling diagnosis, date of onset, medications, date of last office visit, and prognosis:
    - Expect recovery (before 90 days – probable denial under TQ trigger)
    - Expect recovery (90-180 days – consider a short approval period)
    - Expect To stabilize (consider a short approval period)
    - Expect deterioration (consider a longer approval period)

- CTI (Certification of Terminal Illness)
  - For Hospice, can accept in lieu of APS

Potential Information Sources (continued)

- Service plan
  - Many assign points to each task provided to the resident, e.g., 3 pts for 2 person assist, 1 point for bi-weekly bath
  - Points are totaled and cost to stay in the facility is based on score
  - Service Plans vary in content and format since each facility may develop their own- good in that most are signed not only be licensed staff, but also signed by the insured or a family member

- Admit Assessment
  - Includes review of ADL's and level of supervision needed, usually based on report of resident and family as a pre assessment or on day of admit
  - Not necessarily reliable if the insured requires more care than reported by insured/family on admit.

- Provider Plan of Care (or Plan of Services)
  - A formal treatment plan used by Nursing Homes, Home Care Agencies, Hospice providers, etc.
  - Identifies disabling diagnoses

Potential Information Sources (continued)

- OASIS (Outcome and Assessment Information Set)
  - CMS-designed assessment tool and service plan used by Medicare-certified agencies
  - Documents:
    - Disabling and comorbid diagnoses
    - Functional deficits
    - Skilled nursing needs
    - Cognitive impairment

- Medical Records
  - Can help provide view into premorbid clinical status
  - Can be used to clarify or resolve inconsistencies in other information sources
  - Can be ordered on a case-by-case basis

- Additional Records, if applicable (e.g., PT)
  - Do not always address ADL's , primary focus is on outcomes and goals.
  - Typically a secondary request

Cost and Cycle Time Impacts

Information Sources	Method to Obtain	Typical Range of Costs	Typical Cycle Time Impact
BEA	Vendor Order	$200 - $450 per assessment	5-15 business days
Provider Statement	Direct request to physician or provider	$0-$40 external hard cost per document retrieved (copying costs in some cases) Internal costs for labor*: (1-3 outreach attempts per document retrieved)	2-15 business days (Possible delays for faxing/emailing authorization forms)
Personal Care Questionnaire			
MDS			
APS			
CTI			
Service Plan			
Admit Assessment	Via Records Retrieval Service	External cost of $30-$90 per document retrieved Internal cost of making referral*	10-14 business days for record retrieval and authorizations
Provider Plan of Care / Services			
OASIS			
Medical Records			
Additional Records			

* Internal Costs for document retrieval do not include cost of obtaining authorizations

Assessment Matrix Example

Type of Claim	CTI	BEA	Personal Care Questionnaire	Provider Statement	APS	POC	Discharge Summary (if applicable)	MDS (NH ONLY)	Admit Assess.	OASIS (Medicare Agencies)
NH					X		X	X		
ALF		X		X	X	X			X	
HC		X		X		X			X	X
ICP-Independent Care Provider		X	X		X					
Hospice	X					X			X	
Adult Day Care		X			X				X	
NECIP		X			X					
DME ONLY		X			X					

NECIP- No Eligible Care in Place - claim opened when it is anticipated care will be in place in near future, i.e., “pre approval”
DME-Claim for Durable Equipment only - eligibility requirements are the same

Claims Decision Assessment Methodology Summary

- This is the biggest single risk management decision we can make!
- Consider potential information sources
- Cost / cycle time / quality impact of information sources
- Align potential information sources with claim types
- Matrix establishes a consistent approach by claim type
  - Ordering only what you need

Claims & Underwriting

Provider Eligibility Decisions

Angie Forsell, VP Clinical Services, LTCG

ILTCI

Introduction

- What difference does it make if not all provider eligibility criteria are considered?
- What is the administrative cost to establish provider eligibility?
- What tools do claims staff need?
- How can carriers minimize administrative cost, improve efficiencies, and still make accurate, consistent, actuarially sound decisions?

Adherence to policy language

What are the actuarial expectations related to the administration of a policy's provider eligibility language?

- Impact on benefit trigger
  - NH may include medical necessity trigger – low threshold
  - ALF may be 2 ADL/Cog – higher threshold

- Impact on benefit
  - NH may be indemnity
  - ALF may be expense incurred
  - Benefit amount may vary by benefit type
  - Policy may not cover non-Nursing Home facilities at all

- Impact on incidence rates
  - Increasingly attractive senior living communities may result in earlier claims
  - Will claimant transition services to an eligible provider so that any "savings" attributed to a provider denial would be short-lived?

Provider eligibility administrative practices

Practices must be

- Consistent
- Defensible
- Supported by policy language
- Adjustable as regulations change
- Reactive to conflicting provider landscape if benefits are sought outside the issue state

Provider eligibility administrative practices, cont'd

Where do you start?

- Determine if policy language is clear
  - Establish operating definitions of undefined terms
  - Staff left to administer policies without specific guidance will make inconsistent, often inaccurate, decisions
- Evaluate policy language compatibility with current, applicable regulation and consider needed practice changes (e.g., California licensed home care)
- Consider product design, intent, pricing assumptions
- Address conflicts with marketing material
- Guard against applying arbitrary standards

Define the undefined

How undefined terms are administered can have dramatic impacts on incidence and duration

– "Nursing Care"
  - If interpreted to mean only services that *can legally be provided only by a nurse*, **many**, but not all, **ALFs will be excluded** from coverage
  - When administered to mean services that *can only be provided legally under the formal direction of a nurse*, **more ALFs will be included**

– "24 hour-a-day nursing care"
  - If interpreted to mean a nurse must be physically on premises 24/7, **few ALFs will qualify**
  - If interpreted to mean a nurse is on call, **many**, if not most, **ALFs will qualify**

Define the undefined, cont'd

- "Provides services recognized by Medicare"
  - If interpreted to mean skilled nursing, therapy and personal care, then **custodial care agencies won't qualify**
  - If interpreted to mean that at least some, but not necessarily all, of the services provided must be recognized by Medicare, then **agencies that provide only bathing assistance will qualify**

- "Primarily engaged in providing nursing services"
  - If an ALF provides medication administration but no other nursing care, is it engaged ***primarily*** in providing nursing care?
  - Was policy intended to cover **nursing homes** only?

Define the undefined, cont'd

- "Under the supervision of a nurse or physician"
  - ***"Supervision" isn't defined, so which facilities satisfy this requirement?***
    - Facility who has a nurse under contract to be ***on call*** to be present, if needed?
    - Facility who delegates medical oversight of each resident to the ***resident's personal physician***?
    - Facility that employs *a* nurse who is ***on premises fulltime (40 hours/week)*** to supervise staff and services and is on call when not physically present?
    - Facility who ***employs nurses***, one of whom is ***on the premises around the clock?***

Define the undefined, cont'd

- "Methods and procedures for administering drugs and biologicals"
  - Facility may not be permitted by state law or may choose not to have clinical staff on site to manage all aspects of medication administration, how might they meet this requirement?
    - Facilities with arrangements with a ***contracted nurse or outside pharmacy***?
    - Facilities that secure, dispense and retain records of medication administered, but receive ***medications pre-dosed by a non-contracted pharmacy***?
    - Facilities who permit ***unaffiliated clinicians, agencies or family members*** to come into facility to ***administer medication to an individual resident***?

Define the undefined, cont'd

- "Care and services sufficient to meet the needs of residents with ADL deficits and cognitive impairment"
  - Does not state "all" ADL deficits or "all" stages of dementia, therefore which are eligible providers?
    - Facilities that ***assist with some, but not all ADLs***, e.g., incontinence care
    - Facilities that accept residents who are a ***"one person" assist, but won't accept*** residents who require ***"two person" assist*** or mechanical lift?
    - Facilities that accept persons with ***mild to moderate memory loss***, but not persons with ***end stage dementia and/or dementia-related behaviors*** such as wandering, aggression, etc.

Meeting the administrative challenges

- Address the practical difficulty of calling every provider for every claim to evaluate eligibility under policy terms
- Rely upon publicly available sources of information, e.g., Medicare.gov, online state licensing guidelines
- Identify the remaining policy criteria gaps, then establish a database or similar source to which staff can refer to make the decision as to the provider's eligibility under all policy criteria

Payments

Michael Gilbert, President, AssuriCare

Overview – Payment Considerations

How can carriers minimize administrative cost, improve efficiencies, and still make accurate, consistent decisions?

- Processing Efficiency
- Payment Accuracy
- Consistency (with policy language)
- Paying only for actually incurred claims
- Identifying FWA (Fraud, Waste & Abuse)

Overarching Assumption of Claims Payments

- Promptly pay all appropriate and valid claims

- Act as a steward for the company's loss ratio and claimant benefit pool:
  - Put appropriate controls and processes in place to pay claims per the policy language and benefits while preventing frivolous or inappropriate claims
  - Identify and reduce Fraud, Waste and Abuse where possible
  - Proactively identify opportunities to release reserves

Sample Policy Language - “Covered Expenses”

- “…must include copies of itemized bills, paid invoices and, if necessary, cancelled checks or other verifiable proof of payment for Covered Expenses (“Proofs of Loss”)…”

- “…The expenses must qualify as Covered Expenses under the Policy…”

- “…The Covered Care and related Covered Expenses must be consistent with and received pursuant to Your Plan of Care as prescribed by a Licensed Health Care Practitioner…”

Facility Claims vs. Home Care Claims

- Different policy language
- Different state licensing requirements
- Different invoicing process & frequency
- Different proofs of loss available
- Different review process
- Different methods & sources of FWA

Facility Claims

- Nursing Facility sample language:
  - …expenses You incur for care and support services, meals and room charges provided by the Nursing Facility.
  - …include expenses for: private duty Nursing Care provided by a Nurse who is not employed by the facility; and all levels of care (including skilled, intermediate and custodial care) provided by the Nursing Facility.
  - …do not include expenses for medications or any items or services provided for Your comfort or convenience, such as: transportation; televisions; telephones; beauty care; guest meals; and entertainment.
- Assisted Living Facility sample language:
  - …include expenses You incur for Assisted Living Care, support services, meals, and room charges provided by the ALF.
  - …do not include expenses for medications or any items or services provided for Your comfort or convenience, such as: transportation; televisions; telephones; beauty care; guest meals; or entertainment.

Facility Claims

- Invoicing process & frequency
  - Monthly
  - Typically single submission per claimant
  - Submitted by family or provider
  - Services typically paid ‘month in advance’ – often submitted to insurer in advance

- Typical Proof of Loss
  - Facility invoices/statements
  - Bundled packages for multiple services
  - Often no information provided on ADL services provided

- Typical review process
  - Efficient data entry of monthly service amount(s)
  - May compare against public rate schedule

Facility Claims - Typical sources of FWA

- No charge breakdown leading to payments for non-covered services
- Services paid in advance; paying for days claimant not in facility
- Paying for services in a non-qualifying room within a multi-level facility
- Claimant not disclosing other 3rd-party payment source (double-billing)
- Chasing overpayments
- Late release of reserves

Facility Claims – Tools & Best Practices

- Good:
  - Require invoice submission after services delivered
  - Request invoice which contains breakdown of bundled service fees to determine if covered
- Better:
  - Require invoice submission after services delivered
  - Require breakdown of bundled service charges
  - Require faxed monthly attestation form to accompany each facility invoice
    - Dates resident in and out of facility
    - Attestation of facility for ADL services provided
    - Attestation of other 3rd payer source
- Best:
  - Require on-line submission of facility invoice and attestation documentation
    - Control submission to ensure pre-payments cannot be invoiced
    - Validate / require charge breakdown to reduce payment for non-covered services
    - Record dates resident in/out of facility
    - Record ADL services provided
    - Disclosure of 3rd-party payer sources
    - Claims data entered directly into claim system ready for adjudication

Home Care Claims

- Sample Policy Language - General
  - …assistance You receive in Your Home with: simple health care tasks; personal hygiene; managing medications; performing Activities of Daily Living; and supervision needed when You have Severe Cognitive Impairment.
  - …tasks a Provider furnishes in Your Home: meal planning and preparation; doing laundry; light house cleaning (such as: vacuuming, mopping, dishwashing, cleaning the kitchen or bath, and changing bedding)…
  - …does not mean any type of: pet care; residential upkeep, construction, renovation or routine home preservation (such as painting); lawn or yard care; snow removal; transportation or vehicle or equipment maintenance; or similar tasks.

Home Care Claims

- Invoicing process & frequency
  - Weekly / Bi-weekly / Semi-monthly / Monthly
  - Typically multiple submissions per claimant / provider
  - Submitted by family or provider

- Typical Proof of Loss
  - Timesheets / DVNs / Care notes
  - Attested by claimant and/or caregivers
  - Proof of payment (cancelled checks)

- Typical review process
  - Data entry of service amount(s) by service day
  - May compare services / hours against approved POC
  - Incomplete/NIGO invoices increase cycle time and administrative cost

Home Care Claims - Typical sources of FWA

- Invoicing for services not actually delivered
- Maximizing daily benefit amount (billing to policy limits every day)
- BE criteria no longer exist or did not exist
- Non-covered family members providing services but billing for aide/agency not present
- Insured in hospital/facility with provider continuing to bill for homecare services
- Caregiver using the claimant's policy as a revenue source; exerting undue influence on claimant to continue services
- Caregiver only/primarily providing care to uninsured spouse
- Caregiver providing only IADL or homemaking services vs. ADL services
- Continued billing for deceased claimant

Home Care Claims – Tools & Best Practices

- Good:
  - Require detailed care notes / DVNs by day of service
  - Require negotiated proof of payment
- Better:
  - Require attestation by claimant **and** provider/caregivers regardless of AOB
    - Reduce likelihood that provider can drain benefit without claimant's authorization
    - Return control of benefit to claimant
- Best:
  - Require validated electronic submission of services with Electronic Visit Verification technology
    - Standardized claims submissions more efficient to process
    - Technology forces complete (in good order) invoice submission
    - Verify care actually delivered as reported
    - Reduce/eliminate overbilling for care not provided
    - Gain longitudinal view of claimant / provider behavior – better identify patterns of behavior indicating FWA
    - Proactive reserve release
    - Better identification of recoveries
    - Enables rules-based adjudication and straight-through processing
    - Claimant satisfaction improvement – paperless invoicing submission process

IP / Informal / PCG Claims vs. HH Agency Claims

- Conventional wisdom:
  - Many HH Agencies already use EVV technology
  - Licensed agencies have more oversight
  - Typical conclusion:
    - HH Agency claims are less risky than IP claims
    - Require less detailed review during claims process

- Demonstrated reality:
  - Agencies “know the process”
  - Agency-controlled EVV systems configured by office – not reliable for actual care validation
  - Analyzed data shows similar levels of waste and overbilling in HH Agency vs. IP/PCG claims
  - Agency AOB removes claimant control/oversight from invoice submission process
  - Multi-carrier / multi-claimant analysis shows single agency behaviors across claimants

Summary

- Goal is to promptly pay all appropriate and valid claims
- Act as a steward for the company's loss ratio and claimant benefit pool:
  - Put appropriate controls and processes in place to pay claims per the policy language and benefits while preventing frivolous or inappropriate claims
  - Identify and reduce Fraud, Waste and Abuse where possible
- Facility & Home Care claims pose unique challenges
- Good → Better → Best approach creates a progression to improve risk management while controlling administrative cost

Questions?