

**WRITTEN TESTIMONY OF
HMS
FOR THE RECORD
FOR
THE JOINT COMMITTEE ON HUMAN SERVICES
FOR
A HEARING ON HOUSE BILL HB 5284**

March 1, 2012

Health Management Systems, Inc. (HMS) submits the following comments to The Joint Committee on Human Services in support of HB 5284.

***HMS is the nation's leader in cost containment solutions for government-funded entities. Our clients include Medicaid health and human services programs in more than 40 states; the Centers for Medicare and Medicaid Services (CMS); and Veterans Administration facilities. HMS helps these healthcare payers to ensure claims are paid correctly and by the responsible party. Overall, our services make the healthcare system better by improving access, impacting outcomes, containing costs, recovering dollars, and creating efficiencies. As a result of HMS's services, our clients collectively recover over \$2 billion annually, and save billions of dollars more by avoiding erroneous payments.

Since 1991, HMS has performed cost avoidance and recovery activities on behalf of the Connecticut Department of Social Services. Under our most recent competitively procured contract, HMS identifies, recovers, and prevents overpayments made by the Medicaid program to providers and insurers. During the last state fiscal year, from these activities, HMS recovered nearly \$40 million and saved the State an additional \$151 million through avoided claims payments.

More specifically, HMS's work with DSS includes Third Party Liability services; determining when an individual has both Medicaid and private health insurance coverage. By Federal and state law, Medicaid must remain the **payer of last resort**; that is, all other available third party resources must be used before the Medicaid program pays a claim. On average, 8-10 percent of Medicaid recipients have some type of other private insurance coverage.

Given HMS's experience in Connecticut, as well as our experience with over 40 Medicaid programs nationwide, we are very well familiar with Federal and State Medicaid statute supporting Third Party Liability. On the Federal level, Congress passed the Deficit Reduction Act in 2005, requiring states to pass legislation compelling insurers to share their eligibility data and reimburse the Medicaid program for purposes of Third Party Liability. Connecticut passed their DRA compliant statute in 2009. HB 5284 would bring the State's DRA statute up-to-date with best practices learned since the original statute was put into place, resulting in increased savings and recovery opportunities for the Medicaid program.

For example, HB 5284 adds third party administrators (TPAs) to the definition of insurers. At least thirteen states specifically include TPAs in their definition of insurer within their DRA compliant statutes.

TPAs house private insurance eligibility information and therefore must be included in the definition of insurer for Medicaid Third Party Liability purposes. It's important to note that CMS guidance to states supports the inclusion of TPAs.

Yet another best practice, this bill also prohibits insurers from denying Medicaid third party liability claims due to the lack of prior authorization. Frequently, insurers will deny Medicaid claims because the recipient did not receive prior authorization before receiving care. Such denials are administrative in nature and should not be applied to Medicaid Third Party Liability claims. State Medicaid agencies have robust prior authorization requirements in place. If Medicaid deemed the service medically necessary, so too should a commercial insurer. At least seven other states prohibit prior authorization denials.

HB 5284 also adds specific data elements to be transmitted between insurers and the State. In order to ascertain whether a Medicaid recipient has other coverage, insurers must share coverage and eligibility information with the State or its vendor. The bill standardizes the necessary data elements such as member's date of birth, plan type, and the effective dates of coverage. These additional data elements improve the efficiency and accuracy of the TPL data matching process by more completely conveying the correct coverage and eligibility information.

The bill also removes the authority for insurers to perform TPL data matches themselves. Presently, state law authorizes insurers to inform DSS when a Medicaid recipient has other coverage. Not only do insurers not always know when a recipient is enrolled in Medicaid, but they do not have the tools, experience or technology to perform matches with Medicaid eligibility data to identify overlapping coverage. Additionally conflicts of interest can and do arise; for example, the insurer would not be properly incented to perform a comprehensive data match for coverage, particularly if the match would result in added financial responsibility to that insurer.

HB 5284 also requires insurers to share coverage and eligibility data no less frequently than monthly. Present law does not specify a timeframe by which insurers must adhere. Given the changing nature of insurance coverage, matches must occur at least monthly to ensure a more accurate and expedient third party identification and recovery process.

Ultimately, if the provisions contained within HB 5284 are adopted, Connecticut can conservatively realize at least \$1 million more in annual savings while ensuring a more robust, efficient Medicaid Third Party Liability program.

Thank you for the opportunity to comment. If you have any questions, please contact, Keith Reinold, Regional Vice President, at 617-38-1361 or kreinold@hms.com or Kristen Ballantine, Director State Government Relation at 202-870-3288 or kballantine@hms.com.