



LOOKING BACK, MOVING FORWARD

How HMS Recovered Millions for a Regional Blue Plan



THE PROBLEM Since the error rate in Medicare and Medicaid claim payments runs from 8% to 12%, it's easy to see how the costs of fraud, waste, and abuse can add up. That's roughly 10 cents of every health plan dollar wasted.

One regional Blue plan knew how damaging those kinds of losses could be, especially with 150,000 Medicare Advantage and 500,000 Medicaid members. Feeling the pinch of tighter reimbursement from federal and state governments, the plan wanted to enhance its own efforts through two of HMS clinical solutions: Overpayment Identification and Recovery, and Complex Clinical Reviews.



THE PROCESS First, HMS provided an in-depth analysis of the customer's claims payment policies and procedures, looking at everything from authorizations to payment methodology. HMS ran thousands of algorithms against the historical data to find and prioritize both claims payment mistakes and clinical vulnerabilities. Because of these algorithms, the Centers for Medicare and Medicaid Services recognized HMS as the most effective Recovery Audit Contractor.

Second, the customer requested a comprehensive clinical audit and recovery plan. The implementation process turned out to be much easier than the plan anticipated, since HMS handled most of the administration—building in client oversight with regular, manageable meetings.

Third, HMS followed up with Overpayment Identification and Recovery, and a Complex Clinical Review. HMS covers all aspects of clinical reviews: inpatient and outpatient claims, durable medical equipment, reimbursement methods, covered vs. non-covered services, readmissions, and level of care. The clinical review team includes more than 140 program integrity professionals on staff, supported by 300-plus independent physician reviewers. This team of experts knows how to make determinations to recover wasted dollars.



THE RESULTS HMS increased the regional Blue plan's recoveries from \$1.5 million to \$30 million — in the first year alone.

What's more, the collaborative relationship between HMS and the plan will only continue to deliver value as the industry moves error identification upstream. It's a logical shift, since prepay reviews allow payers to check claims against medical records before paying. By resolving errors early in the payment cycle, payers can eliminate the costs of pay and chase.

HMS also helped the plan improve procedures across the board, from outdated provider contracts and authorization language to the claims payment system itself. The plan claims the improvements made to the system easily matched the value of the recoveries and could save the plan substantially more in the future.

"We were proud to work with our customer to find contract glitches, procedures, and payment inefficiencies that were costing them millions," said David Deane of HMS's Commercial group. "Together, we made the state's healthcare better."

● **HMS** powers healthcare with integrity through payment integrity, eligibility, and coordination of benefits solutions. HMS's clients include health and human services programs in more than 45 states; commercial payers, including group health plans, Medicare Advantage plans, and more than 160 Medicaid managed care plans; employers; the Centers for Medicare and Medicaid Services; and Veterans Administration facilities. As a result of the company's services, clients recover billions of dollars every year and save billions more through the prevention of erroneous payments.