Minutes - APPROVED
Claims and Appeals Committee
May 10, 2021 – 3:30 p.m.
Zoom

Present: Bud Shattuck, Don Fischer, Donna Dawson, Tom Brown
Excused: Tanya DiGennaro
Staff/Guests: Judy Drake, Chair of the Board of Directors; Elin Dowd, Executive Director; Michelle Cocco, Clerk of the Board; Steve Locey, Rob Spenard, Locey & Cahill

Call to Order

Mr. Shattuck, Chair, called the meeting to order at 3:32 p.m.

Election of Vice Chair

It was MOVED by Ms. Dawson to nominate Don Fischer as Vice Chair, seconded by Tom Brown, and unanimously adopted by voice vote by members present. MOTION CARRIED.

Committee Charter

Ms. Dowd said the Committee was formed as part of the 2021 Municipal Cooperative Agreement (MCA) and Executive Bylaws. The intent was to keep more members engaged and involved in the decision-making process as well as lessen the burden on the Audit and Finance Committee. It was also felt that having a specific committee looking in more detail at the audit that is performed on third party administrators would be beneficial to the Consortium. This Committee will hear all appeals that come to the Board of Directors for action and recommend a determination. It will also monitor claims data and trends and oversee all third party administrator claims audits.

Ms. Dowd said the Committee will not talk specifically about medical claims or make decisions on individual medical claims. With regard to confidentiality, she said the Committee will see very general information and expects members will respect confidentiality as decisions are made. The Committee will see claims information but anything that has to do with specific claims information goes to an external appeals process. She reminded members of their signed Code of Ethics acknowledgement that outlines the Consortium's expectation with regard to confidentiality.

BMI Audit Report

Ms. Dowd presented the Executive Summary of the BMI Audit report for the audit of medical claims adjudicated by Excellus and noted that any recommendations for plan changes will be made by this Committee. She reviewed the audit results that were specific to the $2 million worth of claim payments and 195 claims that were sampled. Of the total findings, $31,000 went back to Excellus and they agreed immediately that $8,000 were done in error and disputed $23,000 worth of claims that were audited. She said $2 million in claims were processed without any error.

Ms. Dowd showed different details in how claims were broken down such as eligibility, cost control programs, pre-authorization, fraud and waste, whether another party was liable including Medicare, plan design, and standard industry practices. Information was presented on areas where further review is needed or where possible errors were identified.

Mr. Locey shared a spreadsheet prepared by Locey and Cahill showing each of the claim errors identified in the audit and information related to each claim. Information included what type of benefit the claims falls under, what plan was involved, the amount of the claim, whether it was agreed to by Excellus, and if there were any related claims. Mr. Locey explained the process BMI uses to audit claims and reported they identified 65 claims for additional review that could potentially be errors; of those 20 claims were able to be closed out following the receipt of information.

Mr. Locey explained the spreadsheet provides a summary of all claims identified in the audit and the outcome or current status, noting that anything found in the audit needs to be examined to find out if there was a systemic problem. Locey and Cahill reviewed claims included on the spreadsheet; the document will continue to be updated as progress is made. Locey and Cahill will also follow-up on any recoveries that were to occur and will monitor areas where potential changes to processes might need to made, noting a look will be taken at any claim that was found to be in error to see whether there is a systemic problem. He commented that Excellus is pushed to pay claims in cases where an employee or employer is billed for a claim that was the result of a misinterpretation by Excellus. Rarely would a member be asked to be responsible for payment when an error occurs in the processing of a claim.

Mr. Locey said at some point this Committee will be asked to make a recommendation and provide direction on outstanding claims; currently there are 18 items outstanding on the spreadsheet. Mr. Locey explained the types of things that won't come before this Committee includes things that the State would have to send out for an independent third-party review that will be followed by both the claimant and the insurance plan (Consortium); examples include anything denied for a medical necessity, experimental/investigational, clinical trials, services related to rare decisions, and out-of-network issues. Once a decision is made it would be binding on all parties involved. Mr. Locey said the Consortium receives very few appeals; the Committee has only met twice to review appeals since it began operations ten years ago.

Mr. Locey said they will be reviewing the list of claim errors and where further information is needed, noting these are claims that BMI and Excellus disagree on. Claims that cannot be resolved will come before the Committee for a recommendation on who to agree with or possibly an interpretation on the plan document. Of the outstanding claims there was only one large claim that is in excess of $100,000; further information needs to be gathered on this claim. Mr. Locey said the spreadsheet will continue to be refined to inform the Committee on where each claim stands in the process.

Ms. Dowd commended Mr. Locey for preparing the document in a very short timeframe. She spoke of outcomes and said the Consortium may need to articulate how a particular benefit will be paid going forward but decisions will be clearer as the process of research and investigation moves forward. The final outcome could be in the form of a resolution being presented to the Joint Committee on Plan Structure and Design and/or specific comments to Excellus directly on how to pay a claim. Ms. Drake requested the Committee receive a copy of the spreadsheet.

Ms. Dawson questioned timing of the audit. Mr. Locey clarified that this is an audit of 2018 and 2019 claims; this process should have been completed in 2020; however, part of the delay is a result of the pandemic. Also, BMI has been approached in the past about expediting the audit in a more timely manner.

Mr. Brown said as a health care provider he is aware that there are many claims that's are denied. This results in a push back and forth between the provider and the insurance company that produces a check and balance. He spoke of the Consortium's denial rate and said it is very

low compared to other averages. Mr. Locey said he will check with Excellus to get information on error rates in terms of claims that aren't paid on the first pass through the system and what buckets they fall into; however, the Consortium's plans are generous and when looking across-the-board at covered lives there are few plans that have some restriction on benefit. The majority of claims are going through plans that have no requirements for prior authorization, no managed care, review or limits on many things.

Ms. Dowd said the Consortium wants to make sure its Third-Party Administrator is adjudicating claims according to the plan. She said the other thing that is not being seen is when claims are not being paid and spoke of an accumulator issue that arose last year as a result of complaints from customers as opposed to being identified in an audit.

Appeal Process

Ms. Dowd provided the Committee with the current appeal process as posted on the Consortium's website and reviewed steps she is taking to clarify the process and terminology with Excellus and to also map out the timeframe. As Mr. Locey stated earlier in the meeting, this Committee will not hear an external appeal; however, Ms. Dowd said she would like to ensure that those who are using the process understand and know how to file an appeal if necessary.

Mr. Shattuck asked if when a retiree is denied by Medicare whether Excellus automatically denies the claim as the second payee without reviewing the claim. Mr. Locey said there are questions for Excellus relative to Medicare as there have been situations where Medicare denied a claim but Excellus paid it. Mr. Locey said he questions why Excellus is paying a claim when Medicare has ruled the claim as not being medically necessary and will be following up with Excellus to make sure these claims are being paid accurately and consistently.

Mr. Locey explained situations where in particular areas such as anesthesiology and radiology, people were going into the hospital for care and found that medical providers were being brought in to provide certain services and these providers may not have been in-network. The State passed legislation on these surprise billings that protects members in those situations from any balance billing. Mr. Locey will provide the Committee with information on this and also on whether lab billing was included in the legislation.

Next Meeting

The next meeting was scheduled for May 24th at 3:30 p.m.

Adjournment

The meeting adjourned at 4:50 p.m.