
Re-thinking TPL Casualty Recovery: The Massachusetts Experience

A White Paper

August 2010



RE-THINKING TPL CASUALTY RECOVERY: THE MASSACHUSETTS EXPERIENCE

BACKGROUND

The University of Massachusetts Medical School (UMMS), Center for Health Care Financing (the Center) provides various financial services to the Commonwealth of Massachusetts including third-party liability (TPL) recovery and cost avoidance of Medicaid spending. The Center is responsible for state Recovery, Casualty Recovery, Enhanced Coordination of Benefits (ECOB), Premium Assistance and other activities for the state's Medicaid agency.

In 2008, the Center sought to improve its TPL recovery capabilities by adopting new approaches ideas and business practices in a comprehensive effort to make its operational processes more efficient and productive. This White Paper describes the results of this effort in the area of Casualty Recovery.

CASUALTY RECOVERY THE OLD WAY

The Casualty Recovery unit’s mission is to maximize revenue for the state through TPL identification and recoupment of payments initially disbursed by the state’s Medicaid program related to injuries or other losses for which another payer is legally responsible. The main tasks of the recovery process are to:

1. Identify potential recovery sources,
2. Assert a lien if required, and
3. Settle and collect settlement monies for the Commonwealth of Massachusetts.

The Casualty Recovery unit first identifies the “Recovery Triangle”— the plaintiff’s counsel, the liable third party insurer, and the claimant. Various information systems and referral sources provide support to the identification process. In concert with the Medicaid Management Information System (MMIS), these supporting entities include data matching, trauma diagnosis code matching, Medicaid recipient declarations, cross-referencing to the state Department of Revenue’s Payment Intercept Program, and the Medicaid Lien Inquiry System.

Typically, the Casualty Recovery process took 10 to 12 days, as reflected by the following diagram below.

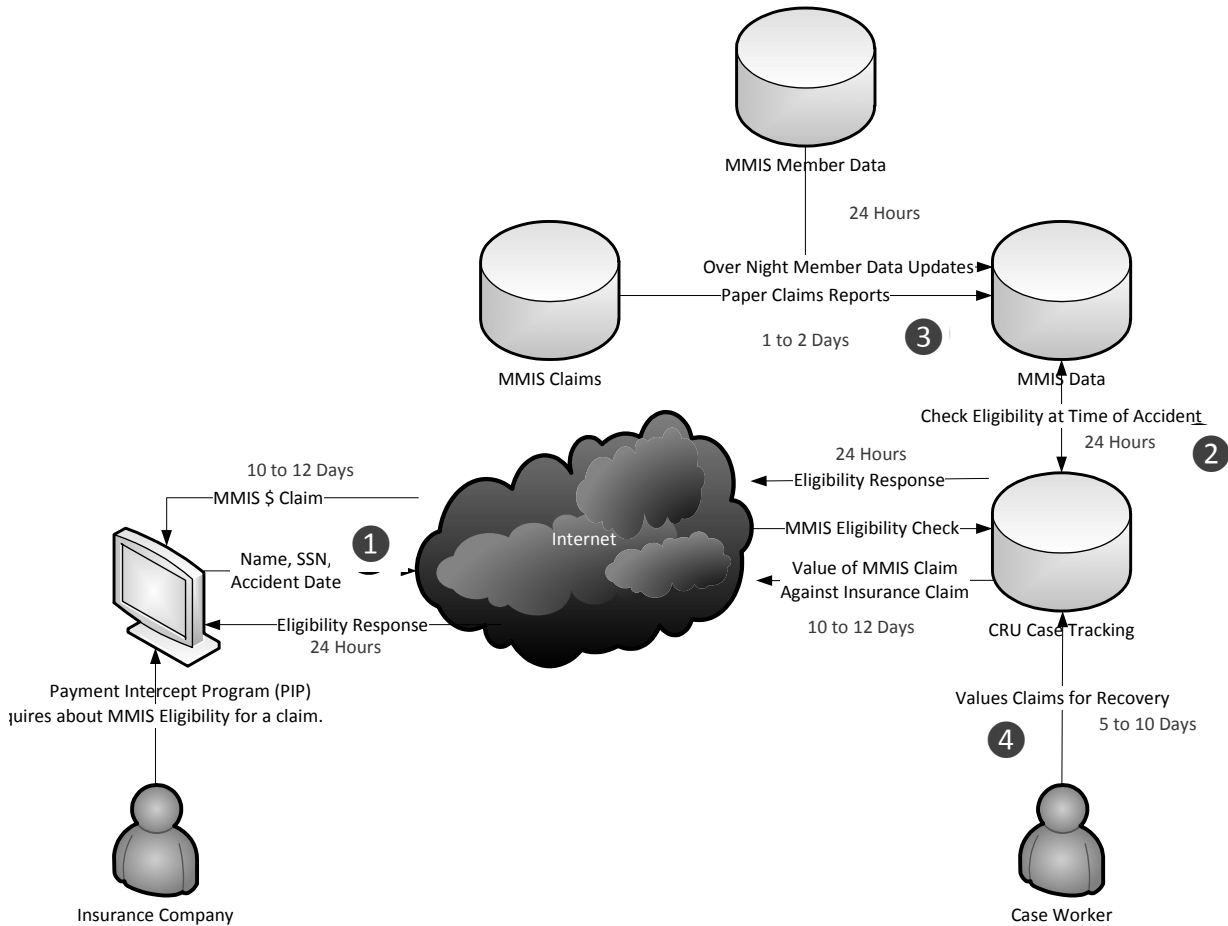


Figure 1 – Casualty Recovery the Old Way

WORKFLOW

- ① **Day 1** – Inquiry processing, from several sources;
 - Payment Intercept Program (PIP), phone or fax inquiries,
 - Medicaid Lien Inquiry System.
- ② **Day 2** – The intake worker screens the referral to determine viability for recovery, and then completes the following steps;
 - Enters all the inquiry information into the case tracking system,
 - Checks MMIS eligibility,
 - Checks for previous cases,
 - Creates a paper file.
- ③ **Day 3** – In situations where the person is an eligible Medicaid member at the time of accident, the worker requests all the claims from MMIS;
 - Log in to MMIS, place order for all active and archived MMIS claims following the accident date,
 - Send all MMIS Claims (current and archived) in paper or electronic format to case worker for evaluation.
- ④ **Days 5 to 12** – A case worker begins the valuation process. This process involved a manual set of steps to calculate the recoverable amount;
 - Days 5 – 7: Once all the claims and MMIS information are received, the worker manually compiles the information to document and calculate the dollar amount recoverable from the accident claim;
 - where additional information is required on a claim, the worker will log in to the MMIS to get further information on claim line details,
 - the final recoverable amount is approved and recorded in the system.
 - Days 8–9: send PIP information back to the inquirer
 - Day 10: complete administrative filings and supervisor signoff
 - Day 11: send a decision-ruling letter to the insurance companies and lawyers
 - Day 12: scan and load all letters and correspondence into the document management system.

There may be additional delays in the process, depending on the complexity of the case and amount of claims information received. Throughout the process, the paper file is updated with all pertinent information from the recovery calculation.

ISSUES AND PROBLEMS

Upon closer examination of the “as is” Casualty Recovery process, the Center found that there was a strong case for improvement in several areas:

Timeliness

TPL recovery must not only be accurate and fair, but timely. By law, a response back to an inquirer pertaining to a claim must be processed *in ten business days or less*, or the state loses their ability to recover claims. The time to complete a casualty recovery claim was heavily impacted by delays in receiving information from MMIS, and time delays in the completion of manual processes.

Efficiency

The processes were inefficient and resource-intensive. Typical inefficiencies included;

- Manual steps (in checking, verifying and forwarding),
- Checkpoints requiring manual intervention,
- Critical steps subject to error or delays (time waiting).

Data and Systems Redundancy

The Center had five different information systems supporting the four TPL business areas, where clearly there were process overlaps and unnecessary information replication (stovepipes) amongst them. Thus, systems integration and cost-of-ownership issues arose due to differing architectures, implementation paradigms and business practices.

Information Transparency

The mash of differing systems provided management with fewer tools for measurement than desired. Reports from the various stovepipe systems provided a fragmented view of Casualty Recovery and other TPL processes overall.

The Center recognized that sub-optimal Casualty Recovery processes and the systems used to support them were clearly intertwined. When the Center’s management looked closely at TPL recovery as a whole, they realized that all four business areas shared common needs despite business differences. These were:

- The processes to determine eligibility and information checking in the MMIS,
- The access of MMIS member and claims data,
- The processes that related to accounts receivable and payments tracking,
- The necessity for general case tracking such as document management and case notes.

Given the strong linkage between process improvement and the associated information systems used, the Center determined that a change to their TPL information systems was a necessary prerequisite to overall improvement.

The Center used five different applications to support the business processes in four business areas, as follows;

Casualty Recovery: a legacy case management system hosted and supported by an external vendor. This system was not meeting the current needs and did not provide enough flexibility for change to meet future needs of Casualty Recovery.

Estate Recovery: a five-year-old system supported by the UMass application support team. This system provided all of the functionality needed for the Estate Recovery Unit (ERU), but was purpose built and was deemed to be too costly to modify for other business areas at the Center.

Enhanced Coordination of Benefits (ECOB): an MS Access application written and supported by internal business staff.

Premium Assistance: Two databases. The main application was an old FoxPro application hosted but no longer supported by UMass. The second was an MS Access application written and supported by internal business staff.

WEIGHING THE OPTIONS

It made sense to consider an option that included integrating all of these systems into one solution. The rationale for this was that common aspects of each business did not require separate processing; there were newly-discovered processes that required automation and where ongoing support and the costs of ownership could be reduced.

Thus, the Center considered the following options;

1. Maintain the current systems (by default, redesign processes around existing systems),
2. Enhance existing systems to fit the new process set,
3. Change one existing system to support all of the business areas required,
4. Replace the current systems with one integrated solution.

All of the options had to meet specific and shared business area needs. Of equal importance was the fulfillment of key objectives around:

- Automation of the current manual processes,
- The reduction of administrative effort and increase in efficiencies,
- The overall reduction of operational costs,
- Flexibility for the future.

After careful review, it became clear that keeping the existing systems was not a real option, and would only add to the cost leakages. The second option was dismissed on the grounds of cost and obsolescence. The third and fourth options were put forward as candidate solutions, as both had feasible routes to solve the problems.

A committee was formed from each of the business areas along with the IT department. The purpose of the committee was to put forward plans for the redesign of key business processes and to start the process of evaluating a possible replacement Information system.

In early 2008, the Center decided to explore the marketplace to determine if there were existing commercial-off-the-shelf (COTS) software applications that could be used to support its objectives.

THE JOURNEY

The Center identified the following criteria that would be used to help them guide the choice of a replacement system to support its process reengineering intentions;

- Provide standard case management capabilities,
- Be easily configured to meet the unique needs of each of the Center's program areas,
- Provide integration and flexibility to meet the needs of different program areas,
- Be based on industry standard technology,
- Meet sufficient MITA levels and the appropriate HIPAA standards,
- Provide tools needed to meet current and future needs,
- Reduce operational costs for ongoing support and maintenance,
- Integrate to MMIS and other required systems,
- Support as much paperless or reduced paper options as possible.

In mid-2008, the Center selected TP Systems' SOHEMA case management software application as its preferred choice. During reviews of the proposed solution, the Center deemed that the system had sufficient scope to address its broader needs, in particular the replacement of the Estate Recovery and Premium Assistance systems in the future. SOHEMA would serve as the underlying platform for one integrated solution for all case management activities to be implemented by the Center.

The Center found that SOHEMA provided an important set of tools to support process redesign, quickly and through simple configuration. SOHEMA and the new, improved and re-designed recovery processes were implemented over several months with a transition to full production in July of 2009 for Phase 1 and July 2010 for Phase 2.

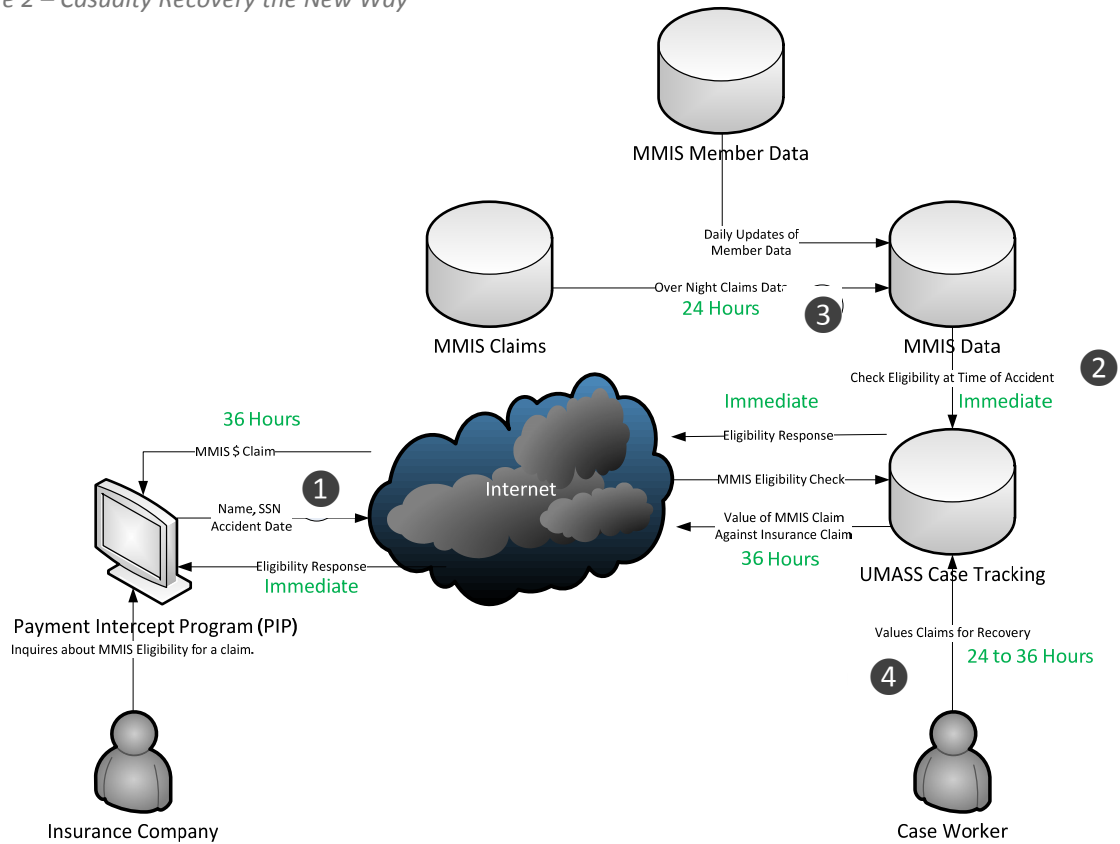
CASUALTY RECOVERY THE NEW WAY

The new system enabled the breakdown of recovery activities into logical areas, which meant that teams could focus on specialized groups of activities in their case work:

- Referral, intake and validation,
- Claims ordering,
- Recovery valuation,
- Case correspondence,
- Accounts receivable.

The following diagram and narrative shows how the new process still achieves the same basic activities as the old process, with the substantial improvements in time and effort to complete. Of note, built-in delays at several junctures were eliminated.

Figure 2 – Casualty Recovery the New Way



WORKFLOW

- 1 Day 1** - As first step, the intake worker performs inquiry processing. Then, the intake worker screens the referrals to determine whether it will be pursued for recovery and completes the following steps;

 - Enters all the inquiry information into the case tracking system,
 - The worker validates the data from PIP or that was entered during the initial referral.
- 3 Day 1** - After determining that an injured person is an eligible MMIS member at the time of accident, the worker needs to request all the claims from MMIS.

 - When a case is created in the intake process, the claims are automatically ordered
 - Archived claims still need to be manually ordered if required.
- 4 Day 2** - After the claims are received the next day, the worker will begin the valuation process:

 - Using the new claims screen, a worker simply scrolls through the claim lines and checks off the lines that will be recoverable and saves the data from the screen.
 - As the worker saves the claim lines that are recoverable the system automatically calculates the recoverable amount.
 - After marking all claim lines for recovery, the worker can signify the completion of the process by marking the case as recoverable.
 - PIP is automatically notified of the recoverable amount.

- The correspondence queue is updated and the next workers can print all letters required through the queue.
- All paper letters, records and correspondence are scanned and loaded into the document management system in SOHEMA.

THE INTRODUCTION OF WORKFLOWS AND QUEUES

Much of the streamlining and automation of business processes came about through the adoption of a new concept called “work queues”. Work queues coordinate and help workers manage the priority of work at each stage of a case. Each work queue provides a list of cases ready for work, with a visual reference for the priority of work to be completed.

This visual reference includes a traffic light and the number of days the case has been in the queue. Red and yellow indicate cases that are past their critical point and require immediate attention. As workers complete work at that stage of the workflow for the work queue, the cases are removed from the work queue and move to the next queue for the next set of tasks to be completed by the next team. The following describes the teams and related work queues:

Referral, Intake and Validation team

- Workers enter the manual referrals into the system as they are received via phone or fax inquiries.
- Workers use the **VALIDATION QUEUE** to select new referrals and complete a validation process to ensure that all contact and accident information is accurate and correct.

Ordering Team

Workers use the **ORDER QUEUE** to manage the orders for the new cases. When the case was created the active MMIS claims were automatically ordered, but where archived claims are also required the worker will initiate that order.

Valuation Team

- Workers use the **VALUATION QUEUE** to value the claims recovery for cases whose claim lines were received from the previous day. The worker will review all claims, marking the ones that will be recovered and finalize the recovery process.
- An automatic update is sent back to the Payment Intercept Program (PIP) after the claims are finalized.

Correspondence Team

Workers use the **CORRESPONDENCE QUEUE** to complete the correspondence and other finalization processes for the case. All form letters are generated and sent and all other documentation is scanned and added to the cases for reference.

Accounts Receivable Team

Workers use the **AR QUEUE** to process all payments in the system. After finalizing, the recovery steps for the case payments will be received and processed in the system. Workers are able to use the queue to help manage all outstanding accounts receivable activities for cases that have been finalized.

OUTCOMES AND EVIDENCE

The new business processes and the supporting case management system have given the Casualty Recovery unit the opportunity to rework their business processes to deliver cost savings, increased efficiency and improved stakeholder satisfaction. Among them:

- **Timeliness**
 - Reduced the overall **time** to process from 10-12 days to a **36-hour turnaround**
 - Reduced to twenty-eight hours for an electronic activation, and three days for a manual activation request
- An estimated 40% reduction in non-system **overhead costs**
 - Labor – 35% reduction
 - Materials (paper, toner, etc.)
 - Technical services
- Sundry costs and **going paperless**
 - \$15,000 savings per year
 - Eliminate file storage and archiving costs
 - Eliminate the need for 7,000 manila folders per year
 - Eliminate the need for 250,000 sheets of paper per year
 - Eliminate the need for 24 toner cartridges per year
 - Eliminate the need for 2 fax machines and 5 printers
- Reduced **information systems variable costs**
 - \$225,000 savings per year
 - One service provider
 - Lower ongoing maintenance for one system
 - More flexible product reduces the enhancement and maintenance costs
- **Electronic files**
 - Instant access to information for all workers
 - Significant paper reduction
 - No onsite or offsite file storage
 - No paper file handling
 - No lost files
 - Environmentally friendly
- **Customer satisfaction**

Customer service ratings have improved dramatically and has become commonplace for attorneys to call up and thank the staff for such a quick response.

- Increased stakeholder survey ratings to **4.8 out of 5** (previously 3.7)

BENEFITS BEYOND CASUALTY RECOVERY

The Center's re-thinking of Casualty Recovery has resulted in numerous ancillary benefits to the Center as a whole.

Utilizing one common system for multiple program areas or lines of business provides a benefit to the entire organization through centralization and re-use. This includes:

- Consistent practices across lines of business for managing common sets of data
- Centralized processing of persons, organizations, cases, financial data etc.
- Elimination of business silos with respect to information and some practices
- Centralized policy and procedure management. With common practices the policies and procedures for these common practices can be standardized across the lines as well.
- Training and knowledge management for the applications is made easier with one system. There is no longer a need to have silos of knowledge for each application in each line of business. The knowledge for the common areas of the system are now shared and can more easily be administered by line of business.
- Reuse of Interfaces to other systems and their information. One central system allows the Center to manage one set of interfaces to MMIS, the eligibility system and other systems. For the Center, this means that Casualty Recovery, Estate Recovery, ECOB and Premium Assistance can all utilize the set of MMIS interfaces for accessing MMIS member, claims and provider information. This greatly reduces the costs related to managing and administering these technical interfaces and their operations.
- A significant reduction in the operational and support costs related to managing the application for multiple lines of business. Historically, each line of business at the Center would develop and maintain its own applications. A centralized application reduces server and hardware costs, staff costs for operating the systems and other operational costs related to running and managing the application. In addition, one common system means that there is one common set of skills to maintain and manage the application.

Overall, these sets of benefits result in savings related to operating the applications, but also indirectly in running each line of business. Standardizing of business practice and reusing information and capabilities provided many intangible benefits across the organization, which could be summarized as a fresh and actionable insight that could lead to more efficiencies in the future.

SUMMARY

The success of this initiative was based on the ability to manage processes, people and technology within a dynamic business environment.

In a very short period of time, the Center has been able to realize significant improvements as a result of its efforts to re-think and re-engineer TPL recovery. Recovery is now more efficient and less costly. The Center continues to look for new ways to improve its four lines of TPL business. It presents an exciting and optimistic outlook for the Center as it seeks to be a leader in the TPL recovery domain.

In a broader context, the experiences are applicable and relevant to TPL Recovery in other states. The processes and technology can be applied to other entities, which are likely to accrue similar benefits in efficiencies and cost-savings from such an initiative and the lessons learned.

About the UMass Medical School's Center for Health Care Financing

The Center for Health Care Financing (the Center), founded in 1996, is one of many units that comprise UMass Medical School's Commonwealth Medicine division. Commonwealth Medicine provides academic, clinical and financial expertise to state agencies to improve the delivery of state and local public assistance health programs

The Center identifies and prepares claims for program services and administrative health-related expenditures made by state and local governments for which they are entitled to federal reimbursement. As an adjunct to this activity, the Center analyzes health services rate structures and makes recommendations for revisions to state rate methodologies. The Center also implements projects to reduce overall state health-care costs by identifying and coordinating with other payers, including private and other federal insurers, who are legally liable for the cost of medical services provided to an individual.

www.umassmed.edu/commed/financing

About TP Systems

Since 1977, TP Systems has earned our clients' trust by helping them improve their performance through innovative and cost-effective software, outsourcing and IT staffing solutions.

We work with a wide range of clients including government, community services agencies, healthcare providers, and professional services organizations. This industry experience, combined with our comprehensive capabilities enables TP Systems to be responsive to diverse range of client information systems needs.

TP Systems develops, supports, maintains and markets the SOHEMA case management system used by the UMMS Center for Healthcare Financing for Medicaid TPL Recovery.

www.tpsystems.com and www.sohema.com