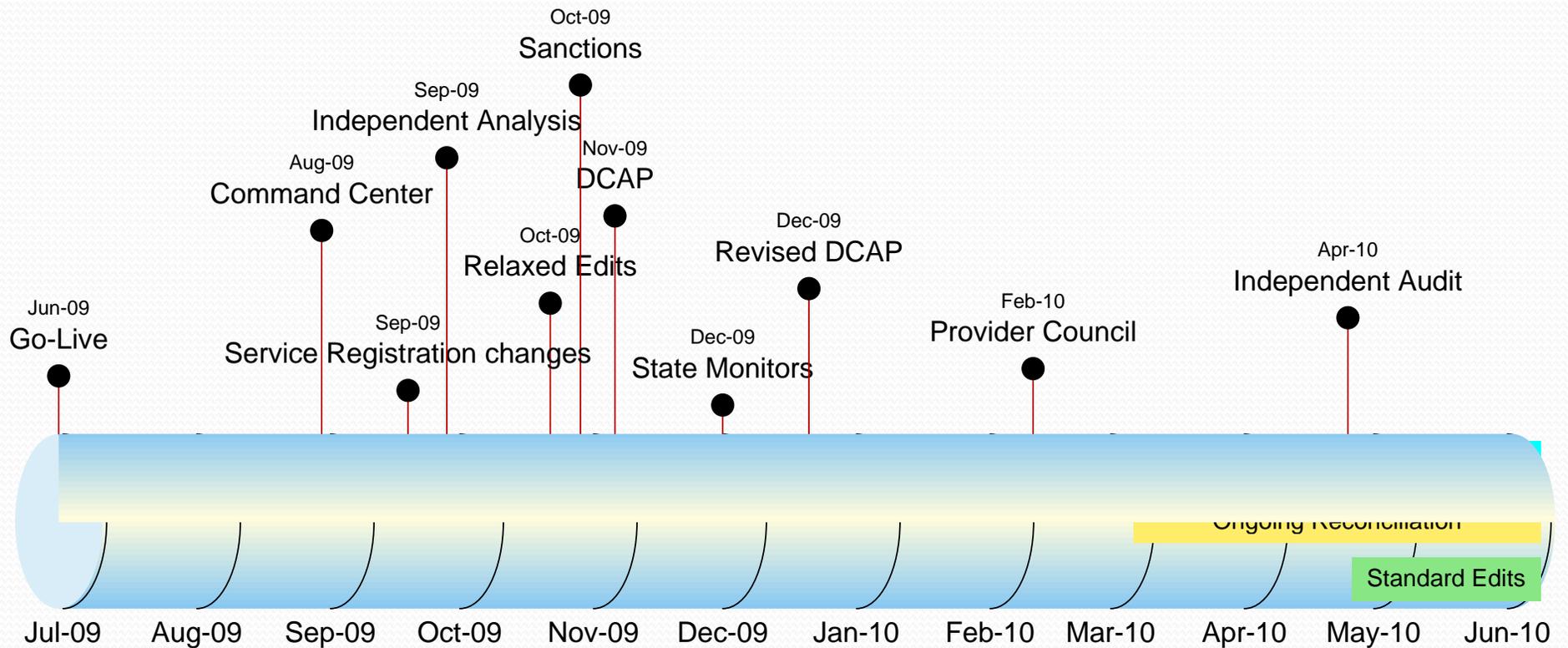


State Monitor Report on Optum New Mexico Claims Processing

July 2010

Timeline





Revised DCAP areas

- Claims processing
 - Denial rates
 - Timely processing
 - Provider claims portal
 - Reporting to Collaborative
- Claims submission
 - Clearinghouse rejections
 - Provider electronic claims formats
 - Fee schedules
 - Service Registration
 - Prior Authorizations



Revised DCAP areas

- Fund Mapping
 - Independent audit
 - Reporting to Collaborative
- Provider Relations
 - Provider Contracts
 - IHS/638 Providers
 - Provider Council
 - Regional offices
 - Call centers



Remediation

- Expedited payments to providers to alleviate financial hardship
- Relaxed edits to allow more claims to process
- Directed Corrective Action Plan and Monitoring
- Independent audit of claims processing
- Provider council formed
- Extensive and repeated provider training
- Conceptual review of Service Registration



Reconciliation

- Reprocessing of all pre-relaxed denied claims
- Reprocessing of all expedited denials
- Comprehensive claims and authorization reports available to providers
- Full claims reconciliation offered to expedited providers
- Relaxed edit impact analysis
- Fund mapping reconciliation and adjustment
- Return to Standard Edits

Reconciliation Results

Expedited Provider Reconciliation Status	# of providers
Agree with report	15
Reconsiderations complete	12
Reconsiderations outstanding	8
Response pending	12
Report sent 6/4-6/16	88
Total	135

Reconsideration Results	# of claims	% of resolved
New Claims	174	38.84%
Previously Paid Correctly	137	30.58%
Overpaid	2	0.45%
Corrected Claims from Provider	67	14.96%
Eligibility/Authorization/Service Registration	47	10.49%
Denied Correctly	3	0.67%
Adjustments - Various	18	4.02%
Total	448	100.00%
Fee Schedule Issue (One Provider)	1350	
In Analysis	1103	



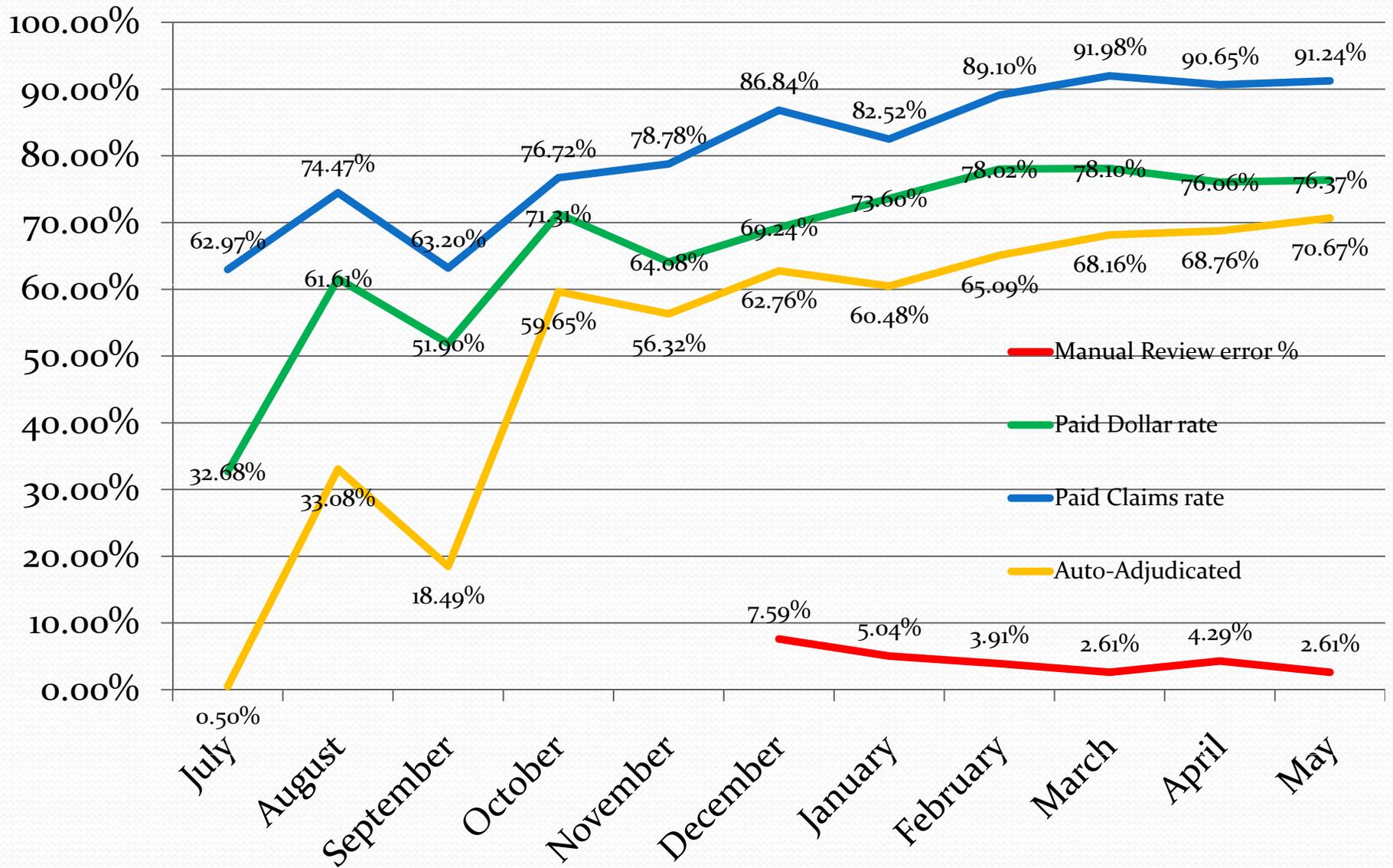
Performance Measures

- # of claims processed by month
- % of claims paid by month
- % of billed dollars paid by month
- % of inappropriate denials by month
- % of claims auto-adjudicated by month
- Turnaround time by week
- Reconciliation results, expedited providers
- Fund burn rate
- Independent audit (Hewitt)

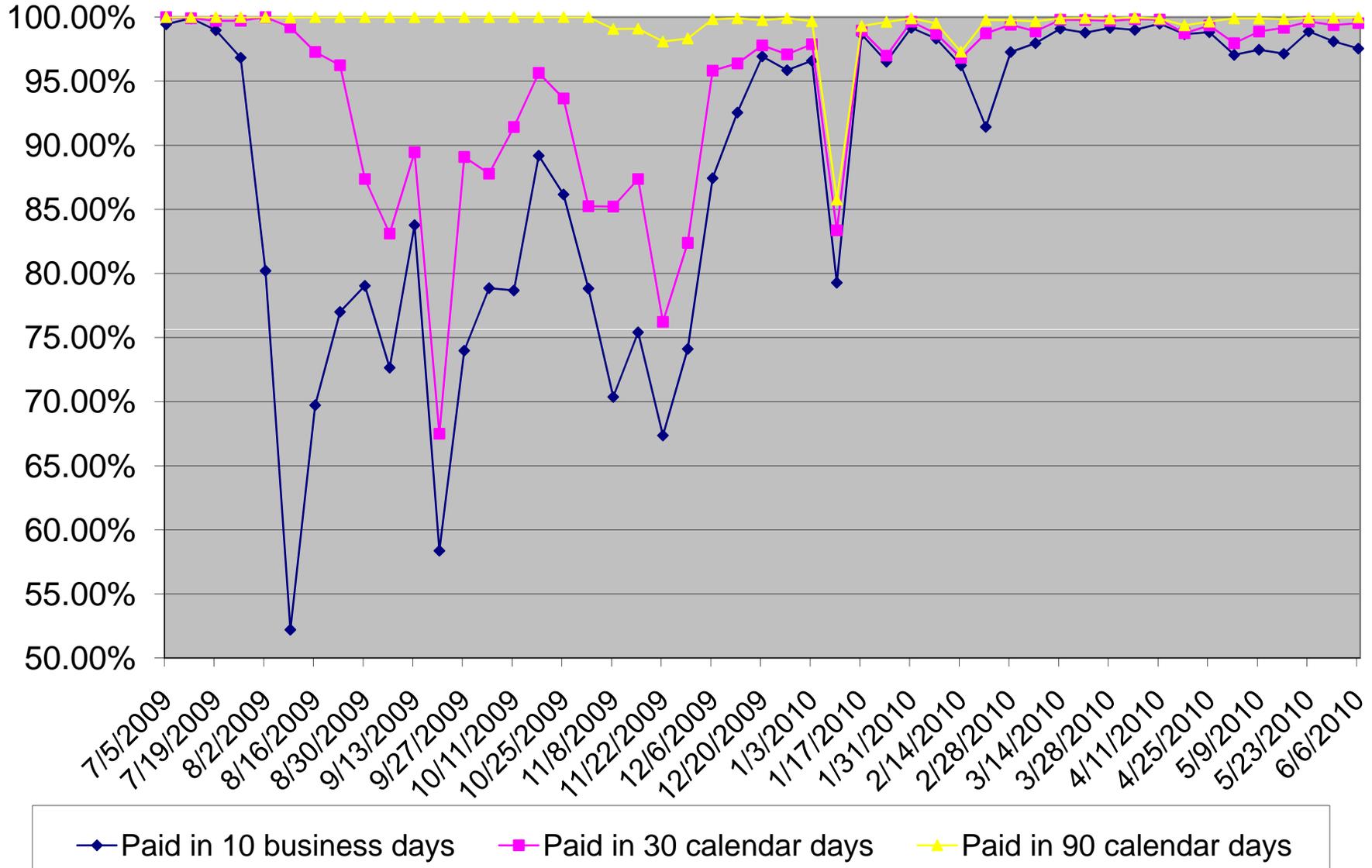
Key Metrics

		Sept '09	Dec '09	May '10
Claims Processed		102538	111556	104345
Claims Paid		64799	96876	95204
Paid Dollars		\$17,856,675	\$27,721,944	\$23,206,019
Denied Dollars		\$16,551,058	\$12,313,771	\$7,181,592
Manual Review error %			7.59%	2.61%
Independent Audit Error rate			7.73%	
Paid Dollar rate		51.90%	69.24%	76.37%
Paid Claims rate		63.20%	86.84%	91.24%
Auto-Adjudicated		18.49%	62.76%	70.67%
Weekly Claim Turn Around Time Metrics				
	Goal	Sept '09	Dec '09	May '10
Paid in 10 Business days (14 Cal Day)	95%	72.19%	93.20%	97.73%
Paid in 30 calendar days	98%	82.29%	96.78%	99.01%
Paid in 90 calendar days	99%	100.00%	99.86%	99.91%

Claims Payments



Weekly Turnaround Time Results





Definitions from Hewitt Audit Report

- Hewitt classifies errors by category according to the financial consequences of the errors.
 - Payment Errors—include benefit payments issued for a different dollar amount than what should have been paid, issued to an incorrect payee, or issued for the incorrect consumer. Payment errors are quantified as overpayments and underpayments.
 - Nonpayment Errors—include errors that do not affect the dollar accuracy of the payment or cannot be quantified as a dollar amount at the time of our audit. *For this audit, funding errors with otherwise correct payments, but incorrect selection of funding pool, were classified as Nonpayment errors.*
- Hewitt measures claim processing performance based on the following four standards.
 - Financial Accuracy—measures the dollars paid correctly. The absolute value of all payment errors is subtracted from the total benefits paid in the sample. The result is divided by the total benefits paid in the sample.
 - Payment Accuracy—measures the frequency of payment errors by dividing the number of correct benefit payments by the total number of payments within the audit sample.
 - Overall Accuracy—is a frequency measure of all error types. This is measured by dividing the number of claims processed without any type of error by the total number of claims in the audit sample.
 - Turnaround Time—measures the time elapsed from the date all information necessary to process a claim is received to the date the claim is processed. Only the received date, not the processed date, is included in our calculation.

Independent audit of claims processing

Hewitt’s independent audit reviewed claims from December and January. The overall error rate of %7.73 is in line with Optum’s manual denial review error rate for December (%7.59) and January (%5.04).

State of New Mexico—OptumHealth Behavioral Solutions (Albuquerque) Audit Results—Hewitt Standards and Objectives

Performance Standards	2010 Audit Results	2010 Audit Results Without High Dollar Error*	Hewitt Commercial Objectives		
			Satisfactory	Good	Excellent
Financial Accuracy	98.38%	99.90%	99.30%	99.60%	99.80%
Overall Accuracy	92.27%	92.73%	95.00%	96.50%	98.00%
Payment Accuracy	96.36%	96.82%	97.00%	98.00%	99.00%
Turnaround Time	96.82%	96.82%	90.00% within 30 calendar days*		

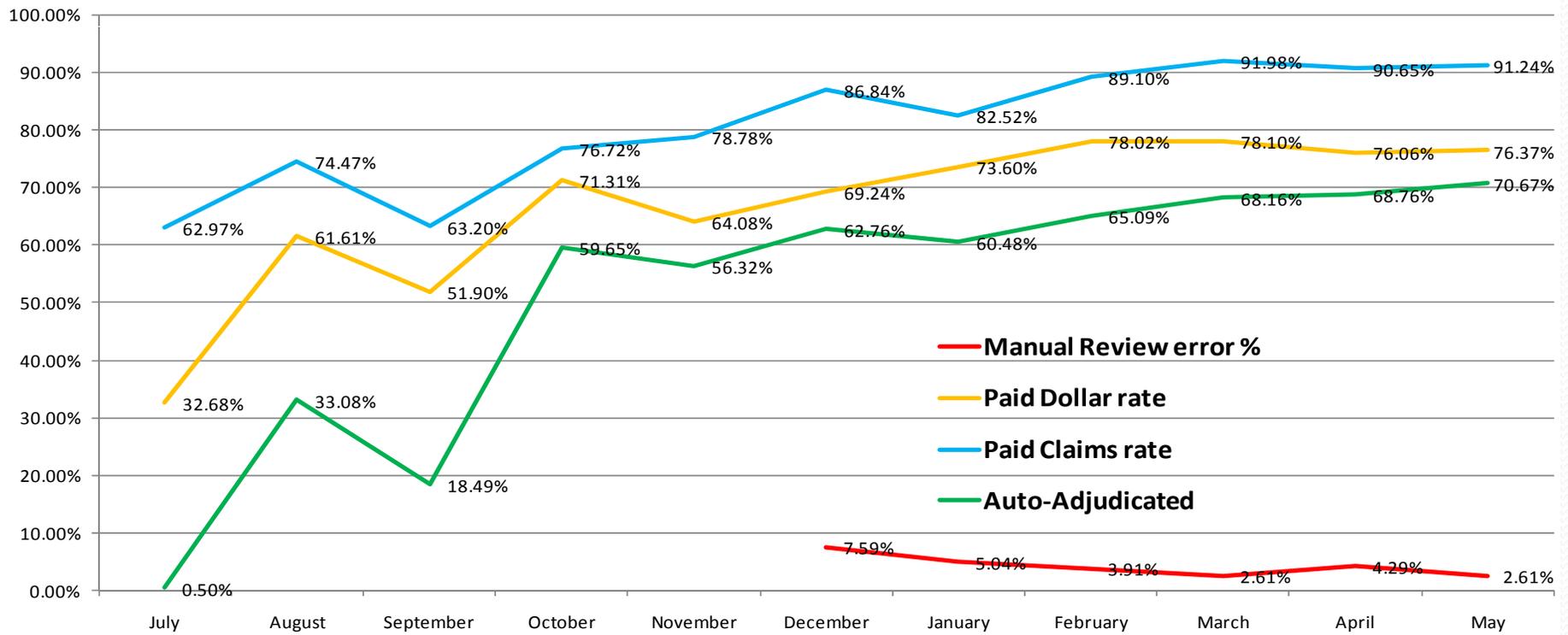
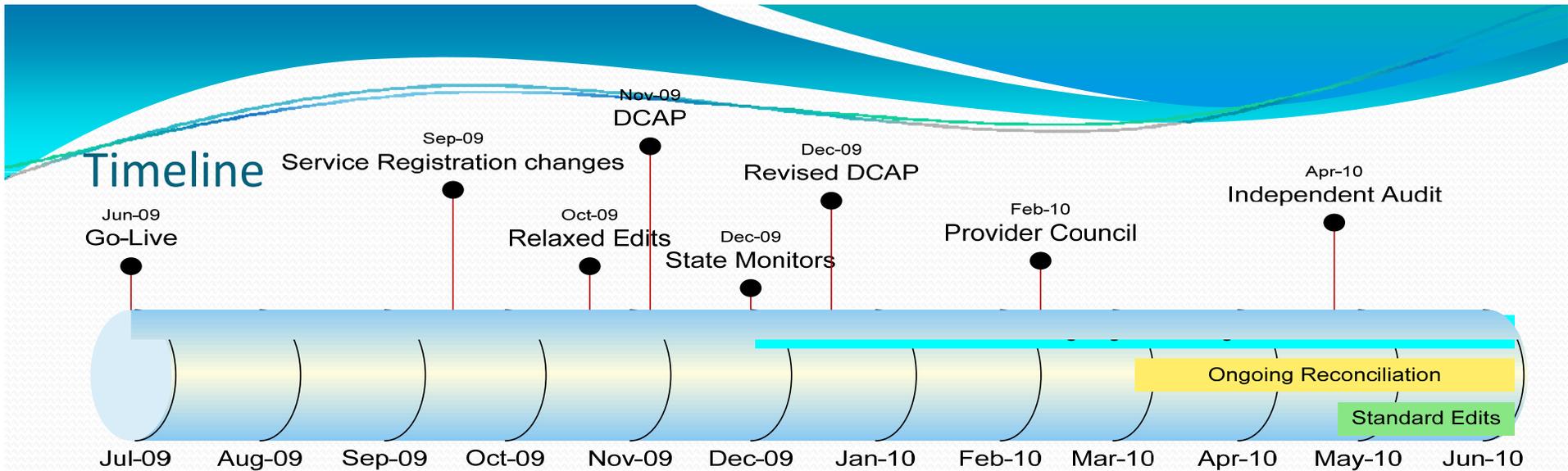
*One high dollar overpayment error (\$4,382.12) was assessed due to an incorrect provider record selection by a claims processor. It is Hewitt's standard procedure to reflect audit results with and without a high dollar error if audit results are significantly skewed by a single finding.



Fund Burn

Agency	Allocation	Remaining	Spent
BHSD	38,149,349	7,376,083	80.67%
CYFD	9,471,316	2,981,218	68.52%
NMCD	6,176,490	2,371,281	61.61%
DOH	7,523,353	1,627,631	78.37%
TANF	680,000	398,744	41.36%
ALTSD	59,401	9,901	83.33%
TOTAL	62,059,909	14,764,858	76.21%

*There is a 1-2 month lag between service dates and claims payments





Conclusions

- Claims processing, fund mapping and payment timeliness have been improving steadily since monitoring and DCAP activities began.
- Ongoing claims processing accuracy under relaxed edits is at or near acceptable levels and improving.
- Reconciliation of expedited claims and fund mapping errors is in progress.
- The return to standard edits is under way.
- Providers have been involved in ongoing operations via the Provider Council.
- State sanctions, DCAPs and monitoring have proved effective.