Effective Cost Management for Medicaid

Introduction

In fiscal year 2017, Medicaid total spending was over $545 billion for approximately 75 million enrollees – making it the largest healthcare program in the nation based on the number of people served. Medicaid is a safety net program deeply interwoven in our healthcare system.

This white paper outlines a principled approach to Medicaid cost containment that leverages industry best practices, instills accountability across the healthcare continuum, and breaks down silos. The paper provides four recommendations for healthcare policymakers and regulators that will prevent wasteful spending and enhance Medicaid sustainability without cutting eligibility, benefits, or reimbursement rates.

Medicaid Program Challenges

For decades Medicaid has experienced high improper payment rates, typically hovering around 10 percent of expenditures, equating to nearly $50 billion in erroneous payments annually. The Centers for Medicare and Medicaid Services (CMS) Payment Error Rate Measurement (PERM) report for fiscal year 2016 indicates a Medicaid error rate of 9.8 percent.

Medicaid improper payments result from a broad range of causes, including errors in billing and pricing, payment for uncovered services or those not medically necessary, third party liability (TPL), and intentional member and provider fraud such as billing for services not delivered. While law enforcement focuses much of their Medicaid effort on outright fraud by bad actors, fraud is estimated to account for less than 20 percent of total improper payments. The rest of the overpayments results from errors. As with fraud, errors must be pursued with equal vigor given the cost to taxpayers and the implications to members, providers, and payers alike.

Managing Costs While Retaining Vital Services

The Medicaid program serves the nation's most vulnerable, predominantly women and children. Retaining vital services for these constituencies fulfills the mission and intent of the program while benefiting all communities with a healthier, more productive population. To enhance program sustainability, lawmakers and regulators have a responsibility to vigorously pursue actions that reduce waste and unnecessary spending. While some of these actions will require legislation, many can be implemented administratively with a change to regulation or operational practice.

I. Secure Medicaid's Payer of Last Resort Principles

By law, Medicaid is the payer of last resort, meaning if a Medicaid member has other health insurance coverage, the other insurer or "third party" must pay first to the extent of its liability. This is referred to as Medicaid third party liability (TPL) or coordination of benefits. A 2013 Department of Health and Human Services (HHS) Office of Inspector General (OIG) report indicated that states identified about $13.6 billion in combined federal-state cost savings from TPL efforts in 2011 alone. With advancement in technology, those savings are likely higher today, but more can be done to ensure that Medicaid remains the payer of last resort. Clarification of roles and responsibilities and better defining obligations that are currently unclear under the law would serve to save the program billions of dollars annually and prevent cost shifting to Medicaid.

a. Expand the definition of health insurer to capture all potential sources of liable third party coverage.

Traditional health insurance companies are clearly captured in the definitions, but there are many other payer types that may be responsible for payments erroneously made by Medicaid, including workers' compensation plans, property and casualty insurers, accountable care organizations, third party administrators, pharmacy benefit managers, and other government programs. Clarifying that these payers are subject to data sharing, claims processing and prompt payment requirements will ensure the responsible payer pays.

- Care should be taken to ensure health savings accounts (HSAs) also be captured for purposes of Medicaid TPL. Minimally, Medicaid should have the right to coordinate benefits with the employer-funded contribution to the HSA.

b. Fully empower Medicaid Managed Care Organizations (MCOs) to conduct Medicaid TPL.

Currently, 77 percent of Medicaid recipients receive their healthcare under a Medicaid MCO, yet some third party payers refuse to share data with or process claims from MCOs seeking to coordinate benefits on behalf of their Medicaid members. Clarifying in CMS guidance that Medicaid MCOs have the same TPL rights as Medicaid agencies, including access to eligibility data, the authority to cost avoid and recover from all other liable insurers, and require that third parties honor the same claims processing standards as is done with state Medicaid agencies today will strengthen efforts to avoid and recover improper payments on behalf of the Medicaid program while ensuring more accurate capitation rates.

c. Hold Medicare and TriCare to the same TPL standards as other liable parties.

Medicare and Tricare restrict state Medicaid agencies' ability to bill claims to only one year from the date of service. Other liable parties must accept claims for up to three years from the date of service. Neither Medicare nor TriCare should receive such an exception as costs are being shifted to the states. Furthermore, TriCare does not recognize the authority of Medicaid MCOs to conduct TPL activities. TriCare must be compelled to honor the assignment of rights and adhere to the same data sharing, claims processing, and payment standards as other liable third parties.

d. Prohibit liable third parties from denying claims due to a lack of prior authorization.

Third parties deny claims valued at upwards of $136 million annually because the member received a service that should have undergone prior authorization. If Medicaid approves the service, the other liable insurer should accept the decision and pay the claim as it would if the member receives prior authorization directly. Georgia has adopted policies to stop this cost shifting; other states should do the same and the federal government can assist by drafting similar policies.

e. Align claims review and claims payment time frames.

Today Medicaid can review claims for purposes of identifying other potential liable parties for up to three years from the date of service. However, commercial insurers often restrict provider billing to within 12 months from the date of service. For purposes of Medicaid TPL, providers should be given the full 36 months to bill a commercial payer for a claim that was wrongly paid by Medicaid, as is done in California today. This will also ensure that providers receive their commercially negotiated rates while preserving Medicaid as a payer of last resort.

f. Apply Medicaid payer of last resort status and authorities to the Children's Health Insurance Program (CHIP).

While CHIP eligibility is currently contingent on having no other health insurance coverage, we have found that between 3 - 7 percent of CHIP applicants and beneficiaries are also covered by commercial insurance, most often through a non-custodial parent. In other cases, a child's medical expenses may be covered under a legal settlement, such as a car insurance policy covering treatment after an accident or a medical malpractice settlement. If other health insurance coverage is not identified at the time of application, but later discovered, often policymakers are reluctant to disenroll a CHIP beneficiary out of concerns associated with disruption in access to, and continuity of, care. And without explicit assignment of rights authority, neither the state nor the MCO serving the CHIP program have recovery rights against the other liable insurer.

Therefore, in order to protect the limited CHIP funding, we encourage CMS to model CHIP assignment of rights, coordination of benefits, and subrogation authorities after Medicaid TPL, including access to eligibility data, the authority to cost avoid and recover from all other liable insurers, and require that liable insurers honor the same claims processing standards for CHIP reclamation claims as is done in Medicaid TPL today.

g. Expand Medicaid TPL activities to Medicaid Disproportionate Share Hospitals (DSH) programs.

Today, the DSH program relies on the individual to disclose health insurance coverage at the time of service. Sometimes individuals do not realize they have other insurance coverage or they choose not to disclose the other coverage due to high out of pocket costs. Access to insurance coverage is volatile, particularly for lower income and transient populations. As their economic and employment situations change, so does their access to other insurance coverage, particularly employer sponsored coverage.

Hospitals do not have the data or resources to look for undisclosed health insurance coverage at the time of service. Cost reports and mandatory state auditing of those cost reports cannot identify instances when an individual appears to be uninsured, but actually has other health insurance coverage. For these reasons, we recommend that CMS and the states implement TPL activities for DSH.

At least one large mid-Atlantic state does that today and has achieved nearly $7 million in savings since 2010. Savings are then reinvested into the DSH program, covering services for only those individuals who are underinsured or uninsured, certifying payments are made to safety net hospitals in accordance with their uncompensated care costs, and ensuring state and federal DSH dollars are spent in the spirit of statutory intent.

II. Strengthen Oversight Provisions and Incentives for Medicaid Program Integrity Efforts

According to the latest CMS Medicaid PERM report, the top two causes of improper payments are non-covered services and pricing errors, both of which can be avoided with better pre-payment claim screening and post-payment review for assurance of proper adjudication procedures.

a. Strengthen the Medicaid Recovery Audit Program (RAC).

Programs such as the state-administered Medicaid Recovery Audit Program (RAC) provide checks on Medicaid waste. The RAC program should be strengthened by enabling states to design audit programs specific to their needs, rather than following a one-size-fits-all federal guideline. For example, states should determine their own RAC staffing requirements, procurement standards, and reimbursement methodologies to enable them to tailor oversight initiatives to their unique program needs.

Additionally, Medicaid programs should be able to cover the cost of their RAC programs using a portion of the proceeds of recovered funds. Any federal share return should only occur after all appeals have been finalized. In the future, should federal Medicaid financing be capitated to state Medicaid programs, states should be able to retain all recoveries.

b. Implement incentives for states to reduce Medicaid improper payments.

CMS should set benchmarks and provide bonus payments for states that achieve these goals. Other incentives can include the retention of saved and recovered funds, and innovation grants.

III. Leverage Premium Assistance Programs

Medicaid eligibility is based on financial need. There are frequent cases where an individual is employed, but still meets the low-income threshold for the program. Many of these employed Medicaid recipients and their family members have access to, but do not participate in employer-sponsored health plans due to out-of-pocket costs. By implementing premium assistance programs, Medicaid programs can maximize employer-sponsored coverage, reduce their total costs, and improve access to healthcare providers.

a. Support state usage of premium assistance programs.

States leverage premium assistance programs today, but the current federal regulatory schema proves challenging. We encourage CMS to promote premium assistance programs through enhanced match, and reduce the regulatory burdens in place today. Examples include flexibility to optionally provide wrap benefits; simplification of eligibility standards, including cost-effective tests; and latitude to impose enforceable penalties on members and employers for non-compliance.

b. Make premium assistance program participation mandatory for employers and employees on Medicaid.

The success of premium assistance programs at the state level depends on participation by employers and members. Employers must be compelled to share comprehensive data and participate in the program. The benefit for employers includes ensuring employees' access to wellness programs and overall a more engaged workforce. Furthermore, making premium assistance programs mandatory for members ensures a robust and more sustainable program while alleviating Medicaid provider access concerns.

c. Compel employers to share data and enact penalties for non-compliance.

For a premium assistance program to work effectively, Medicaid will need timely access to information about recipients' employer sponsored plan information, including employment status, employee eligibility status, summary of benefits and premium and cost-sharing information. States should complement employer data with external data sources, including routine access to state wage and new hire files for electronic data matching.

d. Promote premium assistance programs in Medicaid managed care.

Premium assistance programs must adapt to the new delivery models and apply not only to fee-for-service populations, but to Medicaid managed care and other alternative delivery models. In one state, a pilot

demonstrated a significant cost savings by placing an individual otherwise eligible for Medicaid managed care into a premium assistance program. CMS should work with states to further explore these programs which not only save money, but ensure that Medicaid remains the payer of last resort.

IV. Expand the Use of Data Collected for Medicaid Program Integrity and Third Party Liability

Vast amounts of rich data are collected for Medicaid program integrity and third party liability efforts. However, data usage is often restricted. Without risk to the sensitive nature of said data while concurrently making the healthcare system better, its usage can be expanded to population health, care management, and eligibility verification.

a. Leverage claims and eligibility data for better population health management.

Approximately 20 percent of Medicaid recipients account for nearly 80 percent of Medicaid costs. High-utilizers of healthcare often have severe chronic conditions and are covered by multiple health plans (i.e., Medicare and Medicaid), Medicaid agencies and their contractors have collected decades of claims and eligibility data used for program integrity. This data can be further leveraged to proactively and better manage the Medicaid population. For example, a state Medicaid program or its contracted Medicaid MCO could benefit from comprehensive and decipherable data sets at time of enrollment to identify members who have chronic conditions for potential placement into targeted care management programs and the avoidance of duplicative testing and unnecessary procedures for additional cost savings.

b. Leverage existing data to verify eligibility for health insurance tax subsidy programs.

Tax credits are limited to only those individuals who are not enrolled in, or have access to Medicaid, Medicare, or other health insurance. Beyond applicant self-attestation, existing data sets can and should be leveraged to electronically verify these conditions of eligibility.

c. Bolster and fund existing efforts such as CMS' Trusted Third Party initiative.

An effort to deploy industry best practices for healthcare data use is underway but needs strengthening to achieve maximum benefit and ensure an effective rollout. Funding and codifying the program will enable Medicaid agencies, Medicaid managed care plans, and Medicare to implement population health initiatives to better manage costs and outcomes for chronic care recipients and other high healthcare utilizers. It also breaks down program, payer, and jurisdictional silos to identifying fraud, waste, and abuse.

Impact of Recommendations

The above recommendations will reduce the nearly 10 percent Medicaid improper payment rate. These recommendations will have a significant and favorable financial impact, resulting in billions of dollars in annual cost avoidance and cash recoveries. Additional benefits will include:

- Greater alignment with private sector best practices
- Protection of the safety net program

- Maximization of commercial health insurance
- Strengthened program integrity efforts
- Healthier, more productive Medicaid populations
- Inspired innovation in data use, program integrity practices and care management
- Clearer guidelines and reduced administrative costs for healthcare industry stakeholders

Conclusion

Leveraging available technologies and data, while expanding focus on best practice oversight and compliance measures, will help protect the over 60 million people who rely on Medicaid, safeguard tax-payer dollars, preserve the sustainability for future generations, and set a model for effective government program management.

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