health management systems

HMS White Paper:

Considerations in Medicaid Cost Avoidance

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As government healthcare programs face increasing fiscal challenges, the need for these public payors to coordinate benefits effectively has never been greater. By ensuring that other parties shoulder their portion of healthcare costs, government minimizes the burden upon taxpayers and upon the nation as a whole.

Medicaid, the joint federal/state healthcare program for the indigent and disabled, offers one of the most significant opportunities to contain costs through coordination of benefits. While Medicaid expenditures will total a projected $338 billion in 2006, other parties will be liable for much of this spending. Medicaid is the "payor of last resort"; where Medicaid coverage overlaps with other healthcare benefits, the other coverage takes precedence. Simply put, Medicaid is required to cover the bill for a healthcare service *only if* private insurers, Medicare, and other payors are not.

Determining liability for these costs in the $2 trillion U.S. healthcare system is no easy task. However, Medicaid can improve the success of its COB efforts by employing proven strategies. This article highlight several issues policymakers should consider in pursuing these strategies.

Background

Medicaid follows two approaches to coordinating benefits with other payors:

- *Pay-and-chase*

  Retroactive COB – Medicaid pays claims and subsequently attempts to recover any expenditure for which another party is liable.

- *Cost avoidance*

  COB before adjudication – Medicaid correctly determines liability and presents claims to the appropriate parties before issuing any payment.

Because of the complexity of coordinating benefits with potentially thousands of other parties, state Medicaid agencies employ both these techniques. Cost avoidance, however, is typically the more efficient process, and remains the method of choice for benefit coordination. (The Centers for Medicare & Medicaid Services require agencies to cost-avoid all claims – but allows exceptions for certain pediatric and prenatal services, or where agencies receive a waiver to perform pay-and-chase.)

Based on its experience providing millions of cost avoidance records to Medicaid, Health Management Systems believes that any consideration of this approach should address the following questions:

1. *What is the fiscal benefit of cost avoidance? How much is it "worth"?*
2. *How and when should Medicaid decide to cost-avoid a claim?*
3. *What steps can agencies take to improve their cost avoidance efforts?*

The following pages provide some of the answers.

1. How much is cost avoidance worth?

Unlike the pay-and-chase approach to COB, cost avoidance does not come with a price tag. While the results of pay-and-chase are actual dollars, cost avoidance results in savings of dollars Medicaid might pay needlessly in the future – the cost of claims covered by insurance that is unknown to a state Medicaid agency.

Predicting these costs is an inexact science. As a result, agencies have struggled to assign a meaningful value to cost avoidance. In some cases, they accept information identifying other insurance coverage as a "free" byproduct of pay-and-chase. In other cases, Medicaid has paid wide-ranging fees for the data – fees that usually underestimate its true worth.

If Medicaid is to invest resources in improving cost avoidance, however, decision-makers must understand its value. There are several ways to estimate this.

- *Cost-avoidance reporting*

Medicaid agencies record their expenditures in a quarterly report (Form CMS-64) filed with the Centers for Medicare & Medicaid Services. These reports include self-reported data regarding cost avoidance. What the data actually represents varies widely by state, but the information provides at least an approximation of the value of cost avoidance.

By estimating the portion of the Medicaid population with other health insurance – typically about five percent of all members – one can then determine the annual value of cost-avoiding one member with other coverage. In other words:

Annual value per CAV member =
(CAV $ from Form CMS-64 X 4) ÷ (number of members X 0.05)

- *The value of denied claims*

Another method of estimating the value of cost avoidance is to measure claims that Medicaid denies specifically because members have other insurance. Since most adjudication systems assign a unique code to these denials, this method provides a reliable indication of cost avoidance results. However, some denied claims may have been resubmitted to Medicaid and subsequently paid; the calculation of cost avoidance should not include these claims. After obtaining a total value, an agency can determine the value per cost-avoided member in a manner similar to the first method.

Annual value per CAV member =
(Annual $ of claims denied for CAV -- annual $ of these claims rebilled and paid)
÷ (number of members X 0.05)

- *The value of paid claims*

A third method of estimating the value of cost avoidance is to consider the average Medicaid claim payments per member, the five-percent incidence of other coverage, and an "efficiency factor" – the portion of claim amounts Medicaid successfully avoids paying when it discovers other insurance coverage.

The average paid claim amounts can be considered in aggregate (i.e., total Medicaid expenditures divided by the total number of members) or in various levels of specificity (i.e., the expenditures and population size for different types of members). But it important to realize that this method relies on the value of claims *paid* – not the value of the claims that are denied because of other coverage. So the more closely paid claims mirror these denied claims, the more accurately the cost avoidance value can be estimated.

The efficiency factor (the portion of claims Medicaid avoids paying where there is other coverage) can be determined by comparing a sample number of paid claims to the number of cost-avoided claims for that sample. But if this is not practical, a Medicaid agency can make an estimate with a few rules-of-thumb – or choose to alter its practices in order to achieve a desired level of efficiency. For example, an agency may refuse to issue any payment if the member has other insurance; such an agency would be close to 100 percent efficient in cost avoidance. If an agency nevertheless picks up the cost of coinsurance and deductibles for the denied claims, the efficiency might be in the range of 90 percent. And if pharmacy providers are allowed to override cost-avoidance denials, efficiency may drop to as low as 50 percent.

The cost avoidance value can then be expressed as:

Annual value per CAV member =
Average claim $ per member per year X 0.05 X CAV efficiency factor
Where:
CAV efficiency factor = number of CAV claims ÷ number of all paid claims
Average claim $ per member per year = all annual claim $ ÷ number of members

- *Empirical comparison*

An empirical comparison may be the simplest and most realistic way to determine the value of cost avoidance. One needs only to examine the value of paid claims before a cost avoidance program is implemented, and the value afterward. Or an agency may compare the value of paid claims for two similar member populations – one where cost-avoidance is practiced, and one where it is not. Again, the difference in expenditures is a good indication of the savings generated by cost avoidance. However, the calculation must take into account other possible causes for the difference. In addition, this approach may not be useful for agencies that wish to evaluate the value of a cost avoidance program before implementing one.

2. How and when should Medicaid decide to cost-avoid a claim?

The success of any cost avoidance initiative depends on how accurately other insurance coverage is identified. Medicaid agencies and firms such as Health Management Systems match information from Medicaid files to vast databases of insurance eligibility information in order to identify other coverage. But data matching alone usually cannot provide the level of accuracy necessary for Medicaid to make a reasonable and well-informed decision to cost-avoid a claim. Agencies must perform further work to verify that other coverage is liable. If an agency is to take extreme action upon discovering a member has other insurance – for example, disenrollment – then the eligibility data must meet an especially rigorous "burden of proof."

Why? The problem arises from the dynamic nature of eligibility information, as well as the difficulty of obtaining it from myriad sources and then matching it to Medicaid data. For example, consider these scenarios.

- *Insurance data changes.* Key identifiers of insurance coverage, such as employer group numbers and policy numbers, change on a regular basis – for example, when a contract is renewed or modified. When an employer decides to contract with a new pharmacy benefit manager (often an annual occurrence), the group number also changes. Coverage and related data change as members move to new jobs, marry, or have children. The result is a continuous "churn" of insurance information that quickly renders much of the data obtained by an agency obsolete.

- *Insurance data is incomplete.* Because of the multiple sources of data, Medicaid agencies often obtain eligibility information lacking critical details. For example, an agency may receive the policy number of a members' coverage, but not the policy's effective date or termination date. And in many cases, while pharmacy coverage is provided through a PBM, the coverage information is obtained from a major medical insurance carrier. These carriers typically identify which PBM covers a Medicaid member, but do not record the group and policy numbers used.

- *Insurance data is ambiguous.* Medicaid must make difficult judgments when matching member data to other insurance information. If the Medicaid rolls identify a member as "Robert

A. Smith, II" and an insurer's eligibility file refers to "Bob Smith, Jr.," can the agency be sure that the member, in fact, has other coverage? If the names are identical but the Social Security Numbers differ by a single digit, can the agency be sure?

Or consider the confusion that may arise when an agency's PBM provides Medicaid members with a cash discount card. Discount cards do not represent actual benefits paid by an insurer; rather, the cards function in much the same way that a coupon does, providing a discount on the pharmacy's retail price. However, eligibility information from PBMs sometimes fails to make the distinction. For this reason, Medicaid may incorrectly determine that a member has other pharmacy coverage, wrongly deny a claim, and prevent the member from obtaining needed medication.

Another difficult situation: An insurer creates a Medicaid managed care line of business. However, the eligibility data may not distinguish the new plan and indicate that it is providing benefits on behalf of Medicaid. Instead, the data simply show that the insurer now covers Medicaid members – forcing them to be disenrolled.

As a result of factors such as these, raw eligibility data provides only a partial solution for identifying other insurance coverage. Before cost-avoiding a claim, Medicaid *must* verify that the other coverage exists and that it is applicable. In fact, HMS estimates that more than 30 percent of insurance eligibility files should be updated annually, and that unverified insurance data matches may carry error rates as high as 40 percent.

In deciding to make the investment necessary to verify other coverage, decision-makers should remember that accuracy produces the optimal cost savings for the Medicaid agency – as well as advantages for the Medicaid member and for the healthcare provider. Agencies avoid unnecessary payment, avoid penalizing their members wrongfully, and eliminate the extra work providers must perform when claims are submitted to Medicaid inappropriately.

3. What steps can Medicaid take to improve its cost avoidance efforts?

The science of cost avoidance has advanced dramatically in recent years. As Medicaid has turned increasingly to this technique for coordinating benefits, agencies and vendors have

developed new tools and best practices that have improved its accuracy and efficiency. Other agencies and vendors can benefit from this experience. Here are some of the key lessons HMS has learned.

- *Start with good identification data.*

Accurate, current insurance eligibility information is the lifeblood of any Medicaid cost avoidance system. The higher the quality of the raw data, the less verification is necessary – and the greater the opportunity to prevent unnecessary expenditures. So any attempt to improve cost avoidance should begin with improving the reliability and comprehensiveness of the insurance eligibility records. Provisions of the federal Deficit Reduction Act of 2005 give states new powers to obtain this information from a variety of entities; unfortunately, many states do not yet realize the full application of these powers.

HMS obtains eligibility data from a growing network of healthcare entities, which currently number more than 150. They include major insurers, health maintenance organizations, third-party administrators, pharmacy benefit managers, TRICARE intermediaries, and self-insured employers. Since insurance coverage is so dynamic, HMS's Carrier Relations Team works to keep the information up-to-date. As a result, HMS can access eligibility data for at least 90 percent of most populations for its clients.

- *Build quality assurance into the verification process.*

An eligibility database is only as dependable as its least-accurate record. So Medicaid agencies need to build quality assurance checks into their data verification processes – in effect, allowing the agencies to "verify the verification." Automated processes and standardized protocols can help ensure that these checks are applied thoroughly.

HMS's proprietary eligibility verification system, *eCare*, is an online work management tool that applies these checks at three levels.

– <u>System edits ensure that field-level information meets reasonable parameters</u>. For example, dates must appear in an mm/dd/yyyy format, and policy types must be entered via a pull-down menu of allowable choices.

- The system automatically checks for integrity among disparate data sets. For example, eCare does not allow a verification representative to record "medical coverage" in a verification of coverage by a pharmacy benefit manager. Or if a policyholder's spouse is listed as a member of an "employee and children" policy, eCare flags the error. Mistakes like these may seem obvious, but the right QA checks make sure they are prevented.

- The eCare system supports re-verification. For most clients, HMS tests the quality of its verifications by carefully repeating a representative sample of them. The eCare system ensures the re-verifications are conducted consistently, and provides a complete audit trail.

- *Use automated tools to maximize efficiency.*

Tracking down other insurance coverage is a time-consuming, labor-intensive process. And resource limitations can cripple the effectiveness of even the most well designed cost avoidance program. So it's crucial that Medicaid leverages the power of technology to streamline insurance identification and verification.

For example, besides promoting quality assurance, the eCare system allows HMS staff to extract as much relevant information as possible at each point in the verification process. The system automatically groups and prioritizes records to be verified in a logical queue. An HMS verification specialist can check all the records for a carrier with a single telephone call. All the necessary data, prompts for missing information, and a customized call script are at the specialist's fingertips.

HMS also enhances its verification process with *eBoss*, a proprietary interface that automatically verifies coverage through Web-based inquiries. Using eBoss, HMS can complete and document hundreds of verifications per hour. And in some cases, HMS verifies coverage through industry-standard electronic data queries (known as ANSI 270/271 transactions). Depending on the requirements of verification for a particular member population, HMS may employ a combination of all these automated tools.

Putting it all together

While there always will be practical and statutory needs for pay-and-chase, the cost avoidance method of COB is increasingly essential to Medicaid. Medicaid faces complex new challenges – such as coordinating drug benefits with Medicare Part D. The pace of healthcare transactions is quickening. Medicaid is coming under more pressure to "get it right the first time" rather than attempt to recover inappropriate claim payments months later.

Decision-makers need to invest resources today if they are to meet these challenges tomorrow. But investing in cost avoidance requires an understanding of its true worth, the need for verification, and other techniques that can improve cost avoidance results. By drawing on the collective knowledge base of both agencies and vendors, Medicaid can gain this understanding.

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Health Management Systems helps Medicaid and other government healthcare programs contain costs, and has active clients in 25 states. For information about HMS, visit www.hmsy.com or contact HMS at 877-HMS-0184.