Medicaid Value Purchasing
Ten Ideas for Containing Cost While Maintaining Access
Introduction

How do you contain the growth in Medicaid program costs while protecting beneficiary access to quality care? This paper presents a list of ten value purchasing ideas that we hope are helpful to states that need to save money.

Because this paper was prepared by the payment method development team at Conduent, most of the ideas focus on provider payment rates and methods. Our account managers and other industry experts can draw on their wide-ranging experience to offer you additional cost-saving suggestions.

Although we would be pleased to assist states in analyzing or implementing any of these ideas, that’s not how we developed the list. Instead, we compiled ideas developed during our work with various states. Some ideas can be implemented by state staff on their own; some would require changes to the Medicaid Management Information System (MMIS) that would be done by the fiscal agent; and some would benefit from consulting advice.

Our suggested goal is not to cut Medicaid costs per se, but rather to expand the value that Medicaid programs receive for the payments they make to providers. That value is defined as access to quality care. If Medicaid pays more than it needs to for some services, it can cut payments for those services and direct the savings to other priorities. It’s simply not true that Medicaid payment rates are low always and everywhere. Ideally, a Medicaid program should be able to explain any pay cuts using the same words at the same time to all constituents – the Governor, the legislature, beneficiaries, providers, the media and CMS. The question is: “Where are those areas of potential opportunity?” This list will differ in different states; you should view the ten ideas offered here as a starting place if a particular idea is appropriate for your state.

We hope this paper will be useful to the Medicaid programs we serve. For further information, or to offer comments and further suggestions on value purchasing, please feel free to contact a Conduent account manager or Dawn Weimar at 262-365-3592 or dawn.weimar@conduent.com.

This paper was written by Darrell Bullocks, Connie Courts, Jeff Gray, Kathleen Martin, Nathan Ray, Yleana Sanchez, Angela Sims, Debra Stipcich, Kevin Quinn and Dawn Weimar. Please note that opinions expressed are those of the authors and not necessarily those of Conduent. Any comments on federal and state law are from a policy analyst’s perspective and should be reviewed by Medicaid legal counsel.
Background: Medicaid Spending Key Points

1. **Medicaid is a major purchaser of healthcare.**
   
   2014 spending is estimated at $490 billion. If Medicaid agencies were publicly traded companies, 26 would rank in the Fortune 500.

2. **Medicaid spending is projected to grow faster than Medicare.**
   
   Federal actuaries projected that Medicaid spending would jump by 27 percent between 2012 and 2014 (Chart A). The estimate was made before the Supreme Court ruled that states need not implement the Medicaid expansions mandated by the Patient Protection and Affordable Care Act, so it is almost certainly an over-estimate. But many states are expected to expand Medicaid, ensuring that total spending will grow at a high rate.

![Chart A](image)

Medicaid Spending, 2000-2020

Source: CMS. Medicaid spending forecast was done before the Supreme Court decision allowing states to choose to opt out of the Medicaid expansion

3. **Medicaid managed care is growing rapidly...**
   
   Between 2002 and 2010, Medicaid managed care spending grew by 165 percent, almost three times faster than Medicaid spending overall (Table A). Several large state programs, including California and New York, are moving large numbers of beneficiaries from fee-for-service to managed care.

4. ...but fee-for-service remains dominant.
   
   Even though managed care grew, it still accounted for only 23 percent of Medicaid spending in 2010 (Table A). Fee-for-service still accounts for 73 percent of Medicaid spending nationwide. FFS payments to hospitals are about equal with payments to managed care plans for all services. The long-term services and supports sector remains overwhelmingly fee-for-service, with little managed care.
5. **Spending per person varies with the basis for eligibility.**
Children and non-disabled adults (typically, related to the children) represent three-quarters of Medicaid enrollees but only about one-third of Medicaid spending (Chart B). People over age 65, who typically have Medicare as their acute care coverage but may rely on Medicaid for long-term care coverage, represent 10 percent of enrollees and 22 percent of spending. Adults under age 65 with disabilities are the most expensive eligibility group, representing 15 percent of enrollees but 43 percent of spending.

**Chart B**

**Eligibility and Spending, FY 2009**

"Children" are age 18 and younger, "Adults" are age 19-64, "Aged" are 65 and older, and "Disabled" are aged 65 and younger eligible due to a disability.


6. **Medicaid plays different roles in markets for different services.**
For many acute care services, Medicaid is one among several purchasers in the market. Medicaid pays for about one-fifth of all inpatient stays, for example. (The figure includes both fee-for-service and Medicaid managed care.) In other markets, however, Medicaid may be the dominant payer. Examples include the markets for long-term services and supports (especially home and community services) and the sub-markets for obstetrics and pediatrics within the markets for physician and hospital care.
An estimated 30 percent of U.S. health care spending is wasted, according to an Institute of Medicine panel. The “excess cost” for 2009 was estimated at $210 billion in unnecessary services, $130 billion in inefficiently delivered services, $190 billion in excess administrative cost, $105 billion in excessively high prices, $55 billion in missed opportunities for disease prevention and $75 billion in fraud.

Dissatisfaction with current methods of reducing healthcare costs - such as across-the-board scheduled cuts of physician fees - has directed attention toward value-based purchasing. Instead of providing incentives to increase the number of services delivered, value-based purchasing uses incentives to improve quality and economy in the delivery of necessary services. Value-based purchasing takes many forms, one of which is episode-based, or bundled, payment. Bundled payment refers to a single payment that reflects the expected (not actual) costs for a clinically defined episode of care. The unit of payment is the episode, not the service as it is under fee-for-service methods or the individual patient under capitation payment. Each episode typically involves multiple services, and one individual may have several episodes within a given time period.

### Table A

<table>
<thead>
<tr>
<th>Medicaid Spending 2002 and 2010 in Billions</th>
<th>2002</th>
<th>% of Total</th>
<th>2010</th>
<th>% of Total</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Managed care</td>
<td>$34.10</td>
<td>14%</td>
<td>$50.60</td>
<td>23%</td>
<td>165%</td>
</tr>
<tr>
<td>Fee-for-service</td>
<td>$205.00</td>
<td>82%</td>
<td>$285.60</td>
<td>73%</td>
<td>39%</td>
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<tr>
<td>Acute care</td>
<td>$116.90</td>
<td>47%</td>
<td>$162.60</td>
<td>42%</td>
<td>39%</td>
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<tr>
<td>Hospital inpatient</td>
<td>$52.60</td>
<td>21%</td>
<td>$76.40</td>
<td>20%</td>
<td>45%</td>
</tr>
<tr>
<td>Hospital outpatient</td>
<td>$9.80</td>
<td>4%</td>
<td>$15.90</td>
<td>4%</td>
<td>58%</td>
</tr>
<tr>
<td>Community pharmacy</td>
<td>$23.40</td>
<td>9%</td>
<td>$15.90</td>
<td>4%</td>
<td>-32%</td>
</tr>
<tr>
<td>Physician or clinic</td>
<td>$16.40</td>
<td>7%</td>
<td>$27.80</td>
<td>7%</td>
<td>70%</td>
</tr>
<tr>
<td>Dental, other prof clinic</td>
<td>$14.70</td>
<td>6%</td>
<td>$26.90</td>
<td>7%</td>
<td>84%</td>
</tr>
<tr>
<td>Long-term care</td>
<td>$88.10</td>
<td>35%</td>
<td>$123.10</td>
<td>32%</td>
<td>40%</td>
</tr>
<tr>
<td>ICF/MR</td>
<td>$11.20</td>
<td>4%</td>
<td>$13.40</td>
<td>3%</td>
<td>20%</td>
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<tr>
<td>Nursing facility</td>
<td>$48.40</td>
<td>19%</td>
<td>$52.10</td>
<td>13%</td>
<td>8%</td>
</tr>
<tr>
<td>Home &amp; community based</td>
<td>$28.80</td>
<td>12%</td>
<td>$57.60</td>
<td>15%</td>
<td>100%</td>
</tr>
<tr>
<td>Premium payment</td>
<td>$10.90</td>
<td>4%</td>
<td>$14.20</td>
<td>4%</td>
<td>30%</td>
</tr>
<tr>
<td>Total spending</td>
<td>$250.10</td>
<td>100%</td>
<td>$390.40</td>
<td>100%</td>
<td>56%</td>
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<tr>
<td>Offsets to spending</td>
<td>($3.80)</td>
<td></td>
<td>($6.90)</td>
<td></td>
<td>81%</td>
</tr>
<tr>
<td>Net spending</td>
<td>$246.30</td>
<td></td>
<td>$383.50</td>
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<td>56%</td>
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<tr>
<td>Administrative costs</td>
<td>$11.90</td>
<td>5%</td>
<td>$17.90</td>
<td>0%</td>
<td>50%</td>
</tr>
<tr>
<td>Net spending incl. administrative</td>
<td>$258.20</td>
<td></td>
<td>$401.40</td>
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</tr>
</tbody>
</table>

Notes:
1. Source: Conduent analysis of CMS-64 reports
2. Pharmacy payment is net of rebates
3. Administrative costs do not include CHIP

1. Bundled Payment

An estimated 30 percent of U.S. health care spending is wasted, according to an Institute of Medicine panel. The “excess cost” for 2009 was estimated at $210 billion in unnecessary services, $130 billion in inefficiently delivered services, $190 billion in excess administrative cost, $105 billion in excessively high prices, $55 billion in missed opportunities for disease prevention and $75 billion in fraud.

Dissatisfaction with current methods of reducing healthcare costs - such as across-the-board scheduled cuts of physician fees - has directed attention toward value-based purchasing. Instead of providing incentives to increase the number of services delivered, value-based purchasing uses incentives to improve quality and economy in the delivery of necessary services. Value-based purchasing takes many forms, one of which is episode-based, or bundled, payment. Bundled payment refers to a single payment that reflects the expected (not actual) costs for a clinically defined episode of care. The unit of payment is the episode, not the service as it is under fee-for-service methods or the individual patient under capitation payment. Each episode typically involves multiple services, and one individual may have several episodes within a given time period.
Over the last 30 years, the leading example has been diagnosis related groups (DRGs) for hospital inpatient care. The success of DRG payment stems from its simplicity. Each stay is assigned to a single DRG, each with its own fixed payment rate. The fixed rate encourages efficiency, especially in reducing unnecessary services and inefficiently delivered services. Sicker patients are assigned to higher-paying DRGs, thereby evening out profit margins across patients and enabling better access to care. Because DRGs make clinical sense, they encourage a standardized, evidence-based approach to providing care while optimizing patient outcomes. Even when not used for payment, analysis by DRG enables cost comparisons across hospitals and regions.

But DRG payment bundles only the hospital services for a single stay. Related services by other providers – physicians most notably – are outside the bundle, as are readmissions and follow-up care. Payment for physician care, meanwhile, continues to be made based on of 9,600 individual CPT service codes. Collaboration with other providers or other steps that might improve efficiency are often penalized because payment is sent down the notorious silos of provider-specific payment methods. The challenge is to expand bundled payment so that it applies to broader time periods and crosses different provider types. In principle, episode-based payment need not include a hospital stay, but in practice, many bundling initiatives include them because these services and these patients tend to be expensive.

**Initiatives in Bundled Payments**

Although there have been Medicare demonstrations and other bundled care initiatives for years, the impetus has grown recently. This payment model applies best to episodes that can be defined cleanly and show relatively little variation in the patterns and amount of care. In 2008, the Medicare Payment Advisory Commission recommended to Congress that Medicare put greater emphasis on bundled payment, especially for hospital care. Under the Acute Care Episode Demonstration, Medicare makes a single payment that covers all hospital and physician services for certain cardiovascular and orthopedic procedures. In August 2011, Secretary of Health and Human Services Kathleen Sebelius announced, “Instead of paying for each care separately, CMS will provide one lump payment to providers for an episode of care.” The Episode of Care Payment Demonstration project, which was authorized by the Patient Protection and Affordable Care Act, created additional initiatives to bundle physician, hospital and other payments. These initiatives could lead to “very substantial” healthcare savings, according to an analysis in the New England Journal of Medicine. Importantly, CMS contracted with five leading analytical organizations to develop algorithms that define episodes of payment. Although these groupers (as they are known colloquially) were developed for Medicare, some are being refined for broader populations – and all represent advances in defining episodes of care.

In the private sector, the Robert Wood Johnson Foundation developed the Prometheus payment model in 2006 to move from “...volume-driven healthcare to value-driven healthcare.” Prometheus is an acronym for Provider payment Reform of Outcomes, Margins, Evidence, Transparency, Hassle-reduction, Excellence, Understandability and Sustainability. The foundation is Evidence-informed Care Rates, which are casemix adjusted and calculated for acute, chronic and inpatient conditions. These existing ECRs
can potentially affect payment for half to two-thirds of healthcare spending related to an inpatient care episode. The Prometheus model aims to not only reward providers for outcomes but also to reward outcomes achieved through teamwork across disciplines. An allowance for potentially avoidable complications is built into the payment rate, creating a win-win for providers and patients when complications are avoided.

A well-known example of bundled payment is the ProvenCare program at Geisinger Health System. It bundles 90 days of hospital and physician services for specific services, including hip replacement surgery, cataract surgery, coronary artery bypass graft, percutaneous coronary intervention, bariatric surgery, lower back surgery, perinatal care and erythropoietin management. ProvenCare has attracted extensive media attention in part because of reported reductions in complication rates, mortality, readmissions, length of stay and cost.

In all these initiatives, casemix adjustment is essential. That is, episodes must be defined so that providers are paid more for sicker patients than for patients who are less medically complex. Otherwise, access to care might be jeopardized for those who need it most. At the same time, payments cannot depend on actual costs for an episode. Doing so would undermine the incentives for efficiency that generate the financial benefits of bundled care.

Implications for Medicaid

For Medicaid programs, the promise of bundled payment is obvious - lower spending that stems from providers paying more attention to cost, better clinical information about where the money goes, and greater provider accountability for positive outcomes. We see the following implications for Medicaid agencies and Medicaid managed care plans interested in bundled payment initiatives:

- **Medicare models are useful but would need adaptation.** Federal initiatives to date have been heavily focused on the Medicare population (e.g., demonstrations based on orthopedic and cardiovascular procedures). The Medicaid population is very different – not only because of the obvious importance of obstetric and pediatric patients, but also because of higher prevalence of conditions seen in young adults.

- **Recent grouper development efforts offer promise.** The recent CMS initiative to fund episode grouper development, coming on top of previous efforts by various organizations, means that we now know more about defining episodes than ever before. Although much of the focus has been on the Medicare population, extensions to Medicaid are also more possible now.

- **It’s all about acute care.** Many benefits of episode-based payment would also apply to long-term services and supports, but this area remains largely untouched. In particular, many Medicaid programs continue to pay for home and community based services using highly disaggregated approaches (e.g., per 15 minutes of service) to multiple providers even for the same beneficiary. Because Medicare is so focused on acute care – even the nursing facility and home health benefits are tied to acute care – any bundling initiatives in long-term services and supports likely will have to be developed by Medicaid itself.
• For Medicaid agencies, passing responsibility to managed care plans will not be sufficient. The opportunities for making healthcare more efficient stem from the incentives facing the clinical decision-makers. Even when a Medicaid agency passes the responsibility of paying providers to managed care plans, the agency will still face the pressure of constantly increasing costs unless the plans improve provider incentives.

• Who to pay is a major question. Regardless of whether it is the Medicaid agency or the managed care plan that seeks to broaden the use of bundled payment, a major question is who to pay. Many Medicare initiatives have assumed a single payment to cover the services of multiple providers. These providers must agree to divide both payment and clinical and operational decision-making responsibilities. When such arrangements are already in place – e.g., accountable care organizations or physician-hospital organizations – bundled payment is much easier to implement. Otherwise, settling provider questions of legal structure, liability, conditions of participation and so forth will be a time-consuming obstacle.

• The most immediate opportunity is to bundle readmissions into payment for hospital stays. Maryland, Florida, and Utah are among the states that have already measured rates of potentially preventable readmissions for populations that include Medicaid. In one analysis performed by Conduent, the rates of potentially preventable readmissions (PPRs) within 15 days were 10 percent for bipolar patients (APR-DRG 753-1) and 1 percent for cesarean delivery patients (APR-DRG 540-1). Hospitals could be put at risk for these readmissions, with payment rates increased to reflect the DRG-specific risk of PPRs. The clear incentive would be for hospitals to reduce readmissions, not only by improving their own processes but also by trying to improve patient compliance and care in the community. Because such an initiative would involve only hospital payment, it would fall short of the more ambitious goals of bundled payment. Nevertheless, it would help address a costly issue in healthcare that affects many patients.

• Systems considerations. Medicaid Management Information Systems are typically structured to calculate payment by provider type, so a bundled payment initiative would probably require a new provider type. Changes would also be necessary to logic that ensures that bundled services are not billed and paid separately.

2. Paying for Quality

Any discussion of value purchasing has to include the growing promise of pay-for-quality (P4Q) initiatives. While most ideas in this white paper focus on payment, the emphasis in P4Q is on the value side of value purchasing. But P4Q initiatives can also save money. Reducing unnecessary hospital readmissions, for example, has been described as “...one of those magical occasions in which better care can both save money and improve outcomes.”

Within the past few years, there has been growing interest in P4Q, beginning with Medicare’s early efforts on hospital quality programs. More recently, the Patient Protection and Affordable Care Act requires P4Q programs across the board for Medicare, Medicaid and accountable care organizations. The act has a number of provisions that create measurements, adjust payments, establish demonstration projects and authorize grants to states, all with the goals of improving care quality and aligning Medicare and Medicaid initiatives.
A Shift in Payer Attitudes

Payers traditionally have not seen themselves playing a role in quality. When Congress authorized Medicare and Medicaid in 1965, the first paragraph specifically prohibited any federal employee from exercising “…any supervision or control over the practice of medicine or the manner in which medical services are provided.” But the truth is that payment methods cannot be neutral in affecting quality. Even if payment methods do not quite amount to “supervision or control,” they do affect the practice of medicine. Under fee-for-service payment, for example, quality initiatives that reduce the volume of services - such as preventive care or reduced readmissions - penalize providers through lower payments. On the other hand, capitated payment to managed care plans penalizes plans for providing care, even when necessary for quality care.

Over the last 20 years, there has been growing concern about quality of care, especially at the turn of the 21st century when several reports documented serious issues. The Institute of Medicine, in To Err is Human, famously estimated that 44,000 to 98,000 hospital patients a year die from preventable errors. In 2005, the influential Medicare Payment Advisory Commission declared, “It is now time for decision makers to distinguish among providers on the basis of quality as they put policies in place to limit growth in spending.” That view has deepened in Medicare and spread to Medicaid and commercial payers. Table B shows some of the measures currently used to measure hospital care.

Dimensions of Quality

Underuse, Misuse or Overuse

A traditional categorization has been that quality problems may reflect underuse, misuse or overuse of services, with very different financial implications for providers and payers. Quality initiatives involving immunizations, mammograms, and beta blockers for heart disease are examples of efforts to address underuse. These initiatives are rarely controversial; and it helps that they increase provider revenue. In principle, payers reap savings from avoided disease, but in practice the cost is immediate while the savings may show up only years later. (Prenatal care is an exception, especially important in Medicaid.) Efforts to reduce misuse can be uncontroversial if narrowly construed; examples include surgical errors and other so-called “never events” that are, in fact, quite rare. Efforts to reduce overuse are the most controversial, because they infringe on clinical decision-making and reduce provider revenue. Examples commonly cited include many imaging scans, repeat physician and ER office visits, and surgical procedures such as tonsillectomies and hysterectomies. Note that medical services are very rarely useless always and everywhere. Much more common are situations where specific care is not useful because it does not meet the standard of “right service, right time, right way.”

Structure, Process, Outcomes

Another dimension of quality involves categorizing measurement and improvement efforts as structure, process or outcomes. (Patient satisfaction could be a fourth category) Examples of “structure” include requirements that clinical labs be accredited and that nursing facilities meet minimum nurse-to-resident staffing ratios. Examples of “process” include Medicare initiatives to measure the rate of prophylactic antibiotic therapy before surgery or the number of patients counseled about smoking. Examples
of “outcomes” include measuring surgical mortality rates and the incidence of pressure ulcers among nursing facility residents. Generally, structural aspects of quality are usually easier to measure than process aspects, which in turn are easier to measure than outcomes. To be fair to providers, measuring outcomes typically requires casemix adjustment, which can be difficult.

### How Quality Problems Arise

A third dimension involves assumptions, often implicit, about how quality problems arise. A long-standing view, especially among payers, is that quality problems reflect mistakes, often due to carelessness. The anesthesiologist pushed the wrong drug; the physician missed the diagnosis; the personal care attendant didn’t care enough to turn the patient. The result might be a “law enforcement” response, since specific incidents of bad care should be investigated and punished. A contrasting view, perhaps more prevalent among providers themselves, is that quality problems much more frequently reflect the impossibility of comprehending the totality of modern medicine and the poor processes often seen in delivering care. As neurosurgeon Guy Clifton says, quality failure stories are commonly about “good people working in bad systems.” Proponents of this second view tend to focus improvement efforts not only on eliminating quality failures but also on enabling quality successes.

### Table B

<table>
<thead>
<tr>
<th>Quality Measure</th>
<th>Source</th>
<th>Incidence of Related Quality Issues</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never events</td>
<td>National Quality Forum</td>
<td>Rare</td>
</tr>
<tr>
<td>Hospital-acquired conditions</td>
<td>Medicare</td>
<td>Rare</td>
</tr>
<tr>
<td>Patient safety indicators</td>
<td>AHRQ</td>
<td>Rare</td>
</tr>
<tr>
<td>Potentially preventable complications</td>
<td>3M</td>
<td>Common</td>
</tr>
<tr>
<td>Potentially preventable readmissions</td>
<td>Medicare</td>
<td>Common (CHF, AMI, pneumonia)</td>
</tr>
<tr>
<td>Potentially preventable readmissions</td>
<td>3M</td>
<td>Common (broad list)</td>
</tr>
<tr>
<td>Clinical process measures: inpatient</td>
<td>Medicare</td>
<td>Common</td>
</tr>
<tr>
<td>Clinical process measures: outpatient</td>
<td>Medicare</td>
<td>Common</td>
</tr>
<tr>
<td>Customer satisfaction</td>
<td>HCAHPS</td>
<td>Common</td>
</tr>
<tr>
<td>Risk-adjusted mortality</td>
<td>3M</td>
<td>Common</td>
</tr>
<tr>
<td>Ambulatory care sensitive admissions</td>
<td>AHRQ</td>
<td>Common</td>
</tr>
<tr>
<td>Potentially preventable admissions</td>
<td>3M</td>
<td>Common</td>
</tr>
<tr>
<td>Potentially preventable ER visits (EAPGs)</td>
<td>3M</td>
<td>Common</td>
</tr>
</tbody>
</table>

HCAHPS = Hospital Consumer Assessment of Healthcare Providers and Systems; CHF = congestive heart failure; AMI = acute myocardial infarction (heart attack)

Source: Conduent
State Initiatives
In Medicaid, P4Q initiatives started in managed care, with incentives to counter potential underuse of preventive care such as mammograms, pap smears and immunizations. The Rite Care program in Rhode Island was among the leaders, with similar initiatives in other states. The incentives involved process measures and were applied by the Medicaid program to the managed care plans. Providers were affected only indirectly. Outside managed care, quality initiatives were usually limited to structural measures (e.g., requiring licensure) and to investigating and penalizing specific mistakes, such as unexpected patient deaths.

That’s changing now. Maryland and New York, are both among the leading states where P4Q initiatives are both seen in the fee-for-service sector and have become more ambitious by targeting outcomes of care. In these three states, hospitals are measured based on casemix-adjusted performance on PPRs and potentially preventable complications (PPCs). As a result, Maryland saw a 12 percent drop in PPC incidence between SFY 2009 and SFY 2010, generating a reduction in hospital cost of approximately $63 million (after casemix adjustment). The 11 PPCs related to infection showed a 19 percent decrease overall, with decreases ranging from 6 percent to 28 percent, saving approximately $34 million. These states emphasize potentially preventable events, as opposed to events that are always or almost always preventable. Performance already affects payment in both New York and Maryland.

In a very separate concurrent initiative, Medicaid programs nationwide are required by CMS to deny payment for “healthcare acquired conditions” (HCACs) in hospitals, a list essentially identical to the Medicare list of hospital acquired conditions (HACs). The HAC/HCAC initiative is an example of the “law enforcement” approach to quality. Because payment is reduced for specific patients, the HAC/HCAC list had to be limited to complications that were always or almost always preventable. As a result, it does not include serious hospital-acquired infections such as pneumonia and septicemia that may or may not have been preventable. In Medicare, only 0.16 percent of over 9 million stays included a HAC. Moreover, because payment is affected only if the HAC affects the DRG assignment, payment was reduced for only 0.04 percent of stays. Conduent analysis showed similarly low incidence in the South Carolina and California Medicaid programs.

Advice for States
• Focus on measures that matter. The HAC/HCAC initiative is an example where the goal is worthy but the initiative is unlikely to have a meaningful effect. Within the hospital sector, the alternative approach of focusing on potentially preventable events would have wider applicability. The developers of the PPC approach, for example, found that potentially preventable complications added almost 10 percent to the cost of hospital care in the California and Maryland all-payer populations. For Medicaid, where long-term services and support are especially important, opportunities may exist to encourage quality improvements. Certain important outcomes, such as the incidence of pressure ulcers, are already measured for each nursing facility and posted at www.medicare.gov/nhcompare. For home and community based services, where Medicaid is the dominant payer, quality measurement remains rare.
• Use broad measures, outcome oriented, case mix adjusted, relative to a benchmark. Our view is that the traditional “law enforcement” approach has its place in pursuing specific medical errors and incompetent providers; but the alternative approach of enabling excellent care offers much more opportunity to make improvements. Doing so often requires a broad approach rather than a patient-specific approach, focusing on outcomes and accounting for differences in patient acuity. Ideally, it should lead to collaborative, rather than confrontational, relationships among the many people involved in delivering healthcare today.

• Move carefully… When Medicaid programs set out to identify high-quality and low-quality providers and adjust payments accordingly, they travel treacherous ground. Provider objections include: P4Q efforts focus on what’s handy, not what’s important; thin evidence linking payment and quality; the typically small bonus payments are disproportionate to the cost of providers achieving objectives; providers will avoid sicker patients; benchmarks based on averages aren’t appropriate for all patients; P4Q incentives reward providers for what they should already be doing; providers may be penalized for actions of other providers they don’t control; and P4Q plans lack a “business case” to save money.

In our view, these objections all have merit. But should providers do nothing if perfection is impossible? Objections to P4Q must be balanced against objections to the current world of payment, where higher quality is rarely rewarded and lower quality is often rewarded if it increases utilization.

In implementing P4Q measures, states would be wise to avoid haste, to learn lessons from other states and other payers, and to engage in genuine consultation with providers and other stakeholders.

• … but move forward nonetheless. As noted earlier, payment methods generate financial incentives that affect how, and how well, healthcare is delivered to Medicaid beneficiaries. Because these incentives cannot be neutral, we recommend that Medicaid programs explicitly attempt to identify and reward providers of high-quality care. In our view, P4Q today is roughly at the stage of development that case mix-adjusted payment was in the early 1980s. If done carefully, P4Q may have as much impact on the next 30 years of healthcare payment that case mix adjustment has had in the previous 30 years.

3. Fee Schedule Policy Review

The typical Medicaid fee schedule covers more than 15,000 distinct services provided by physicians, clinical labs, waiver providers, DME suppliers and other providers. These services are billed using approximately 9,600 CPT and 5,600 HCPCS codes. It’s almost impossible to ensure that coverage policy, provider billing, fee levels, and MMIS edits are appropriate for each one. Instead, we recommend a focused fee schedule policy review reviewing only the top 200 services ranked by total payments. When we did this for one Medicaid program, we saw that those top 200 services accounted for 95 percent of the payments in a 6-month period. We also found several problems worth fixing:

- The MMIS maximum units edit was set at 999 for some services where it should have been 1.
The most common emergency room visit code billed by physicians was Level 5 (99285), which seemed very unlikely to reflect appropriate billing.

Medicaid fees were many times higher than Medicare fees for some services, usually because the CPT/HCPCS definition of the service had changed at some point in the past and the Medicaid fee had not. For other services, the Medicaid fee exceeded the Medicare fee, which at least raised the question of whether the Medicaid fee was unnecessarily high. (Medicaid fees can be appropriately higher than Medicare fees for policy priorities such as obstetric and preventive care.)

Some services that can be split into a professional component and a technical component were always paid at the full fee – even when the physician billed only one component.

Site-of-service payment reductions were not taken even when the physician performed the service in a hospital and the hospital also billed Medicaid for the service.

Some services were paid at a percentage of charges or priced manually even though a fee could be calculated using Medicare fee levels or other benchmarks.

Some items rented for beneficiaries under the durable medical equipment fee schedule were costing Medicaid more than if the items had been purchased outright. (See also Section 5.)

Modifiers in the fee schedule were inconsistently or incorrectly applied and/or priced. We looked in the fee schedule at the most commonly billed modifiers that affect pricing such as 50 (bilateral procedure), TC (technical component), 26 (professional component), and 80 (assistant surgeon). We used the Medicare physician fee schedule as a general guide to determine whether or not a procedure code was eligible to be assigned these modifiers. We found some procedure codes with a modifier pricing record that should not have had one, some that did not have the modifier pricing record that should have had it, as well as some that had a pricing record with incorrect or inconsistent prices.

Excessive use of “miscellaneous” codes such as 97799 (unlisted physical medicine procedure) or E1399 (DME: miscellaneous).

Another potential issue – not seen in that review but now more prevalent – would be the inappropriate use of modifier 59, which is used to bill for a distinct service for which payment otherwise would not be made.

Our typical approach would be to form a working group with state staff and fiscal agent personnel, and then create an analytical dataset that combines utilization data, Medicaid fee schedule fields such as fees and maximum units, and the Medicare fee schedule used by Medicare contractors. (The Medicare fee schedule is not a gold standard for Medicaid, but differences in payment policies can bring to light issues regarding particular services.) The working group would then sort the file by total Medicaid payments and conduct a series of analyses to uncover anomalies such as those listed above. Resulting policy changes can often be made quickly to MMIS reference tables without a formal change request. The review could also be the first phase of an initiative to update and validate the fee schedule.
4. National Correct Coding Initiative

The National Correct Coding Initiative (NCCI) is a CMS program ensuring that Medicare and Medicaid pay only for services appropriately billed by physicians, other individual practitioners, ambulatory surgical centers (ASC) and hospital outpatient departments. All of these providers bill for services using the approximately 15,000 CPT and HCPCS procedure codes referred to above. Because these codesets are so disaggregated, there are numerous opportunities for providers to deliberately or inadvertently make billing errors in their favor, such as billing for a service that is inherent in another service. The NCCI does not apply to claims from hospital inpatient departments or other institutional providers.

Medicare implemented the NCCI in 1996 to ensure accurate coding and reporting of services by physicians; it has broadened in application since then. NCCI coding policies reflect coding conventions defined in the American Medical Association’s Current Procedural Terminology, national and local Medicare policies and edits, coding guidelines developed by national societies, standards of medical and surgical practice, and current coding practice.

NCCI edits apply to services for the same patient on the same day from the same provider. They comprise two types of edits: 1) NCCI edits, or procedure-to-procedure edits that define pairs of procedure codes that should not be reported together for a variety of reasons; and 2) Medically Unlikely Edits (MUEs), which define for each code the number of service units beyond which any additional units are unlikely to be correct (e.g., removing more than one gallbladder).

Currently, CMS has five methodologies for Medicare Part B. CMS has deemed each of these methodologies appropriate for use by Medicaid programs. They are:

- NCCI procedure-to-procedure edits for practitioner and ASC services.
- NCCI procedure-to-procedure edits for outpatient hospital services (including emergency department, observation, and hospital laboratory services) incorporated into the Medicare outpatient code editor (OCE) for hospitals reimbursed through the hospital outpatient prospective payment system. Note that adoption of the entire OCE is inappropriate for Medicaid, because most of the more than 70 additional OCE edits enforce coverage and payment policies that are specific to Medicare.
- MUE units-of-service edits for practitioner and ASC services.
- MUE units-of-service edits for outpatient hospital services.
- MUE units-of-service edits for supplier claims for durable medical equipment.
- The five Medicare NCCI methodologies currently contain approximately 1.3 million procedure-to-procedure and MUE units of service edits.\(^{33}\)

The NCCI edits are in the public domain.\(^{34}\) A Medicaid program can choose to implement them in the MMIS itself (usually through its fiscal agent) or to license commercial software that includes the NCCI edits as well as additional edits developed by the vendor. Either way, each Medicaid program should have edits installed for both practitioner and hospital outpatient claims, and should update the edits at least annually. Medicaid
5. Durable Medical Equipment

For a small program, DMEPOS raises more than its share of value purchasing concerns. The acronym stands for “durable medical equipment, prosthetics, orthotics and supplies” and represents just 1.3 percent of Medicaid spending nationwide. Yet DMEPOS has been the subject of many Office of Inspector General (OIG) and Government Accountability Office (GAO) investigations. These investigations focus on Medicare, but many of the problems apply to Medicaid as well. States may want to review whether their policies and practices are appropriate in several areas.

- **Supplier enrollment.** Although many DME suppliers are reputable businesses, the area has been plagued by fraud for years. The reasons appear to be that committing fraud is so easy and that suppliers often have less to lose than other provider types. Unlike hospitals, physicians and most other providers, DMEPOS suppliers do not need professional licenses, years of training, or extensive capital investments. While Medicare has made improvements to tighten enrollment standards for DME suppliers, the GAO recently pointed out the ongoing weaknesses in that process:

  “GAO’s previous work found persistent weaknesses in Medicare’s enrollment standards and procedures that increased the risk of enrolling entities intent on defrauding the program. CMS has strengthened provider enrollment. For example, in February 2011, CMS designated three levels of risk-high, moderate, and limited – with different screening procedures for categories of providers at each level. However, CMS has not completed other actions, including implementation of some relevant provisions of the Patient Protection and Affordable Care Act. Specifically, CMS has not (1) determined which providers will be required to post surety bonds to help ensure that payments made for fraudulent billing can be recovered, (2) contracted for fingerprint-based criminal background checks, (3) issued a final regulation to require additional provider disclosures of information, or, (4) established core elements for provider compliance programs.”

- **Sufficient regulatory authority.** Committing fraud can be as simple as applying for a provider number, obtaining or stealing Medicaid beneficiary and physician numbers, and then submitting claims. Abusive practices, such as providing equipment and supplies of questionable necessity, are similarly tempting. Loose regulations, written in an era when the bigger concern was enticing providers into the program, often do not give Medicaid the ability to deny enrollment to current or prospective applicants. Medicaid programs may want to check that applicable regulations on provider enrollment, medical necessity and waste, and fraud and abuse give them the authority needed to control any problems.
• **Fee schedules vs. cost-based and charge-based pricing.** In general (see Section 9), fee schedules are a safer approach to payment than reimbursements based on costs and charges, which are more easily manipulated by providers. In the DMEPOS area, where many products are specialized, it can be tempting to rely too heavily on cost-based and charge-based pricing. This can be checked by summing MMIS payments by allowed charge source code (or similar field) to see how payments are made in practice. Use of vague “miscellaneous codes” such as E1399 (DME miscellaneous) should be kept to an absolute minimum.

• **Applicability of Medicare fees.** Unfortunately, the most obvious source for a fee schedule is not always the value purchasing benchmark it could be. The OIG has issued literally dozens of analyses documenting unnecessarily high Medicare fees for items such as power wheelchairs, home oxygen equipment, hospital beds and diabetic supplies. Medicaid programs typically do not have the time and resources to do their own analysis of all DMEPOS fees. Two possible steps would be to search for any Medicaid fees that exceed Medicare fees and to examine in depth the fees for the most common DMEPOS codes.

CMS, for its part, has been trying for years to lower fees and implement competitive bidding. A demonstration project found that competitive bidding would result in Medicare payments 26 percent less than the fee schedule. Many of these efforts were effectively opposed by the industry and its lobbyists, demonstrating the lengths to which providers will go to avoid competing on price. The current Medicare competitive bidding program (CBP) recently earned tentatively positive reviews from the GAO.

“Although the first year of the CBP Round 1 rebid has been completed, it is too soon to determine its full effects on Medicare beneficiaries and DME suppliers. GAO found that, in general, the Round 1 rebid was successfully implemented. GAO also found that utilization of selected DME declined in the CBP areas; while there are many possible reasons for this, it does not necessarily indicate that beneficiaries have not had access to needed DME. GAO does not assume that all pre-CBP utilization was appropriate and the CBP may have reduced unnecessary utilization of DME. More experience with DME competitive bidding is needed, particularly to see if evidence of beneficiary access problems emerges. For that reason, it is important to continue monitoring changes in the number of suppliers serving CBP-covered beneficiaries.”

• **Rental vs. purchase.** For items such as wheelchairs and hospital beds, it’s cheaper for a payer to rent the equipment for short-term use but buy it for long-term use. The purchase points need to be set appropriately for different pieces of equipment. An OIG analysis, for example, found that Medicare was paying $7,215 on average to rent oxygen concentrators that could be bought for about $600. To search for similar problems, a state could check MMIS data for the most common paid claims showing modifier RR (rental). The analysis could be done either in conjunction with or parallel to the “fee schedule policy review” described in Section 3.

• **Prior authorization (PA).** Prior authorization is commonly required for the more expensive DMEPOS items, but ensuring its effectiveness can be a challenge. Providers are typically familiar with the buzz words that authorizers wait to hear; so few requests get denied. PA staff may also be at a disadvantage in discussing specific DMEPOS
items and HCPCS codes with providers. Checking the percentage of refusals and comparing DME claims with diagnosis information from medical claims can provide useful information on PA effectiveness. (A caveat: even if almost all PA requests are approved, the existence of the requirement may discourage providers from initiating inappropriate requests.)

6. Imaging Services

Imaging services are expensive, high-growth and increasingly powerful diagnostic tools subject to overuse. This combination of attributes should prompt payers to pay particular attention to their coverage and payment policies.

Standard imaging usually comprises x-ray and ultrasound, while advanced imaging services include computed tomography (CT), magnetic resonance imaging (MRI), and nuclear medicine modalities such as positron emission tomography (PET). Even among standard imaging modalities, technological advances have significantly improved performance. Overall, the current technology provides clarity and flexibility (for example, in rotating images in virtual 3-D) that would have been almost unimaginable two decades ago.

The Growth in Spending

In the Medicare program, the volume of imaging services per beneficiary paid grew by 81 percent between 2000 and 2010 - more than twice as fast as major procedures and evaluation and management services. In response, Medicare tightened policy, which appears to have contributed to a slowdown in growth. Nevertheless, the increase since 2000 has been remarkable. (Similar figures for Medicaid are not available, but all indications are that growth has been comparable.)

Concerns Regarding Overuse

To be sure, much of the growth reflects better technology, which in turn has benefited millions of patients. But payers, health policy analysts and even the radiology community itself have expressed concerns that overuse “...adds unjustifiable costs” and “...exposes individuals and the general population to unnecessary radiation doses.” Reasons for concern include the following:

• The pursuit of certainty. Physicians have an understandable tendency to overuse diagnostic tests. Although surgery and other treatments themselves can be overused, the decision to go forward with a procedure usually carries more disadvantages (e.g., risk and pain) than simply ordering another diagnostic scan. The provider is relieved of some diagnostic uncertainty and malpractice risk, the patient feels thoroughly evaluated, and someone else usually pays. Although appropriateness criteria are available for many imaging applications, the criteria are frequently ignored.

• Imaging economics. The owners of imaging machines - whether they are hospitals, physicians or entrepreneurs - have strong incentives to operate them as much as possible. Because advanced imaging machines are expensive to buy, payment rates are relatively high. But the incremental costs of performing another scan - the technician's salary, the cost of contrast media and so forth - are relatively low. One hospital, for
example, increased its profit by about $1,000 every time it performed a PET scan. “The more scans you do, the more money you make. If I do eight PET scans a day, that's two million dollars a year, or a 35 percent profit margin,” said the chairman of radiology. Estimates show that each new MRI scanner and CT scanner adds 733 and 2,224 scans to the Medicare population, respectively.

- **Self-referral.** Growth continues in “self-referral” imaging services, in which the physician sends a patient to receive imaging services from a device that the physician owns or leases. Proponents cite the advantages of same day service, more convenient locations for patients and more timely information to the physician. Recent studies, however, indicate that this is only partly true. Low-cost x-rays, for example, are performed the same day (74 percent of the time.) But same-day imaging for CT scans, MRIs and nuclear medicine occurred only 15 percent of the time. If the argument for increased self-referral is more timely diagnostic information, this does not appear to show up in actual care practices. Other studies have documented physicians’ tendency to order more scans when they have a financial interest in the device. Acquiring an MRI made ordering scans 22 percent more likely for orthopedic surgeons and 28 percent more likely for neurologists.

- **How fees are calculated.** Medicare RBRVS fees, which many Medicaid programs use as benchmarks, reflect an assumption that imaging machines operate 50 percent of the time (25 hours per week). In fact, a MedPAC survey found that utilization rates for CT scanners and MRI units in six markets were 73 percent and 91 percent, respectively. In addition, RBRVS assumptions about time per scan become outdated as faster machines come to market. In its March 2009 report to Congress, MedPAC recommended lowering physician payment rates for expensive imaging services to more accurately reflect how the machines are used. Similar issues may exist for Medicare hospital outpatient department fees, which also serve as a model for some Medicaid programs.

**Implications for Medicaid**

- **Prior authorization.** Because the clinical benefits may not justify the expense of advanced imaging scans, Medicaid programs may consider prior authorization requirements or, if these are already in place, review the PA program to ensure it is as effective as possible. Programs could also apply more focused approach of comparing self-referring providers with their peers. Outliers could be “locked in” to PA requirements, while other providers would face lower standards of scrutiny. This would require regular review of normal versus outlier behavior as some providers move in and out of the managed utilization preauthorization process. A Conduent account manager can provide more information about how we can help states implement effective PA processes.

- **Payment rates.** It may be possible to reduce payment rates without limiting access. With the rapid growth in availability and use of imaging scans - not to mention billboards advertising availability - it is hard to argue that these services are in short supply. Rates can be lowered either directly or by implementing multiple-procedure discounting. This way if two scans are performed on the same day the second procedure would be paid at 50 percent of the standard fee.
7. Pharmacy Pricing

Prescription drugs dispensed by community pharmacies remain a leading item in Medicaid budgets nationwide, accounting for $16 billion in spending in 2010. After a one-time reduction in spending levels when Medicare Part D was implemented in 2006, Medicaid drug spending is now projected at a fast clip in the period to 2020 (Chart C).

Chart C

Medicare and Medicaid Spending on Prescription Drug

Almost all Medicaid spending is for drug ingredients; dispensing fees to pharmacies are relatively minor. Ever since Medicaid began paying for drugs, the challenge has been how to set fees for numerous drug products. The goal has always been to find a reliable measure of actual market prices, but the goal has been elusive as pharmaceutical manufacturers seek to manipulate the measures in order to generate profits for the pharmacies that order their products. Almost all states currently pay a percentage of benchmarks known as average wholesale price (AWP) and the wholesale acquisition cost (WAC). Almost all states also have a maximum allowable cost (MAC) list. These lists vary considerably in the number of drug products covered and in how aggressively they set prices. CMS publishes a quarterly list that shows the payment method used by every Medicaid program. In the claims processing system, fee levels typically can be changed quickly, making pharmacy an attractive area from which to generate substantial savings in a short time period.

Although the AWP and WAC benchmarks have long been discredited, they are still used in the absence of better alternatives. That is changing, however. In 2011 the Office of Inspector General released a survey showing that 44 states would prefer CMS to set a national benchmark based on pharmacy acquisition costs. In 2012, CMS recognized the importance of defensible, evidence-based decision-making in prescription drug pricing and began a two-part Medicaid drug survey of retail prices. The new data will allow states to benchmark their pharmacy costs against the national average as well as against other...
payers. CMS will provide states with the National Average Retail price (NARP) as well as a National Average Drug Acquisition Cost (NADAC) pricing file. NARP can be seen as indicating revenue to a pharmacy while NADAC reflects pharmacy expenses. According to the agency, “CMS anticipates that the NADAC files will give State Medicaid agencies covered outpatient drug information regarding retail prices for prescription drugs. State Medicaid agencies will be able to use this information to evaluate their own pricing methodologies and compare payments to those derived from this survey.” In addition, CMS will compile a comparison of state drug payment rates and utilization for the 50 most widely prescribed drugs. The top 50 file will cover 70 percent to 75 percent of drug utilization.

The NADP and NADAC files are expected to be superior to existing benchmarks, and should also enable Medicaid programs to make their MAC programs more effective. If state-specific fee changes jeopardize access to prescription drugs, these issues can be addressed through targeted initiatives such as higher dispensing fees in rural areas. Enrolling mail-order pharmacies can also promote access.

8. Third-Party Liability

Third-Party Liability (TPL) is a broad term encompassing disparate activities in a Medicaid program, including identifying third parties liable for a Medicaid beneficiary's care, avoiding payment when Medicaid is not liable (“cost avoidance”), and reclaiming payments after the fact when cost avoidance was not possible. The work tends to be complex and contentious, and in some Medicaid programs it may not receive the attention and effort it deserves. Yet an effective TPL operation can save many millions of dollars while ensuring that the agency remains in compliance with federal and state law.

The following points are based on our experience in performing TPL functions for Medicaid and commercial payers. The goals are to accurately identify TPL situations, avoid claim costs up front whenever possible, and effectively reclaim payments already made when necessary. These points apply both to Medicaid agencies and to Medicaid managed care organizations (MCOs).

Managing TPL Work

Most states and MCOs rely on a single vendor to identify and reclaim all TPL claims in which commercial health insurance exists or other third parties are liable for care. Unfortunately, a single party process can give the vendor an advantage at the cost of the state. Reclaiming dollars from other parties after the fact generates checks to Medicaid that can be tallied and reported. The more effective approach for Medicaid, however, would be to avoid the claim cost up front.

Understanding TPL identification and reclamation as a multi-party process allows the State agency or MCO to focus each vendor on its core strength, substantially improving overall recovery and cost avoidance. Creating the proper multi-party process requires alignment of a vendor's incentive and the state's objectives. Recovery processes require one type of incentive, identification processes require another. Structuring, managing and optimizing this multi-party process is critical.
Identifying TPL Situations
While providers themselves often identify situations of dual eligibility for Medicaid and insurers such as BlueCross BlueShield, other TPL situations may be much harder to identify. Cases can go unrecognized, unreported, and unrecovered due to a number of potential issues including:

- **Incomplete and incorrect responses**: Letters to beneficiaries and other parties may be incomplete, incorrect, or misleading as to the injury and recoverability. An experienced TPL vendor can recognize which responses require more investigation and which begin the most activation of recoverable cases.

- **Timing of claim/case filing**: Due to the nature and timing of the beneficiary questionnaire process and filing, information may be missing or unreported. Thorough investigations can reduce or eliminate any gaps in the process.

- **Diagnosis codes**: Most beneficiary questionnaire processes are triggered by specific diagnosis codes, but these often do not encompass every type of potential recoverable injury. Multiple claims can be used to identify ongoing treatment and/or multiple visits related to possible third party liability.

- **Individual lawsuits**: TPL situations may become known only when a lawsuit is filed. Our experts can identify these potential cases as early as possible.

- **Mass tort**: Claims subject to mass tort may be recoverable with prompt and effective action. Otherwise, they may not be identified as recoverable, or the Medicaid program may not be involved in time to participate in the cases outcome.

- **MCO cases**: Tort cases contain claims recoverable by separate parties. A Medicaid agency and a Medicaid MCO may have separate, recoverable claims.

An effective identification process enables identification of potential cases over a broad range of circumstances, including motor vehicle accidents, injury on private or commercial premises, work-related injuries or medical conditions, medical malpractice, product liability, and assaults. Existing processes often count on information from Medicaid beneficiaries or their attorney, often prompted by presence of an accident-related diagnosis code on the claim. Payers may also be required to match their data with motor vehicle accident records or workers’ compensation lists.

Unfortunately, comparing Medicaid fee-for-service and Medicaid MCO tort identification rates to commercial rates implies that these standard processes are not enough. More thorough claim analysis (e.g., for ongoing treatment) and searches of court dockets and other data sources are necessary to ensure maximum identification of recoverable injuries within the Medicaid population.

Reclaiming Payments
When states must reclaim payments from other carriers, they could improve their performance by increasing provider involvement of in recovering payments from the other insurance carrier. Instead of billing the other carrier after the fact, coordination with the provider can generate a win-win in which the provider may receive better payment sooner and the Medicaid program avoids the cost and uncertainty of carrier billing.
In reclamation, a disciplined and through process is necessary to recover the most dollars. The standard process includes three reclamation billings at 90-day or 180-day intervals. Oversight of this process is essential in ensuring full recovery. Claims not immediately paid on the first billing may require additional effort or documentation to be successfully recovered. A simple step, often overlooked, is to monitor acknowledgment of receipt by the carrier.

An effective TPL recovery process must also deal efficiently with denied claims. Many denials do not negate the recoverability of the claim, but are merely process requirements of the other carrier’s payment process. Claims may be recoverable from the other carrier even if the carrier has denied the claim for reasons such as lack of authorization, presence of Medicaid-specific codes, data entry or form errors, duplicate claims, dental claims, or errors in claim form type.

9. Payment Based on Cost or Charges

Though less prevalent than in the past, Medicaid programs continue to pay many providers at a percentage of cost or charges for many services. These include hospital outpatient departments, nursing facilities, critical access hospitals, care providers for people with intellectual disabilities, adult day care centers and various other services where Medicaid is the largest or even the only payer. Such a strategy can be fiscally risky. We recommend reviewing each area of the Medicaid program where payment is based on charges or cost, and see if a better way exists.

Charge-Based Payment
Consider charge-based payment first (sometimes also called payment by report). Even today, a common Medicaid approach to hospital outpatient payment is to pay for most services at a percentage of charges, then settle at a percentage of cost after cost reports are submitted. But hospitals have been boosting charges faster than costs for years. States recoup the over-payments at cost settlement time, but in the meantime hospitals effectively receive an interest-free loan, possibly for several years.

Hospitals in most states typically have outpatient cost-to-charge ratios in the range of 30 percent. A Medicaid program that pays even 40 percent of charges would still be paying more than cost.

Payment by report may also be made to physicians, therapists, DME suppliers and other CMS-1500 billers. This approach is appropriate when fees don’t exist for rare services. The frequency of by-report payments should be similarly rare—certainly under 1 percent of payments to physicians. Excessive use of so-called CPT or HCPCS “dump codes” may mean that Medicaid is paying too much.

Cost Reimbursement
Payment at a percentage of cost removes the vulnerability to provider charge-setting practices but still means that Medicaid bears all the financial risk for provider decisions about utilization and unit costs. Cost reimbursement also depends critically on the integrity of cost reports and the auditing process. States may rely on Medicare contractors for audits, but Medicare’s interests aren’t always the same as Medicaid’s.
For example, Medicare audits only 15 percent of hospital cost reports, and it focuses on areas where Medicare uses cost reimbursement. For other provider types, Medicaid may have to hire its own auditors, sometimes at considerable expense.

Cost reimbursement inherently rewards higher cost, even though states try to blunt the incentive using caps, allowances, peer groups and other tools. Over a period of years, these efforts can result in a highly complex reimbursement system that seems quite detached from the amount and quality of care actually provided to Medicaid beneficiaries.

A better approach is for Medicaid to take control of payment by defining the unit of payment and setting rates that do not depend on an individual provider’s costs. If the unit of payment comprises a bundle of services, then the provider has an incentive to manage use. The more financial risk borne by the provider, however, the more important it is to vary payment rates according to beneficiary needs (also known as acuity or casemix). Otherwise, providers have financial incentives to over-serve less needy patients and under-serve more needy patients.

Although cost reimbursement is often an unwise approach to payment, we should note that cost data can be very useful in monitoring adequacy of payment (in combination with more direct measures of beneficiary access to quality care). The crucial distinction is whether the payment method rewards individual providers for increasing or decreasing cost. Therefore, where feasible, it makes sense to collect cost data from providers even while moving away from cost reimbursement as the way to calculate provider specific payment.

10. Medicare Crossover Claim “Lower Of” Pricing

We list this idea last but consider it worthy of the top ten because it represents a clear opportunity to reduce Medicaid payments without jeopardizing access to care for beneficiaries. As of 2012, however, we believe that most states have already implemented the idea. Those that have not done so, or who may not have done it for all applicable provider types, may well want to consider it.

The initiative refers to claims for services provided to patients eligible for Medicare and Medicaid. Typically, Medicare is the primary payer and then the Medicare coinsurance and deductible is billed to Medicaid. The dollar amounts are largest for hospital inpatient care, hospital outpatient care, nursing facilities and physicians. Medicaid programs routinely paid the full Medicare coinsurance and deductible amounts until well into the 1990s. Then the Balanced Budget Act of 1997 (§4714) specifically authorized Medicaid programs to implement alternative methods for paying crossover claims. The most common method is referred to as “lower-of” pricing or “comparison pricing” Medicaid pays the lower of two amounts:

• Medicare coinsurance and deductible
• What Medicaid would have allowed if it had been the primary payer, minus what Medicare has already paid
Additionally, Medicaid need not pay a crossover claim for a service that is not covered by Medicaid. As Table C shows, “lower of” crossover pricing always yields savings, except in the rare instance where Medicaid and Medicare pay the same amount for every service. Savings can be significant, equaling 25 percent to 50 percent of crossover payments. (A state should make its own estimate.) Yet beneficiary access is unlikely to be jeopardized, because providers view these patients as Medicare patients in deciding what services to offer. Moreover, the net impact on the provider is not a dollar-for-dollar reduction, because the shortfall from Medicaid qualifies as bad debt, for which Medicare will make partial reimbursement.58

Implementation of lower-of pricing typically requires an MMIS change order, a state plan amendment and possibly a change in state regulation. If crossover claims do not already process through the same pricing logic as claims for which Medicaid is the primary payer, then the change order could become complicated, depending on the individual state’s complexities in pricing Medicaid-primary claims.

### Table C
Example of Savings from Lower-Of Logic for Medicare Crossover Claims

<table>
<thead>
<tr>
<th>Claim</th>
<th>How Medicare Priced the Original Claim</th>
<th>How Medicaid Prices the Crossover Claim</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Medicare Allowed</td>
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</tr>
<tr>
<td>Total</td>
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<td>$3,200</td>
</tr>
</tbody>
</table>

Notes:
1. Under traditional Medicaid pricing of crossover claims, Medicaid pays the full Medicare patient liability, that is, $200. Under “lower of” pricing, Medicaid pays the lower of the Medicare patient liability and the difference between what the Medicaid allowed amount would have been if Medicaid were the primary payer and what Medicare has already paid. For clarity, the table assumes that the Medicare figures are the same on each claim but that the Medicaid allowed amount differs for the services on the four claims.
2. On claims 3 and 4, where Medicaid did not pay the full Medicare coinsurance and deductible, Medicare will reimburse the provider for part of the difference as bad debt.

### Readings/Resources on Value Purchasing
#### Articles and Books
(* indicates Conduent author)

- Rick Mayes and Robert A. Berenson, Medicare Prospective Payment and the Shaping of U.S. Health Care, (Baltimore, Maryland; John Hopkins University Press, 2006).
Kevin Quinn*, “New Directions in Medicaid Payment for Hospital Care,” *Health Affairs*, January/February 2008; 27(1):269-280


**Internet Resources**

- Information on requirements relating to Medicaid payment methods can be found at www.cms.gov/medicaid rdf/

Kaiser Commission on Medicaid and the Uninsured (KCMU): www.kff.org
- Excellent overall web resource on Medicaid.

Medicaid Statistical Information System (MSIS): msis.cms.hhs.gov
- Enables skilled analysts to do on-line queries using a data mart of Medicaid information, including payments, by state

Center for Health Care Strategies (CHCS): www.chcs.org
- Information on Medicaid payment reform and many other topics

- HCUPnet (hcupnet.ahrq.gov) is an on-line tool that enables users to query nationwide data on inpatient stays and emergency room visits. Queries can be focused on “Medicaid” as the expected primary payer.

Payment Method Development group at Conduent: www.conduent.com/medicaid
- Articles and backgrounder on a wide variety of Medicaid payment topics

• Information is focused on Medicare, with many good discussions of Medicare payment policy
• MedPAC also publishes a series of documents called “Payment Basics” with Medicare payment method details for various types of providers, such as hospital, ambulatory surgical center, durable medical equipment and others.

• Includes educational videos on Medicaid payment methods and health care coding for Medicaid managers

• This recently established commission analyzes Medicaid payment and access issues for Congress

• Reports are issued by the Office of Audit Services and the Office of Evaluation and Inspections. Reports may address Medicaid issues or, alternatively, may address Medicare payment issues that are relevant to Medicaid.

• Issues many reports on health issues, including some directly relevant to Medicaid payment

Notes
10. www.geisinger.org/provencare/media.html
18. Maryland Health Services Cost Review Commissioners, Maryland Hospital Acquired Conditions (MHAC) Trends and Data Analysis for FY 2010 and FY2009, memo from Sule Calkioglu to HSCRC Commissioners, January 26, 2011.
19. CMS, Medicare Program; Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and the Long-Term Care Hospital Prospective Payment System Changes and FY2011 Rates, final rule, Federal Register 75:157 (Aug. 16, 2010), p. 50080-50101.
32. CMS, State Medicaid Director’s Letter, September 1, 2010. SMD # 10-017 ACA: 7.


49. Conduent analysis of the National Health Expenditure Accounts.


52. In addition to analyses cited in the previous endnotes, see:


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