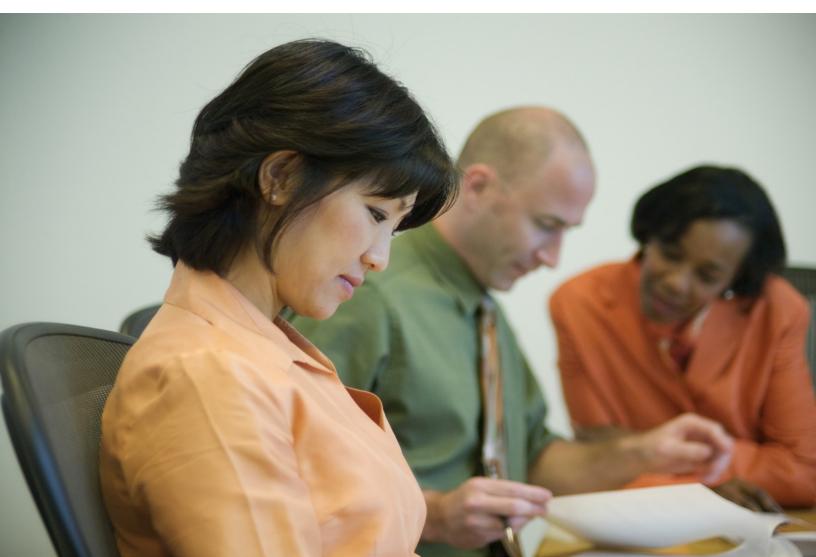# Eight Ways to Reduce State Healthcare Costs

Solutions producing results within the first year of use.

Eight Programs States Can Implement to Save Money within the first Year of Use

Medicaid programs nationwide face many new challenges. Burgeoning Medicaid enrollment and revenue shortfalls (and the resulting budget cuts) have placed a significant burden on the states' ability to support their existing programs. The passage of the American Recovery and Reinvestment Act of 2009 has stretched Medicaid capabilities and resources even further. The Health Information Technology for Economic and Clinical Health Act subsection requires new initiatives such as adopting Electronic Health Records and Health Information Exchanges to share healthcare information more efficiently. It has also required alignment with EHR "meaningful use" standards in order to receive additional federal funding.

More recent legislation has stretched Medicaid budgets even further. The Patient Protection and Affordable Care Act required states to implement Health Insurance Exchanges that enable members to review providers and purchase insurance policies. It also extended Medicaid coverage to children of Medicaid members up to age 26, provided a $250 rebate for each senior to close the Medicare Prescription Drug "donut hole" in coverage, and expanded program eligibility to include all people and families with incomes up to 133 percent of the poverty level. The enhanced FMAP offsetting most the cost of these initiatives ends June 30, 2011 – making each state bear a greater percentage of its healthcare costs.

As costs increase and enhanced funding decreases, states are looking for ways to trim Medicaid budgets. These methods range from implementing modern, more efficient Medicaid Management Information Systems to limiting or eliminating services not federally required to reducing payments to or raising taxes on providers. But the legislative process needed to implement these program changes consumes valuable time.

The bottom line? States need help and they need help now.

The good news is you don't have to wait for a next-generation MMIS to take advantage of quality improvement, and cost and savings initiatives. A full range of technology solutions and processes can be implemented prior to implementing a new MMIS – some of which can be up and running in only 30 days. These solutions leverage the data in your current MMIS to bring financial benefits in the first year of use, provide higher quality care, and prepare states for changes to come.

What does this mean for your program? Electronic Health Records and Health Information Exchanges are now considered part of approved Medicaid systems – qualifying them for 90 percent matching grants for enhancing or replacing outdated systems. What's more, the recent final CMS rule on MMIS and Eligibility extends the qualification to the design, development and implementation of eligibility determination, enrollment and eligibility reporting activities as well as Health Insurance Exchanges. This qualifies eligibility systems integrated with the MMIS for enhanced matching funds through December 31, 2015, giving your healthcare program additional resources for improvements.

Automated Prior Authorization programs reduce administrative burdens associated with PA while allowing more drug therapies or other services to be authorized. This promotes preferred prescribing practices, reduces your members' time spent waiting for pre-approval and lowers your pharmacy program's total drug spend.

Funding sources and readily available solutions may not be the total cure for every issue facing a state's Medicaid programs. But they can be leveraged to bring stability to Medicaid programs, improve care quality – and prepare states for a healthier financial future.

While there are many more great ideas out there, you can launch any of the following eight initiatives to control your programs. Many can be self-funding; based on a contingency pricing framework, you can implement them at no cost to your state with vendor's costs recouped as a percentage of the savings. Additional savings accruing to your state can be used to curb further program cutbacks, fund additional services or expand existing programs. What's more, each can be implemented relatively quickly; and each works swiftly to show measurable financial returns in the first year after implementation.

1. Implement an Automated Prior Authorization Program

Conduent™ SmartPA Pharmacy Application and Conduent SmartPA Medical Application are solutions that automate drug and medical prior authorization. They reduce administrative burdens associated with PA while allowing more drug therapies or other services to be authorized. This promotes preferred prescribing practices, reduces your members' time spent waiting for pre-approval, and lowers your pharmacy program's total drug spend.

These solutions apply a sophisticated set of clinical analytics tools to eliminate the need for human interaction on pre-approved drugs, speeding fulfillment and reserving costly human authorization for exceptions to pre-established rules. They not only reduce administrative costs; they also change your providers' behavior, training them not to prescribe drugs that won't be accepted. The solutions have been in use since 2002 and are currently used in more than 10 states.

Using SmartPA Pharmacy, the state of Florida has reduced the average wait time for most drug approval from two weeks to mere seconds. This same solution helped the state of Missouri reduce the cost of its Medicaid prescription drug program by 9 percent, generating a savings of $280 million over four years. An independent study conducted by the College of Pharmacy at the University of Texas, based on one year of data, indicated that Texas' use of SmartPA Pharmacy saved an estimated $57 million a year. These are only some of the solution's success stories.

Although the solution was originally used for pharmacy PA, the same technology has been applied to medical pre-approvals for additional cost savings. For example, the state of Missouri added online pre-certification of imaging procedures (CT and MRI edits) in 2006, and then added similar programs for Durable Medical Equipment and optical in 2009. These efforts saved $4.4 million in one quarter. In 2010, we partnered with MedSolutions to expand the initiative into a full-fledged radiology program involving advanced imaging and ultrasound, adding further efficiencies.

2. Add a Therapeutic Consultation Program

A therapeutic consultation program, including Drug Utilization Reviews and disease management programs, reduces costs by improving outcomes for patients with chronic conditions. It ensures those patients take their prescribed medications correctly and makes sure unnecessary medications are not being prescribed. Ultimately, this oversight works to reduce doctor and hospital visits caused by adverse drug interactions, skipped doses or ineffective prescriptions.

The solution uses drug claims history to identify patients who are not complying with established treatment guidelines. A therapeutic consultation program also reaches out to prescribers and pharmacists through educational campaigns, either in writing, in person or on the phone, to help them become more effective parts of the consultative process.

In addition to monitoring the patient, program facilitators also work with prescribers to bring their practice patterns in line with clinically based program standards (for example, discouraging them from prescribing antibiotics for viral infections). And by emphasizing the importance of providing clinically sound, cost-effective care, educational interventions encourage prescribers to comply with your established guidelines.

Therapeutic consultations combined with our DUR programs can produce significant results. On average, we can save state Medicaid programs $13 per member per month – $445,158 per intervention every year. We conduct an average of six prescriber interventions every year in several states, ranging from widely distributed clinical education letters to individual prescriber visits. This targeted approach reaches 3,000 prescribers per intervention, affecting the prescriptions of more than 10.5 million patients.

One client implemented a disease management program focused on patients with chronic conditions, especially those at high risk for adverse outcomes. Using an automated severity and risk assessment, we stratified fee-for-service Medicaid patients with a history of targeted diseases, including asthma, depression, diabetes and heart failure. Those identified as medium or high-risk were invited to enroll via mail, and to select a physician and pharmacist disease management team. These trained teams provided face-to-face, patient-focused consultations on prevention and self-management principles, and were reimbursed for providing these services.

The results were significant. Program participants had fewer emergency room visits, emergency transportation usages and 62 percent fewer hospitalizations, as compared to a controlled group of non-participants. The actual savings was $305 per targeted patient per month.

Another example comes from the state of Texas, which worked with us to implement a therapeutic consultation program to promote dose optimization, reduce the overuse of opiates and prevent duplicate drug therapy. Since 2000, this DUR and intervention effort has resulted in more than $45 million in savings.

EHRs and HIEs improve data accessibility and reduce medical errors, facilitating lower costs and higher quality patient-centered care.

3. Transition to Electronic Health Records and Health Information Exchange with e-Prescribing

Electronic Health Records and Health Information Exchanges with e-Prescribing reduce costs while improving the quality of patient care. EHRs are comprehensive health records that include data on medical procedures, diagnoses, lab results and vaccinations – providing a total electronic view of a patient's medical life. The HIE is the framework that enables the exchange of EHRs between all healthcare stakeholders to provide information that can be used at the point of care. EHR and HIE systems not only improve data accessibility and reduce medical errors; they facilitate lower cost, higher quality patient-centered care.

When you implement e-Prescribing, you can increase both efficiencies and patient satisfaction. Instead of handing patients a piece of paper which can be lost, misread or stolen, prescribers send accurate, error-free and understandable electronic prescriptions directly from the point of care to the pharmacy. Prescribers use the HIE to review medications quickly and determine if they meet preapproval criteria while developing a prescription. At the same time, both physicians and pharmacists automatically receive alerts of any potential adverse drug interactions.

This combination of solutions can be implemented in 12 months to 18 months and is already bringing fast returns to states nationwide. For example, the state of Missouri attributes $280 million in savings over four years to its eHealth solutions. And of the 3,500 physician practices enrolled in Missouri's Medicaid program that are trained on the system, 67 percent are using it on a regular basis.

4. Simplify Administration of Home- and Community-Based Services

Institutional care is typically the largest part of a Medicaid agency's long-term care budget. But you can save as much as 70 percent to 80 percent of these costs per participant each year by diverting them from institutions through the implementation of Home- and Community-based Service programs – and provide participants the opportunity to get better in the comfort of their own homes.

Many states find that the most effective way to manage community care and reduce costs involves turning program administration over to a trusted partner. This strategy enables them to automate service plan development and streamline credentialing and payment processing, all of which reduces cost. Just as important, participants gain independence and improved quality of life while receiving the same quality of care at home as they would in a long-term care facility.

For example, one state's program involved 20,000 in-home assessments, and was nearly impossible to manage on a timely manner with the resources in place. So, it contracted with Conduent to process these requests for service. We performed the necessary screenings, gathered and recorded data, and ultimately submitted detailed plans of care to the state for approval. We have continued to work with the state since 2004, and the results have shown not only that participants receive a higher level of care, but also the state now saves an estimated $90 million annually – more than $10,000 per person – for every member diverted.

Credit balance audits review financial and billing statements to identify overpayments, but also collect erroneously paid funds on behalf of the agency. Pharmacy audits look for trends like refill-too-soon, potential incorrectly billed quantities and unusual behaviors in pharmacy claims.

5. Conduct a Hospital On-Site Credit Balance Audit

Due to overpayments hospitals nationwide owe hundreds of millions of dollars in credit balances to Medicaid. And millions more are received every day, often going undetected by state Medicaid agencies. Although duplicate payments create a credit balance on the providers' records, reimbursements are often slow in coming – if they come at all, stretching already limited Medicaid budgets and making it more difficult to serve recipients. However, staffing and technology constraints continue to impede recovery efforts. Why? Credit balance audits involve reviewing provider accounts receivable and billing records, so they must be conducted at onsite at hospitals. Few agencies have the extra resources for an effort this large.

To combat the problem, we provide complete, on-site credit balance audits. Our trained professionals not only review financial and billing statements to identify overpayments, but also collect erroneously paid funds on behalf of the agency. And our solution handles every step of the process, including provider inquiries and appeals, so little to no state resources are needed.

This audit can be used in conjunction with our Credit Balance Analysis System, a web-based solution that enables hospitals to credit balances and reimburse State Medicaid program themselves, instead of waiting for another audit to occur. This tool strengthens provider relations while speeding voluntary recoveries without vendor intervention.

Our onsite credit balance audits have already provided great results in several states. For example, we have recovered $66 million for Texas Medicaid since 2008. And in Florida, we have recovered $9.9 million in Medicaid overpayments since 2009 – $7.8 million of which we recovered in 2010 alone. Although recovery amounts vary by state, these audits, in combination with CBAS, typically recover an average of one dollar per Medicaid recipient annually. Just as important, we can implement this combined solution in 30 days to 45 days, making these audits an ideal way to supplement a cash-strapped Medicaid agency.

6. Take a Look Back at Pharmacy Claims

Pharmacy audits are also effective in uncovering "found" money. They look for trends like refill-too-soon or potential incorrectly billed quantities. (Billing 10 blister packs of 10 pills as 100 units instead of 10 units would be an example.) Typically, these audits involve up to 12 months of claims data for each audited pharmacy.

These audits can also identify unusual behaviors. In one case, our auditors noticed a pharmacy's jump from $5,000 to $30,000 in claims in one month. Further examination attributed nearly all of this increase to one specific drug – with a prescription history more than 60 percent higher than the plan average. In this case, the pharmacy owner was charged with fraud. Other cases could be mistakes; but all are costly to programs already operating on lean budgets.

Regular auditing of pharmacy claims has identified hundreds of millions of dollars – on average, 2 percent to 6 percent of claim payments for our state clients – in non-compliance, error and fraud already, and can be completed in a matter of months.

What's more, this practice is not just a one-time fix. Comprehensive pharmacy audits act as a deterrent, generating future savings. The act of auditing creates a sentinel effect in the medical community, actively discouraging any fraud, waste and abuse within your provider network.

7. Review and Update Provider Payment Methods

When looking for ways to reduce the cost of care, it's also a good idea to look at ways to increase the value of your program's regular expenditures. By examining your provider payment methods, you can uncover previously overlooked cost saving opportunities. Even if you have an efficient payment process, the underlying pricing assumptions may be out-of-date and/or inflated, causing you to pay more than you should for services. If your program is paying more than it needs to, then those payments can be cut and the savings redirected to other priorities.

You can start by reviewing how you pay and determine if you are paying for extra or unnecessary services. For example, major savings can be found with "dual eligible" members covered by both Medicare and Medicaid. By confirming prior Medicare coverage before making payments, you can prevent your Medicaid program from being the primary payer for many services and reduce total reimbursements. For example, Washington, DC's Medicaid program reviewed its payments and recouped $4.9 million from claims where Medicare should have been the primary payer.

You can find additional crossover claims savings with a "lower of" payment method. In this plan, Medicaid pays either the Medicare coinsurance and deductible or the difference between the Medicare payment and what Medicaid would have paid if it had been the primary payer – whichever is lower. Automatically paying the lesser amount reduces aggregate Medicaid payments over time. The savings can be significant, equaling 25 percent to 50 percent of crossover payments.

Incorrect information in your program's fee schedules can lead to incorrect, inappropriate or excessive services. The typical Medicaid fee schedule covers more than 10,000 distinct services, which opens up many risks for overpayments: a service's definition may have changed, but the pricing did not; unit edits may be set too high; split professional and technical components of a service may be paid in full even when only one was billed; and continuing to rent DME for more that it would cost to purchase. Examining your fee schedules regularly – especially for the top 200 services ranked by payment – can ensure their accuracy and prevent overpayments. One example comes from verifying that site-of-service payment reductions are taken for all services at provider-based clinics. Medicare's national fee for a mid-level office visit is $44.72 when provided in a hospital. It jumps to $61.31 if the service is provided outside a hospital – a 37 percent increase. In another case, An OIG analysis found that a Medicare program was paying an average of $7,215 to rent oxygen concentrators that could have been purchased for about $600.

8. Initiate a Total Population Care Management Program

On average, the cost of care consumes more than 95 percent of a government healthcare agency's budget, with 5 percent or less going toward program administration.

Evidence-based guidelines, predictive modeling, patient/provider profiling, reporting, risk stratification, and data-driven management solutions can improve healthcare delivery and quality, while promoting medical best practices and reducing costs.

With so few management resources, it's important that what's available is used to the greatest possible extent to run your program effectively. By implementing an integrated total population care management program, you can enable better health outcomes, improve quality and significantly reduce the cost of care.

This solution uses clinical expertise and a portfolio of tools that can include evidence-based guidelines, predictive modeling, patient/provider profiling, reporting, risk stratification, and data-driven management solutions to improve healthcare delivery and quality, while promoting medical best practices and reducing costs.

The continuum of care requirements for total population has recently expanded from acute care alone to include post-acute care. In the post-acute environment, many patients require medical care in order to recover lost function. They may be frail, disabled or incapacitated as a result of injury and/or illnesses such as pneumonia, stroke or a fracture. Our focus on post-acute care utilization management has allowed us to establish leading-edge, evidence-based technology and analytical capabilities for assessing patients, identifying the correct care setting, establishing the intensity and duration of care and projecting the expected outcome.

As a result, we have had a positive impact on reducing skilled nursing facility utilization with a California-based healthcare program for more than 10 years. We have reduced its SNF days per 1,000 to a level 50 percent below the national average. Our solutions have also reduced costs by as much as 30 percent, decreased lengths of stay an average of two days to five days per injury or illness admission, and reduced inappropriate admissions by as much as 50 percent. Since becoming involved, we've delivered annual savings of $8 million and a consistent ROI of between 200 percent to 300 percent – all while improving the program's overall quality care.

In addition, we have developed other cost and utilization management programs that make a significant, positive impact on patient and payer alike. For example, we're working with the State of Missouri to transition inpatient certifications to an automated web tool. In the first seven months since July 2010, we successfully moved 60 percent of the certifications – 16,000 total – online. Without this automation, the program's administrative expenses would have cost an additional $157,000. As more healthcare providers adopt this solution, certification volumes increase. And as more steps become automated, the avoided cost of manual clinical review will continue to grow.

For the more complex cases requiring manual clinical review, we've helped Missouri avoid an average of $479,000 per month in payments based on denied and negotiated service days through the utilization management process.

In other states, we've implemented automated solutions to process medical service authorizations for non-pharmacy services. This has reduced administrative burdens and their associated costs by automating up to 76 percent of radiology requests and 73 percent of durable medical equipment requests.

Gaining the Funding, Reaping the Rewards

Medicaid continues its transformation, with greatly expanding eligibility and capabilities that will reduce costs and take healthcare into a new era. But waiting for these changes to happen will not deliver the cost savings your program needs. The time to take action, reduce waste and conserve much-needed resources is now.

Technology is available today to improve patient care and rapidly bring states the much-needed cost savings and recouped funds to survive a growing budgetary crisis. At the same time, they can lay the foundation for the technological transformation to come with minimal – if any – capital outlay. The funding for these projects is readily available; states currently taking advantage of it are already reaping the benefits.

Conduent is a proven leader in the healthcare space, with a full range of comprehensive solutions to help your program save money, improve efficiency and deliver a higher standard of patient care. We can help your program make immediate changes to take advantage of new funding opportunities. And as healthcare reform progresses, we help your program transition to and manage new processes. For decades, we've built new processes into MMIS programs. You can use this experience to adopt healthcare reform requirements such as Health Insurance Exchanges and other eligibility and enrollment programs. We integrate them all within your MMIS, increasing your program's efficiencies. You reap the rewards by making the most of your available funding.

When it comes to healthcare, time is always of the essence. We've just given you some good reasons why. And with our solutions, your resources go where they're needed most, with fewer dollars spend on administration and more invested in recipient healthcare. We help you navigate the complexities of healthcare by staying focused on what matters: delivering the right care to the right people, in the right setting, at the right cost.

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