

MEDICAID COST CONTAINMENT: REPORT NO. 2

Prepared for:
The Washington State Legislature

Prepared by:
The Lewin Group, Inc.

December 2002

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I. EXECUTIVE SUMMARY

Today, many states, including Washington, are experiencing serious financial constraints due to declining state revenue and increasing state expenditures. States are seeking options for reducing expenditures and gaining efficiencies in order to meet the increasing financial pressure they are facing.

As one of its efforts to contain costs, the State of Washington established the Medicaid Utilization and Cost Containment Initiative (UCCI), which is designed to find efficiencies and lower expenditures in the State's Medicaid program, without reducing benefits or eligibility. In addition to UCCI, the State is exploring other avenues for potential savings in its Medicaid program. The Washington State Legislature, in conjunction with the Governor's Office of Financial Management (OFM), commissioned The Lewin Group (Lewin) to complete three reports to assist the State in gauging the effectiveness of its Medicaid cost containment efforts, and to identify new areas of potential savings.

This is the second of the three reports. The first report inventoried the cost containment initiatives currently underway in the State's Medicaid program, both within and outside of UCCI. This second report has three purposes. First, it evaluates the cost savings generated by the State under UCCI and provides issues for consideration as the State implements other cost containment initiatives. Secondly, the report identifies cost containment strategies that either slowed or stalled before implementation. Understanding the barriers that hindered these cost containment strategies will inform the topics in the third report, which will explore additional areas of potential cost containment (and non-tax revenue generation) for Washington. Third, the report reviews the assumptions and methodologies in other Medicaid initiatives, such as disease management.

Throughout the development of this report, MAA staff provided valuable insight into the intricacies of their program and the resulting nuances that can affect savings calculations. For most UCCI activities, the information provided to us by MAA allowed us to create independent cost savings estimates associated with the implementation of UCCI. In other cases, the detail required to make more precise and independent estimates of the increase in cost savings due to UCCI was not available.

As a result, we have developed a range of cost recoveries and cost avoidance that can be attributed to UCCI. We estimate that between \$25.4 million to \$30.2 million in cost avoidance and recovery is attributable to UCCI (exclusive of additional administrative expenses associated with UCCI.) This is a substantial victory for the taxpayers of Washington State.

Moreover, we have found that the Medical Assistance Administration (MAA) has been very careful in establishing methodologies to measure cost savings under UCCI, although the exact rigor varies across initiatives. Each UCCI initiative that measures savings appears to adhere closely to its established methodologies. Using these established methodologies promotes consistency in results over time. Although each program measured savings consistently given its particular methodology, we did find inconsistencies across the initiatives, which may lead to an overstatement of savings. In such cases, we provided our suggestions for establishing more consistent methodologies.

For most cost containment activities under UCCI, we evaluated the approach MAA took in calculating its cost savings estimates. In some cases, we agreed with the approach and found no methodological reason to change MAA's savings estimate. In cases where we believe that an alternative methodology is more appropriate, we conducted an independent analysis of cost savings.

Many Medicaid programs have undertaken a variety of cost containment initiatives in recent years. Not many, however, have worked as diligently as Washington to carefully measure the success of these initiatives. We recognize the difficulties the State faces as it attempts to measure its achieved savings, and we would like to commend the Legislature, OFM and MAA for undertaking such a methodical and rigorous approach to measuring the results of its cost containment initiatives under UCCI. The State should also be recognized for understanding the importance of measuring the effects of all of its cost containment initiatives. Without this level of analysis, it is difficult to understand whether these kinds of changes truly have an effect on overall costs.

II. INTRODUCTION

This report provides an analysis of Medicaid cost containment initiatives undertaken by the State of Washington's MAA, as well as an overview of some strategies MAA has not been able to implement in its cost containment efforts. It is the second of three reports Lewin will produce for the Washington Legislature and OFM.

The report is divided into three chapters:

Chapter 3 - An analysis of recent cost containment activities and the resulting cost savings;

Chapter 4 - A debriefing of cost containment activities that stalled before implementation; and

Chapter 5 - An assessment of savings assumptions for certain other cost containment activities.

Immediately following this introduction is Chapter 3, which provides a quantitative analysis of the savings that have resulted from several cost containment initiatives, concentrating most heavily on UCCI-specific activities. MAA already calculated savings estimates for these UCCI initiatives. The Lewin Group reviewed these analyses and in this report we will comment on the methodology employed and the results of the analyses. In addition, where appropriate, we modified the methodology or performed an alternative analysis to establish our own savings estimates. In some cases, MAA has not projected savings amounts, and we will provide original estimates.

In Chapter 4 of this report, we provide an inventory and analysis of cost containment initiatives that stalled before implementation. This analysis will help to inform the topics for the third report in this series, which will review successful cost containment initiatives in other states and project the potential savings Washington may realize with the implementation of these types of initiatives. The lessons learned from the stalled attempts will provide a deeper understanding of the environment in Washington and will strengthen our recommendations for future activities.

Chapter 5 of this report provides a review of some key assumptions underlying potential savings from cost containment initiatives MAA has undertaken recently or may be undertaking in the near future that are not directly incorporated in the UCCI project.

While this report provides an analysis of many of the cost containment activities currently underway in MAA, it is not an all-inclusive list. In some cases, the activity's anticipated savings were small and did not warrant the level of analysis afforded to other measures detailed in this report. In other cases, the nature of the cost containment activity would more naturally lend the topic to inclusion in the third report of this series. In the cases where cost containment activities are still in the design phase, and have not yet been implemented, we did not perform a savings analysis.

Each chapter in the report contains several sections. Each section contains our analysis of the cost containment strategy under consideration, including an overview of the methodology we undertook to evaluate each strategy. We identified these strategies through discussions with MAA and other Department of Social and Health Services (DSHS) staff, as well as from feedback we received from legislative and OFM staff. We gathered information from an on-site

visit to Olympia in September, as well as from many follow-up phone conversations since that time.

Various MAA and other DSHS staff provided much of the data we used to perform our analyses. We would like to thank the many people in Washington who provided these data in a timely and efficient manner. We recognize that the staff providing the data have many duties and competing priorities. We appreciate the extent to which they were able to accommodate our requests, especially given the aggressive timelines associated with this project.

III. ANALYSIS OF RECENT COST CONTAINMENT ACTIVITIES AND THE RESULTING SAVINGS

Many of the cost containment strategies analyzed in this chapter are part of MAA's UCCI program. UCCI was created by the Washington Legislature in the 2001-2003 biennial budget process. The Legislature provided additional staff and resources to MAA in order to "understand, manage, and control medical assistance expenditure growth."¹ Part of the mandate for this initiative requires that MAA establish semi-annual savings goals and report its progress in meeting these goals to the Legislature every six months. This chapter provides an independent analysis of the savings estimates generated for State Fiscal Year (SFY) 2002, as well as methodological issues MAA may want to consider as it calculates savings estimates in the future.

The savings estimates calculated by MAA as part of the UCCI program are comprised of two kinds of savings: cost recoveries and cost avoidance. Cost recoveries are funds that have been recouped by MAA for various reasons. For example, MAA may recoup funds because it overpaid a provider or because a third party (e.g., private insurance) has responsibility for all or part of a claim that MAA already paid. Typically, the cost recoveries accounted for in UCCI represent actual dollars collected. To attribute these recoveries to UCCI, the funds must be recovered *because of* UCCI: i.e., over and above the baseline recoveries that would have occurred had UCCI not been launched.

Cost avoidance is calculated by determining future costs that MAA is projected to avoid incurring as a result of actions undertaken through UCCI. For example, if MAA changes its payment rate for a particular service as a result of analysis conducted under UCCI, MAA's methodology is to take credit for cost avoidance for a 12-month period after the rate change to account for costs the State would not incur as a result of paying a lower reimbursement rate.

For most of the UCCI initiatives discussed in this chapter, MAA has established a specific methodology for counting cost avoidance and recoveries, tailored to the nature of the program in which the initiative took place. Overall, we found that MAA staff who calculated UCCI savings adhered very closely to their pre-established methodologies. This consistency in the application of the methodology over time, in a given initiative, contributes to a more accurate accounting of the actual savings.

We did find, however, some inconsistencies across the various UCCI initiatives. For example, in some cases, estimated rather than actual recoveries were booked. For those cases where the established methodology did not appear to be consistent with the overall UCCI approach, we indicated our proposed methodological changes in the appropriate sections of this chapter. The variations in approaches are described in Table 1.

¹ From the State of Washington's 2001-2003 Biennial Budget Notes, which can be found at <http://leap.leg.wa.gov/leap/budget/lbns/2001dshs.pdf>.

Table 1. Variations Across Programs in Recognition of Cost Recoveries

Service	Cost Recoveries Booked	
	When Identified	When Received
Coordination of Benefits		X
Hospital Audits	X ²	X
Independent Practitioner Audits	X ²	X
Quality Review Services	X ³	X
Pharmacy Quality Review		X ⁴
DME/non-DME Quality Review		X

Each UCCI activity that claimed cost avoidance savings booked cost avoidance for a 12-month period after the point of intervention. We commend MAA for establishing a consistent time period for which to book cost avoidance; the consistency allows for an “apples-to-apples” comparison across initiatives. However, we want to note that accounting for cost avoidance is by no means an exact science. While choosing a consistent time period is important, the length of time for which cost avoidance is counted can be somewhat arbitrary. Moreover, choosing to book cost avoidance for 6 months or 24 months is not more or less methodologically sound than 12 months.

In order to evaluate savings estimates under UCCI, we chose to adopt UCCI’s 12-month cost avoidance methodology to allow for consistent comparisons with the original UCCI estimates. In some cases, we did not have an estimate from MAA of UCCI savings, but we continued to assume savings for the 12-month period. For some of the cost saving measures undertaken by MAA, it is difficult to establish an exact savings amount attributable to UCCI. Most of the difficulty arose from the inability to collect the needed data within the time period and scope allowed by this project. Table 2 outlines the results of our estimates for SFY 2002 versus the most recent SFY 2002 UCCI estimates provided to us by MAA.

² Cost avoidance is booked as the amount identified in the audit report. Once the actual recovery is made, cost avoidance is negated and the actual amount recovered is booked under cost recovery.

³ For different activities within QRS, cost recoveries are booked either when identified or when received.

⁴ Pharmacy QRS identifies an amount to be recovered and then adjusts the provider’s payment the next month. Recoveries are book in the month the payment adjustment is made.

Table 2. Estimates of the Difference in Savings Attributable to UCCI (in millions)

Item	UCCI Estimate	Lewin Estimate	Difference
Rate Change for Schedule II Drugs	\$0.63	\$0.55	(\$0.08)
Alternative Payers – Veterans Administration	\$0.12	\$0.11	(\$0.01)
Coordination of Benefits ⁵	\$27.90	\$16.84 - \$21.67	(\$6.23) - (\$11.06)
Hospital Audits	\$4.01	\$3.09 ⁶	(\$0.92)
Medical/Independent Practitioner Audits	\$5.16	\$2.78 ⁶	(\$2.39)
Durable Medical Equipment/Non-Durable Medical Equipment Quality Reviews	\$1.04	\$0.38	(\$0.66)
Pierce County Brokerage Model	\$1.03	\$1.30	\$0.27
Unique Transport Program	\$0.33	\$0.33	\$0.00
Total ⁷	\$40.22	\$25.38 - \$30.21	(10.01) - (\$14.84)

Table 2 does not list all of the UCCI initiatives; therefore the total savings in these tables cannot be compared to the semi-annual UCCI reports to the Legislature. There are several initiatives for which UCCI estimates were not available or did not fall within SFY 2002. The following list provides an overview of the items not included in Table 2.

- **Pharmacy Initiatives** – Due to constraints in the timeliness of data, the pharmacy initiatives, such as Therapeutic Consultation Services (TCS), are not included in this report. The pharmacy analyses will be added later.
- **Increased Monitoring of Interpreter Services** – This initiative was not included as part of this report. We did not include this item because its anticipated savings were quite small. In addition, this program will no longer be in place once the brokerage model is implemented in January 2003.
- **Change in Kidney Dialysis Rates** – The change in kidney dialysis rates was effective September 2002, after the end of SFY 2002. However, we have provided a cost estimate in Section A below.
- **Change in Maximum Allowable Fees for Injectable Drugs** – MAA did not include a cost estimate for injectable drugs in its most recent UCCI report. However, we received a cost savings analysis from MAA on November 21, 2002. We have commented on that analysis in Section A below.
- **Take Charge/Family Planning Waiver** – We provided an overview of the issues MAA should consider when calculating the savings and costs resulting from this program. The Division of Research and Data Analysis within the DSHS will be conducting a formal

⁵ With COB, Lewin agrees with the UCCI estimate regarding the level of savings that occurred. However, Lewin has developed a range of estimates depicting the degree to which we believe these savings are attributable to UCCI.

⁶ This savings amount does not include a potential upward adjustment due to a revised cost avoidance methodology. Please see Section D of this chapter for more detail.

⁷ Total savings in this table are not reflective of administrative expenses associated with UCCI.

evaluation of the program, which should provide MAA with a comprehensive understanding of this waiver program.

- **Quality Review Services** – In conducting our analysis of this initiative, we were unable to develop an estimate for actual savings. Please refer to Section E of this chapter for further discussion.

A. Fee-for-Service Maximum Allowable Fees/Costs

Currently in the fee-for-service (FFS) rate schedule there are many services and supplies, such as durable medical equipment, for which the provider can be reimbursed up to a maximum fee. The Medicaid Management Information System (MMIS) then checks a claim against a maximum allowable fee (MAF) limit, and pays if the claim is at or below that ceiling. Many MAFs have been increased from year to year, without a review of the current actual acquisition cost faced by the provider. Consequently, the MAF could be substantially higher than the provider's cost, thereby permitting overpayment and waste.

MAA has recently adjusted downward several maximum allowable fees to more accurately set a ceiling for a provider's likely acquisition cost. The result of MAF will be that the MMIS will flag claims that come in above the MAF, thereby avoiding overpayments, which would otherwise be identified only through an audit or quality review. In order to estimate savings due to this initiative, we have focused on MAF changes in three service categories: 1) Schedule II drugs, 2) injectable drugs, and 3) kidney dialysis.

Schedule II Drugs

In April 2002, the State decreased reimbursement of Schedule II drugs from 100 percent of the Average Wholesale Price (AWP) to 89 percent of AWP. The State further decreased the reimbursement rate to 86 percent of AWP in August 2002. In the State's cost avoidance analysis created November 15, 2002, an estimated \$1.2 million in reimbursed costs would be saved for the period April 1 to August 31, 2002. This estimate uses the average reimbursed cost per unit for January through March 2002 as the baseline from which to estimate savings. This average cost per unit was trended forward each month by 0.75 percent, the average monthly increase in cost per unit in Calendar Year (CY) 2001. The additional reimbursement decrease in August created an additional \$95,000 in savings for that month.

The methodology used by the State is similar to the analysis that Lewin would have conducted to estimate savings. In a previous savings estimate created in September, the State based savings off of March 2002 cost per unit. The State has improved its methodology by moving to the weighted average. However, the average monthly trend used to inflate costs is based on a linear progression. Examination of prior months of data shows fluctuations in the cost per unit amounts. The cost per unit seems to spike at the end of each quarter and then drop back down slightly for the next two months. Instead of using a linear trend, we calculated an average cost per unit trend between two three-month blocks, October through December 2001 and January through March 2002, of 0.66 percent. We then trended forward the average cost per unit for January through March 2002 by this percentage. We kept this trended unit price steady for the next three months, before trending the unit price forward again for the next three-month block. This revised methodology produced a total savings of \$1.1 million. This includes \$1.0 million

due to the change in reimbursement and \$93,000 due to the additional change in the discount from AWP in August 2002. This translates to approximately \$550,000 in savings for SFY 2002.

Injectable Drugs

Maximum allowable fees for injectable drugs (Healthcare Common Procedure Coding System J-codes) were implemented by MAA in May 2002. The State has moved from charges up to \$1,100 to the Medicare fee schedule in the reimbursement of these drugs. Estimation of savings for injectable drugs is very difficult. One of the complexities in this process is the fact that the cost of the injectable is embedded in an office visit reimbursement and is not separately reported in units of drug ingredient administered. Several injectable drugs may be included under a single J-code. Since the claims do not show actual units dispensed, there is no way to accurately measure the effects of the fee change on a per unit basis. MAA calculated a cost avoidance estimate based on the assumption that the average reimbursed amount as a percentage of the average billed amount would be consistent over time if there is no change in reimbursement method. Under this assumption, the average reimbursement amount to billed amount percentage from January to April 2002 could be used to estimate the cost to the State if the maximum allowable fees had not changed. Using this methodology, MAA estimated savings around \$165,000 per month, or \$2 million per year.

Given the difficulties in identifying actual units of drugs dispensed, Lewin agrees with MAA's methodology in estimating cost avoidance. Using the most recent claims data and data from a week prior, Lewin found the reimbursed-to-billed amount percentage to be fairly consistent over time. However, the actual reimbursed-to-billed ratio changed with the added week of claims data. The accuracy of any savings estimate will depend on the completeness of the data. The relative completeness of the May to August 2002 data to the January to April 2002 data means that the savings estimate could be over or understated.

Lewin recommends that the State monitor the utilization of J-codes closely. Because the number of units of a particular drug cannot be ascertained from the claims, there is potential for providers to falsify the number of units dispensed in order to increase their reimbursement amount.

Kidney Dialysis Rates

In September 2002, MAA began paying significantly lower rates for dialysis than in past years. Prior to September 2002, MAA reimbursed kidney centers at the amount they billed. Going forward, MAA will begin paying freestanding centers \$197.45 per dialysis treatment, with legislatively authorized vendor rate adjustments in future years.

To evaluate the potential savings due to the implementation of maximum allowable fees for kidney dialysis, we obtained a cost savings estimation spreadsheet from MAA staff. The \$197.45 per dialysis maximum fee is based on the allowable cost data from the CY 2000 Centers for Medicare and Medicaid Services (CMS) Audited Cost Reports that have been adjusted by a Medicaid Acuity factor and trended forward two years. The overall trend for the two years is approximately 3.6 percent (after the Medicaid Acuity factor has been applied). If the kidney dialysis rate had not been updated, it was estimated by the MAA staff that the average kidney dialysis payment would have been approximately \$315.22 for CY 2002. This estimation is based

on the 2001 average payment per dialysis session trended forward 8 percent to 2002. The new dialysis payment was estimated to save approximately \$3.2 million (37.4 percent) for Medicaid-only eligibles statewide by the end of fiscal year 2003, based on a utilization rate of 27,000 sessions for the period from September 1, 2002 to June 30, 2003.

The State's methodology for assessing the impact of the rate changes follows a methodology Lewin would have employed in conducting the same analysis. According to MAA staff, there could be quite a bit of variance in the MAA estimate due to the fact that MAA does not receive data on the number of sessions. However, in MAA staff opinion, with which we concur, the estimate used in the cost analysis for the kidney dialysis rate in lieu of the maximum allowable fee was conservative and the variance in the data would most likely lead to a higher dialysis rate, creating greater savings. MAA's trend rate assumptions are reasonable. Actual savings might decrease if the difference between the 2001 to 2002 trend (8 percent without MAF versus 1.5 percent with MAF) is less than anticipated. However, most of the estimated \$3.2 million will still be realized due to the significant decrease in the payment rate.

We recommend that MAA closely monitor utilization of these services going forward. Because the rate-per-unit has decreased significantly, providers may have incentive to increase their reported utilization to maintain a revenue stream more consistent with the period prior to the change in rates.

B. Alternative Payers – Veterans Administration (VA)

Pursuant to the Veterans' Health Care Eligibility Reform Act of 1996, all enrolled veterans regardless of their priority group will be provided the Uniform Benefits Package, which covers prescription drugs, hospital and outpatient care, emergency department visits, and many other medical needs. In May 2002, MAA stopped paying for pharmaceuticals for Washington's Medicaid-eligible veterans in VA nursing homes based on the VA's obligation to provide these benefits. MAA estimates that Washington will save approximately \$58,000 per month by no longer funding pharmacy benefits for veterans residing in VA nursing homes.

In order to identify Medicaid payments that instead may be payable by the VA, MAA analyzed non-nursing home claims on behalf of clients who resided at two VA facilities, Retsil and Orting, from CY 1999 to CY 2001. The three years of data were relatively consistent, representing around 300 clients each year with an average annual cost of \$3,000 to \$3,200 per client. The CY 2000 data were further aggregated by category of service. Formulary drugs were utilized by 89.1 percent of the clients and accounted for 70.6 percent of the total cost. Identifying the VA as the primary payer on these drug claims would save Medicaid about \$700,000 per year, which translates to approximately \$58,000 per month.

Since May 2002, when Medicaid ceased payment for pharmaceuticals for veterans in VA nursing homes, MAA has tabulated claims data for Retsil and Orting pharmacies. Using the CY 2001 average monthly payment for pharmacy benefits as a baseline, MAA has saved approximately \$53,000 per month (state and federal) from May 2002 to July 2002. A few claims are still being paid to the two pharmacies at those VA nursing homes, but the majority of the pharmacy claims have been eliminated. Lewin did not feel that further methodological examination was necessary since the actual monthly savings of approximately \$53,000 is close to the projected savings of approximately \$58,000.

C. Coordination of Benefits (COB)

Coordination of Benefits (COB) staff work to identify Medicaid FFS claims for which a third party (e.g., private insurance) may have some or all of the financial responsibility as a primary payer. The COB staff generates cost savings through both cost avoidance and cost recoveries. In SFY 2002, the COB unit realized almost \$116 million in cost avoidance and recoveries, with \$91.2 million in cost avoidance and \$24.6 million in cost recoveries. This represents an overall increase of 25.5% from the prior year's avoidance and recoveries. Given the magnitude of these savings, it is clearly important for MAA to continue to seek recoveries and cost avoidance from responsible third-party payers.

Lewin concurs with the overall level of COB savings that MAA has estimated. As mentioned above, the COB unit realized a significant increase in cost avoidance and recoveries during the first year of UCCI. As a result of the UCCI program, the unit received additional staff resources and set aggressive goals for itself to motivate higher productivity. However, determining the amount of the additional savings that can be attributed *solely to UCCI* is difficult because COB cost avoidance and recoveries are driven by many different factors. For example, the total number of claims and claim dollars that ran through the MMIS in SFY 2002 increased from the prior year, generating additional opportunities for COB to avoid and recover costs.

While COB increased its cost avoidance and recoveries to a much greater extent than the increase in total Medicaid expenditures, it is difficult to determine the degree to which that is attributable to increased efficiencies on the part of COB staff as distinct from the natural increase in the dollars associated with the claims that ran through the system. Moreover, if higher dollar value claims were hitting the system in SFY 2002 and the resulting cost avoidance and recoveries therefore were higher than in SFY 2001, it is difficult to determine the extent to which this is attributable to UCCI. Uncovering the exact answers to these types of questions is very difficult and would require an extended analysis that is not feasible within the timelines and scope of this project. As a result, Lewin estimated a range of possible COB cost savings estimates that could be attributed to UCCI.

Nevertheless, it is important to keep in mind that Lewin agrees with two key facts: COB generated nearly \$116 million in avoidance and recovery in SFY 2002, representing an increase of over 25% from the previous year. The secondary issue of how much to ascribe to UCCI should not detract from COB's success in SFY 2002.

In the following sections, we provide a description of the ways in which COB avoids costs and recovers funds to provide context for our estimates. In addition, we have outlined the three different approaches to calculating COB savings attributable to UCCI. The reader should continue to note that this range represents the amounts we feel may be attributable to the UCCI intervention. Lewin does not dispute the overall amount of \$115.8 million in cost avoidance and recoveries realized by the COB unit in SFY 2002.

1. How COB Generates Cost Avoidance and Recoveries

Case management staff within the COB unit identify claims for which a third-party payer (outside of Medicaid) may have some or full responsibility. When these types of claims are identified, the COB unit creates edits in the system that deny all or part of these types of claims

in the future. The future amounts that MAA does not pay due to the edits are booked as cost avoidance. COB staff also realize cost recoveries by undertaking pay-and-chase activities. The State might pay claims but later identify them as cases where a third party bears primary financial responsibility. In these cases, a COB caseworker will pursue the claim and attempt to recover the funds for which Medicaid is not responsible from that third party.

Approximately four years ago, the COB unit undertook a reorganization of its management system to facilitate more efficient cost avoidance and recovery. Rather than having cost avoidance and cost recovery exist in individual silos, COB implemented a case management approach. Caseworkers follow individual claims through their entire billing cycle so that one person is expert on the claim and its history. In an interview with a member of the COB unit, Lewin was informed that this approach has resulted in increased efficiency in the COB unit.

This reorganization of the COB unit pre-dated UCCI. However, the COB unit did receive an additional five full-time equivalent (FTE) positions directly as a result of UCCI. According to MAA, the unit filled only 3.5 of these positions in SFY 2002. They used these positions to expand their case management capacity. As mentioned above, the addition of the case management staff, along with more aggressive goal setting for the unit, were the major changes in COB that resulted from UCCI.

2. Methodology A

Under Methodology A, Lewin assumed that, as a baseline, the increase in COB cost avoidance and recovery would mirror the increase in FFS expenditures from SFY 2001 to SFY 2002. Moreover, under the assumptions in this scenario, the COB unit, even without the intervention of UCCI, would have accommodated the increase in FFS expenditures from SFY 2001 to SFY 2002. The additional savings that can be attributed to UCCI include any increase above the total percentage increase in FFS expenditures.

To calculate the savings attributable to UCCI under this scenario, we compared the total increase in FFS expenditures in SFY 2001, on a date of payment basis, to the total FFS expenditures in SFY 2002. We used the date of payment data to parallel the COB cost avoidance and recoveries, which are booked on a date of receipt/date of payment basis. Overall, total FFS expenditures increased by 7.2 percent from SFY 2001 to SFY 2002. We then assumed that cost avoidance and cost recoveries from SFY 2001 to SFY 2002 would also increase 7.2 percent. We assumed the difference between the expected value and the actual value would be increase in savings due to UCCI. Table 3, following, outlines our calculations.

Table 3. Calculation of COB Savings Attributable to UCCI under Methodology A (in millions)

	Total FFS Expenditures	Cost Avoidance	Cost Recoveries	Total
SFY 2001 Actual	\$1,568.9	\$71.8	\$20.5	\$92.3
SFY 2002 Actual	\$1,682.4	\$91.2	\$24.6	\$115.8
Increase from SFY 2001 to 2002	7.2%	27.0%	20.2%	25.5%
SFY 2002 Expected (actual increased by 7.2%)	N/A	\$77.0	\$21.9	\$98.9
Increase/(Decrease) in Savings - Difference Between Expected & Actual	N/A	\$14.2	\$2.6	\$16.8

This methodology results in an increase of savings which could be attributed to UCCI of \$16.8 million, which is approximately \$11.1 million less than the savings MAA attributed to UCCI.

3. Methodology B

The COB unit performs its cost avoidance and cost recovery functions on a certain percentage of the total Medicaid claims that run through MMIS. Under Methodology B, we assumed that, as a baseline for SFY 2002, the COB unit could perform their cost avoidance and recovery activities on the same *percentage* of total claims, as in the prior year.

To calculate the savings attributable to UCCI under this methodology we reviewed, by month, the percentage of total SFY 2001 claims that were cost avoided or recovered by COB. When we examined these data points, we discovered that October 2000 was an outlier, due to the clearing of a large claims backlog from SFY 2000. To calculate the baseline average percentage of claims cost avoided or recovered, we used 11 months of data from SFY 2001, excluding October 2000. As a result, we projected that, as a baseline for SFY 2002, the COB unit would avoid costs on 2.16 percent of all claims and recover funds on 0.35 percent of all claims.

Further, we assumed the COB unit would realize a 2 percent increase in the average amount avoided or recovered per claim. The two percent figure is slightly above the vendor rate increase for SFY 2002 and accounts for both that vendor rate increase and other somewhat larger increases to the Medicaid fee schedule. In SFY 2001, the COB unit avoided an average of \$129.29 per claim and recovered an average of \$228.38 per claim. As a baseline for SFY 2002, we assumed the COB unit would avoid an average of \$131.88 per claim and recover an average of \$232.94 per claim.

We then compared these baseline estimates to the actual cost avoidance and recoveries realized by the COB unit. The difference between the baseline we established from SFY 2001 data and the actual amounts realized by the COB unit in SFY 2002 could be considered the amount attributable to UCCI. Table 4, following, outlines our methodology and results.

Table 4. Calculation of Baseline Cost Avoidance and Recovery Amounts under Methodology B

	SFY 01 Actual	SFY 02 Expected	SFY 02 Actual
Total FFS Claims	24,442,794	N/A	26,306,226
Percentage of Total Claims Cost Avoided	2.16%	2.16%	2.42%
Total Number of Claims Cost Avoided	555,269	569,364	636,469
Percentage of Total Claims Cost Recovered	0.35%	0.35%	0.41%
Total Number of Claims Cost Recovered	89,613	91,282	108,998
Cost Avoidance Per Claim	\$129.29	\$131.88	\$143.26
Cost Recovery Per Claim	\$228.38	\$232.94	\$225.59

Using the above baseline figures and the actual SFY 2002 results from the prior table, we calculated the additional COB savings that could be attributable to UCCI. Table 5, following outlines these results.

Table 5. Calculation of COB Savings Attributable to UCCI under Methodology B

	Cost Avoidance	Cost Recovery	Total
Expected Number of Claims	569,364	91,282	660,646
Expected Dollars per Claim	\$131.88	\$232.94	\$145.84 ⁸
Expected COB Savings (in millions)	\$75.1	\$21.3	\$96.3
Actual COB Savings (in millions)	\$91.2	\$24.6	\$115.8
Increase/(Decrease) in Savings – Difference between Expected and Actual	\$16.1	\$3.3	\$19.4

This methodology results in a total of \$19.4 million in increased COB savings attributable to UCCI, which is approximately \$8.5 million less than the original \$27.9 million reported in the September 2002 legislative update.

4. Methodology C

In the final methodology in our overall analysis, we assumed that the baseline for SFY 2002 COB savings would be the SFY 2001 savings, increased only for price inflation. By using this methodology we assume that almost all additional savings in SFY 2002 is attributable to the UCCI intervention and that price inflation is the only outside factor contributing to increased avoidance and recoveries.

To calculate the savings attributable to UCCI under this methodology, we compared the actual SFY 2002 cost avoidance and recoveries with SFY 2001 amounts, increased by 2 percent for price trends. We then assumed that the difference between the expected SFY 2002 cost avoidance and recovery and the actual SFY 2002 avoidance and recovery was the increase in savings due to UCCI.⁹ Table 6, following, demonstrates the result of our analysis.

⁸ Weighted average.

⁹ This methodology is similar to the methodology employed by MAA. However, MAA adjusted its baseline COB avoidance and recovery amount to account for the clearing of the SFY 2000 claims backlog. This adjustment lowered their overall SFY 2001 baseline by approximately \$7 million.

Table 6. Calculation of COB Savings Attributable to UCCI under Methodology C (in millions)

	Cost Avoidance	Cost Recovery	Total
SFY 01 Actual	\$71.8	\$20.5	\$92.3
Expected Percentage Increase	2%	2%	2%
SFY 02 Expected	\$73.2	\$20.9	\$94.1
SFY 03 Actual	\$91.2	\$24.6	\$115.8
Increase/(Decrease) in Savings – Difference between Expected and Actual	\$18.0	\$3.7	\$21.7

Our final methodology results in an increase in savings potentially attributable to UCCI of approximately \$21.7 million. This amount is approximately \$6.2 million less than the \$27.9 million calculated by MAA.

As discussed earlier, the amount of the increase in savings experienced by the COB unit in SFY 2002 could take on a variety of values, given the myriad of forces acting upon actual cost avoidance and recoveries. However, to provide an estimate of the dollars that one could attribute to UCCI, we have developed a range of possible values. Table 7, following, summarizes the results of our three analyses.

Table 7. COB Savings Attributable to UCCI under Multiple Methodologies (in millions)

	Methodology		
	A	B	C
Savings Attributable to UCCI	\$16.8	\$19.4	\$21.7

D. Hospital and Independent Practitioner Audits/Payment Review Program

The hospital and medical (or independent practitioner) audit units review cases with large suspected provider overpayments. Once these cases have been researched, the units issue a report that details the amount providers owe the State in order to rectify past overpayments. Since implementation of UCCI, each unit has increased the number of staff members available to perform these audits. In addition to the increased staffing, the audit units have benefited from several other efficiencies.

First, the audit unit has increased its ability to identify and research potential overpayments through the use of the Payment Review Program (PRP). Through both the use of the PRP's algorithms and provider profiles, the audit units have been able to identify global areas of potential concern, as well as individual provider overpayments. Because the PRP is available to audit staff over secured interfaces via the internet, they can access crucial data quickly, through their own desktops. Secondly, in interviews with MAA staff, they report that each unit has set aggressive goals for itself, which has increased the units' overall productivity and efficiency.

The hospital and medical audit units have similar methodologies for estimating cost savings. Both units book cost recoveries and cost avoidance. Cost recoveries are the actual dollar

amounts the unit collects from providers following an asserted overpayment. They are booked in the month the dollars are received.¹⁰ Cost avoidance is tracked on a monthly basis and reflects the amount of outstanding audits for the month. For example, if the audit unit asserts in January that a provider owes the State \$1,000 but the State has yet to collect the money, the amount is booked as cost avoidance. Once the \$1,000 (or the final settlement amount) is collected, the \$1,000 is removed from the cost avoidance column and the final settlement amount – often less than the initial claim – is booked in the cost recovery column.

As we considered the methodology for this savings analysis, we considered the implications of booking cost avoidance for not yet recovered funds. While the cost avoidance is eventually “trued up” and reflected in the cost recoveries column, at any given point in time, savings are likely overstated due to the initial booking of cost avoidance amounts that historic evidence shows will not be fully realized. If the State does not eventually recover 100 percent of the booked cost avoidance amount, the savings booked under cost avoidance will overstate true recoveries. In order to determine the potential effects of the cost avoidance methodology, we analyzed the actual recoveries in both hospital and medical audits.

1. Cost Recoveries

In SFY 2001, the Hospital Audit Unit projected \$3.27 million in recoveries and actually realized \$3.23 million, a recovery rate of almost 99 percent. In interviews with MAA staff, we learned that recovery rates in the hospital unit are generally very high. If that trend is consistent going forward, the effect of the cost avoidance methodology on the overall savings calculation is likely to be minimal, and reflects only the lag between the claim and the recovery, which occasionally spans fiscal years. Thus, the only concern would occur in cost avoidance and cost recoveries booked in different fiscal years, and even then the effect is likely to be minimal.

The high recovery rates of the hospital unit are not similarly experienced in the Medical Audit Unit, however. Actual recoveries vary significantly from fiscal year to fiscal year. From SFY 1998 to 2002, annual recovery rates ranged from 33 percent to 88 percent of the asserted overpayments, with an average of approximately 75 percent. In interviews with MAA staff, we learned that actual recoveries realized for the medical audits are more difficult to predict. Given that medical audits might vary more substantially in the amount actually recovered, the cost avoidance methodology has the potential to skew the true savings amount.

As a result, we adopted a revised cost methodology for calculating cost savings due to recoveries, one slightly different from the one employed by MAA. Rather than book cost avoidance as the amount not yet recovered, we removed all cost avoidance estimates. (Please refer to the next section for our recommendations regarding cost avoidance.) We felt this would more accurately represent true savings due to recoveries at any given point. In addition to the change in methodology, we established new baselines from which to project UCCI savings due to recoveries. To establish the baseline, we calculated an average cost recovery amount per

¹⁰ In subsequent interviews with audit staff, we learned that the hospital data reported to us were not always on a date of recovery basis. However, these data were very close to that basis, given the quick turn-around time typical of hospital audit recoveries. No additional data were available to adjust the reported data to convert them to an exact date of recovery basis. Therefore, we continued to analyze the data under our original assumption of a date of recovery basis.

auditor for each audit unit based on SFY 1998 through SFY 2001 recovery amounts. We trended forward each of the SFY 1998 through SFY 2000 amounts to bring them to a SFY 2001 basis. We then calculated a straight average of the four year's of data, to arrive at a SFY 2001 amount. The average amount was then trended forward one year to establish the SFY 2002 expected savings per auditor.

For each audit unit, we then calculated an expected recovery amount for the entire unit, by multiplying the average recovery per unit by the number of auditors in SFY 2001. This amount represents the total expected recoveries, had UCCI not been implemented. We then calculated an expected recovery amount given the increase in UCCI staff by multiplying the SFY 2002 average recovery per auditor by the actual number of auditors in that SFY. We compared the actual recovery amount to the expected recovery amount, had UCCI not been implemented. The result of this comparison is the total savings we attributed to UCCI. The results of our analysis are displayed in Tables 8 and 9, following.

Table 8. Estimates of Savings due to Cost Recoveries for Hospital Audits (in millions)

	UCCI Estimate	Lewin Estimate	Difference
SFY 2002 Savings Baseline	\$2.4	\$2.4	\$0.0
SFY 2002 Total Savings	\$6.4	\$5.5	(\$0.9)
SFY 2002 Net Savings	\$4.0	\$3.1	(\$0.9)

Lewin's overall estimate is approximately \$900,000 less than the original *total savings* estimate from the final SFY 2002 report. The difference is largely attributable to Lewin's removal of the cost avoidance portion of the total savings estimates. It is important to note, however, that in follow-up conversations with MAA, we learned that the \$970,000 in outstanding hospital audit assertions for SFY 2002 was eventually collected in SFY 2003.¹¹ This amount should be credited to the audit unit in calculating SFY 2003 UCCI cost recoveries. In addition, we have provided our estimate of savings due to cost avoidance in subsection 2.

Table 9. Estimates of Savings due to Cost Recoveries for Medical Audits (in millions)

	UCCI Estimate	Lewin Estimate	Difference
SFY 2002 Savings Baseline	\$0.3	\$1.0	(\$0.7)
SFY 2002 Total Savings	\$5.5	\$3.8	(\$1.7)
SFY 2002 Net Savings	\$5.2	\$2.8	(\$2.4)

Lewin's overall estimate is approximately \$2.4 million less than the original *total savings* estimate from the final SFY 2002 report. The difference is attributable both to Lewin's removal of the cost avoidance portion of the total savings estimates and our much higher SFY 2002 savings baseline. Our savings baseline was calculated from historical data provided by the audit unit and was not adjusted to account for any factors that may lessen the medical audit

¹¹ The \$970,000 figure deviates from the overall difference of \$900,000 due to rounding embedded in the roll-up.

unit's ability to reach the average recovery target from prior years. Additionally, cost avoidance is not included in our estimate. A discussion of cost avoidance for the Medical Audit Unit follows.

2. Cost Avoidance

As mentioned in the prior section, our analysis removed the cost avoidance portion of the savings MAA calculated in its most recent report to the legislature. To be consistent with other UCCI programs, we believe that the audit units should count cost avoidance by annualizing their cost recoveries in each month and amortizing that amount over the next 12 months, beginning in the month after the cost recovery was made.

Lewin calculated the estimated savings associated with cost avoidance for both the Hospital and Medical Audit units. Table 10, following, provides the value of our estimates.

Table 10. Potential Cost Avoidance for Hospital and Medical Audit Units

	Hospital	Medical	Total
Potential Cost Avoidance	\$3.0	\$1.5	\$4.6

Please note, however, that we were unable to add these cost avoidance estimates to our overall savings estimates in order to ensure that we did not account for these savings twice. Specifically, in our interviews with Quality Review Services staff (see Section E, following), we learned that this unit also books cost avoidance for some money recovered by the audit units. We did not have the data available to separate the cost avoidance booked by Quality Review Services that could be attributed to the audit units. Therefore, there may be overlap between the figures above and the cost avoidance booked by Quality Review Services.

We understand that Quality Review Services recently joined the audit units as part of a reorganization within MAA. We recommend that these entities work together to develop a consistent methodology for counting savings that avoids the potential for double counting cost avoidance across units.

E. Quality Review Services

Quality Review Services (QRS) performs a variety of activities that contribute to overall cost savings, through both cost recovery and cost avoidance. The mission of the unit, as reported to us, is to "identify and investigate suspected fraud, abuse and waste while assuring that quality medical care is being given by Medicaid Providers."¹² Prior to UCCI, the unit pursued its mission through the review of certain DRGs, readmission claims, billings with longer than expected lengths of stay, and inpatient billings that should have been billed at lower outpatient costs. The reviews were conducted by two nurses, neither of whom was devoted full-time to these reviews.

¹² Provided in a written statement from QRS staff.

As a result of UCCI, the unit hired new clinical and technical staff, devoted to QRS's review work, who could further the unit's investigations of suspicious billings and assurance of quality services. According to interviews with QRS staff, several new staff members were hired as a part of UCCI. Between August and November 2001, QRS hired a dental hygienist, a dentist, three nurses and a hospital coder to assist in the review process.

To establish savings associated with UCCI, QRS developed a savings baseline amount by projecting the amount of savings that could have been achieved had UCCI not been implemented and additional staff not been hired. In interviews with MAA staff, we learned that much of the historical data used to develop the savings baseline were estimated recoveries. In many cases, QRS did not adjust their recovery amounts to reflect the actual amounts collected. In addition, prior to UCCI, these estimates were not used for the purposes of developing a department-wide budget. Because the attribution of savings was less emphasized prior to UCCI, there is likely to be an overlap between the recovery amounts reported by QRS and the audit units. Therefore, the baseline estimate is significantly less than the amounts reported to us for SFY 2000. Due to these data concerns, we are unable to calculate our own estimate of baseline savings with which to compare claimed SFY 2002 recoveries and cost avoidance. We suggest that the reader of the report keep in mind our lack of a baseline estimate in considering the estimated cost recoveries and avoidance noted later in the report.

To calculate the additional savings above the baseline, QRS staff provided us with several sources of data, including the spreadsheet used to report overall savings for inclusion in official UCCI reports. In addition, QRS staff provided us with an overview of their cost recovery and cost avoidance methodology, as well as several savings tracking sheets they use to document recoveries and cost avoidance. We also interviewed staff to gain a better understanding of the data that are reported in each source.

Given the data and other information we received, we were not comfortable calculating our own estimate of cost savings associated with the QRS unit. Below we have provided an overview of the data we received and our concerns (if applicable) with using these data to construct a savings estimate that is consistent with other UCCI initiatives. Where possible, we have offered potential alternative cost recovery and avoidance amounts from the data we received.

In all cases, however, we have attempted to adjust QRS's cost avoidance amounts to be consistent with the methodology employed in other UCCI cost avoidance calculations. Our understanding is that cost avoidance amounts in QRS's worksheets represent 12 months of cost avoidance; however all cost avoidance is booked in one month, not amortized over a 12 month period. In our analysis of those activities with cost avoidance, we recalculated the cost avoidance to reflect a 12 month amortization. Overall, this lowers the cost avoidance realized in SFY 2002, but the amounts not reflected in SFY 2002 should be carried over into SFY 2003.

- **Review of DRG 468** - QRS reported approximately \$361,000 in savings related to the review of DRG 468. QRS staff reported that prior to UCCI, they conducted reviews of this claims with this DRG. However, also prior to UCCI, the amount reimbursed for DRG 468 was reduced and providers no longer used this code to increase their reimbursement. Because the DRG was no longer being used in this manner, the return on investment from conducting these reviews was decreasing. Thus, QRS ceased conducting these reviews.

Because these reviews were conducted prior to UCCI and are not currently taking place, we believe that removing cost avoidance for this activity may be appropriate.

- **Hospital Readmissions** – QRS reviews inpatient readmission claims. If QRS reviews claims and recovers funds from or avoids paying for unnecessary readmissions or overcharged stays, they book cost avoidance and recovery. Savings are booked as the billings are processed and as funds are received and/or avoided. Therefore, these savings are tracked in a manner consistent with other UCCI programs. The only adjustment we made to QRS's cost savings estimate was to amortize the annual cost avoidance amounts over the 12 month period. Therefore, total cost recoveries and avoidance were reduced from \$2.3 million to \$1.9 million.
- **Length of Stay** – QRS reviews the lengths of stay associated with certain claims. If the length of stay is longer than is anticipated for that type of claim, QRS will deny payment. QRS estimates the value of this cost avoidance and books the annual cost avoidance in one month. Because we do not have data to calculate the actual amount avoided, we recalculated the cost avoidance from the data provided, amortizing the savings over 12 months, accepting QRS's estimates. This results in approximately \$52,000 in cost avoidance, compared to the \$157,000 booked by QRS.
- **Short Stays** – Under Washington Administrative Code, some claims with short inpatient stays should be billed as outpatient claims, which are generally less expensive. QRS reviews these short stays and, where appropriate, forces the provider to rebill an outpatient claim. The difference between the original amount paid and the rebilled amount is collected by QRS and book as cost recovery. QRS does not bill cost avoidance for this activity; however, the case can be made to count cost avoidance as a result of changing provider billing behavior. As a result, we recalculated total cost savings by adding cost avoidance amounts to QRS's cost recoveries. Our estimate was approximately \$128,000 compared to QRS's estimate of \$118,000.
- **Home Health/Hospice** – QRS performs reviews of home health and hospice claims and collects recoveries for overpayments. In interviews with QRS staff, we learned that this activity was transferred into the Aging and Adult Services Administration, effective July 2001. QRS booked cost recoveries and cost avoidance for these activities throughout SFY 2002. Given that we are unsure which unit should take credit for these savings, we have provided a range of potential savings, from \$0 to approximately \$2,000, as reported by QRS..
- **Dental** – As part of UCCI, QRS hired clinical staff to conduct reviews of dental claims. Staff review provider claims for mis-billings and conduct audits of individual providers to ensure licensures are in tact and practices meet quality standards. The PRP has also assisted staff in identifying significant overpayments. In our analysis of cost savings, we were unable to confirm the data provided in the UCCI reporting spreadsheet against the data provided in the dental review tracking sheet. We calculated a new estimate based on the amounts we could identify in the tracking sheet. Under the best case scenario, we calculated almost \$846 thousand in cost recoveries and approximately \$290 thousand in cost avoidance, for a total of over \$1.1 million. It should be noted that our estimates only account for known amounts recovered, per the dental tracking sheet. According to interviews with QRS staff and other data provided on the dental tracking sheet, there are several providers who account for over \$5.3 million in overbillings. These providers were identified through QRS's unit and represent significant potential recoveries and future cost avoidance.

- **Case Reviews** – In interviews with QRS staff, we learned that cost recoveries in this category are the amounts identified in chart reviews as overpayments. QRS staff also calculates a projected cost avoidance from the amount they identify. They reported that they do not adjust cost recoveries and avoidance for the actual amount collected by the Office of Financial Recovery (or other unit within the State) due to a significant time lag between the identification of overpayments and the actual date of collection. In addition, we also learned that in some rare instances, case review cost recoveries may be estimated by calculating 10 percent of the annual amount billed by that provider, rather than the actual amount identified in the review. QRS staff could not recall a specific case in which that scenario took place, but the potential for employing this methodology in calculating cost recoveries exists. Based on the information we were provided, we are uncertain about the actual recoveries and resulting cost avoidance in SFY 2002. We calculated a range of potential values for cost savings related to this activity; however, these values should be considered in light of the limitations on the available data.

Table 11, following, summarizes our analysis of the data reported to us in order to calculate QRS savings and our resulting analysis of these data.

Table 11. Analysis of QRS Cost Avoidance and Recoveries (in thousands)

Savings Activity	Data Reported by QRS for SFY 02	Lewin Analysis
Review of DRG 468	\$361	\$0
Hospital Readmissions	\$2,258	\$1,919
Length of Stay	\$157	\$52
Short Stays	\$118	\$128
Home Health/Hospice	\$2	\$0 to \$2
Dental	\$1,115	\$1,136
Case Reviews	\$640	\$0 to \$338

The amounts above do not include any adjustment for the baseline savings estimate calculated by QRS.

Overall, we consider the work performed by QRS to be very important to both ensuring quality care and avoiding overpayments within Washington’s Medicaid program. Clearly, the increase in staffing, particularly clinically trained staff, has added to the unit’s ability to perform its mission. The integration of the PRP into the work of QRS has increased the unit’s ability to identify and monitor providers, and as demonstrated by the dental reviews conducted in SFYs 2002 and 2003, has returned a great deal for the investment. However, we are unable to provide a conclusive dollar amount that we feel comfortable associating with QRS’s UCCI activity. We recommend that QRS work with other UCCI programs, particularly the audit units, to develop a methodology that will allow them to continue to improve on their accounting of savings and avoid any potential for double counting or mis-estimation.

F. Durable Medical Equipment (DME)/non-DME Quality Reviews

The DME and non-DME Quality Utilization Review Unit is responsible for ensuring that patients utilizing DME and non-DME are receiving appropriate and high quality services. Prior to UCCI, the DME and non-DME Utilization Review Unit reviewed certain claims to determine the medical necessity of services; however, they did not have the staff resources to determine recoupments for claims deemed medically unnecessary. With the addition of staff resources due to UCCI, the DME and non-DME Quality Utilization Review Unit is able to conduct additional reviews and recoup funds from providers.

To evaluate the DME and non-DME savings estimates, we received data from MAA staff regarding cost avoidance and recovery booked by the DME and non-DME Quality Utilization Review Unit for SFY 2002. The data included a spreadsheet of monthly recoveries and the subsequent cost avoidance booked by the unit, as well as assumptions regarding the methodology for counting both cost recoveries and avoidance. To supplement these data, Lewin conducted several interviews with MAA to clarify the data and assumptions.

The DME and non-DME Quality Utilization Review Unit has developed a specific methodology for calculating both cost recoveries and cost avoidance to arrive at their total savings estimate. When the unit identifies an overpayment, they seek to recoup funds from the provider for one year of claims for that service, retrospectively. They book the resulting recoveries in the month that the recoupment was established. For these services, the unit books future cost avoidance in each of the next twelve months going forward, beginning in the next month after the recoupment. In addition, the unit books cost avoidance for one month in cases where they prevail during the fair hearing process. They also book one time recoveries and cost avoidance for certain miscellaneous activities, such as reductions in billing due to negotiation.

The DME and non-DME Quality Utilization Review Unit is very careful in documenting its recoveries and maintains actual receipts from providers for its cost recovery activities. In addition, the unit has developed a specific methodology for calculating savings and the unit appears to adhere closely to it, applying it in a consistent manner. However, in reviewing the methodology to calculate savings, we found several items of concern to us. First, in calculating cost avoidance, the annual amount collected is used as a basis for future cost avoidance. This methodology can present problems if the amount billed in the prior year is anomalous, either over- or under-estimating future savings. In addition, annual cost avoidance is booked on a monthly basis, for *each of* 12 months going forward, even though the basis for the cost avoidance may have been one year's worth of claims; this can overstate the future savings by 12 fold.

To determine the impact of our concerns with the methodology, we recalculated savings SFY 2002 estimates based on the data provided to us, making several adjustments. We adjusted the cost avoidance that resulted from recoveries to reflect 1/12 of the original annualized estimate. This reduction avoids booking annualized cost avoidance amounts on a monthly basis. Due to time and data constraints, we did not review several years of claims history for each service to determine whether the recoveries reflected representative claims experience. We accepted the original amounts provided to us to create our own cost calculation. We felt that the impact of booking annualized cost avoidance amounts on a monthly basis would have a larger overall impact on the calculation. Table 12, following, outlines the result of our analysis.

Table 12. Changes in the Estimate of Savings Resulting from DME and non-DME Quality Reviews (in thousands)

	Cost Recoveries	Cost Avoidance	Total Savings (State and Federal)
Original Savings Estimate	\$124	\$918	\$1,042
Lewin's Recalculated Savings Estimate	\$124	\$259	\$383
Difference (does not add due to rounding)	(\$0)	(\$658)	(\$659)

The result of our analysis suggests that the savings for SFY 2002 is approximately \$383,000 (state and federal), which is approximately \$659,000 less than the original estimate. The bulk of the difference is attributable to reducing the cost avoidance amounts to reflect monthly rather than annual cost avoidance.

Going forward, we recommend that the DME and non-DME Quality Utilization Review Unit adopt the methodology of reducing the annualized cost recovery amount by 1/12 before booking a monthly cost avoidance amount associated with the recovery. In addition, for cost avoidance associated with discontinued billing codes, we suggest the unit review possible substitution of billings to estimate future cost avoidance. For example, if a provider bills for a certain service and the code for that service is discontinued, the provider may try to bill for the same service in the future, but under a different code. Undertaking this analysis will allow the section to avoid inadvertently overbooking savings for services that continue to be delivered.

G. Non-emergency Transportation

The Transportation Services Program has undertaken two new cost containment initiatives as part of UCCI. First, they implemented a true brokerage model for non-emergent transportation services in Pierce County. Secondly, they established a formal tracking mechanism for the Unique Transport program. These two programs account for the total savings booked by the Transportation Services Program under UCCI.

1. Pierce County Brokerage Model Change

In July 2001, the non-emergent transportation brokerage system in Pierce County was modified to become a true brokerage model. Prior to that date, the broker in Pierce County had its own providers to which it referred transportation services. In 2001, the brokerage company divested its provider business and was no longer able to refer services to itself. As a result, the average cost per trip decreased in Pierce County. As part of the UCCI initiative, MAA calculated the estimated savings that resulted from the transformation of the Pierce County system.

To estimate cost savings that resulted from the new Pierce County model, MAA compared the average monthly average cost per trip for each month in SFY 2002 with the anticipated monthly average cost per trip, had the new model not been implemented. The savings estimate, which is booked as cost avoidance, is the difference between the monthly averages, multiplied by the

actual number of trips per month and summed over the entire SFY 2002. The result of this estimate is a savings of approximately \$1.03 million (state and federal).

To establish the estimated cost of providing services had the new brokerage model not been implemented, MAA uses the forecasting function in Excel® to develop a linear trend of the cost per trip. The cost per trip projection is based on a 12-month base period, from July 2000 to June 2001. In reviewing this approach, we noted that the cost per trip amounts do not tend to follow a linear trend during this time period. A review of the regression model shows an R² value of 0.0071, which indicates that a linear trend may not be the most appropriate modeling tool for these data. The cost per trip values tend to fluctuate greatly in this time period.

MAA staff provided us with additional data points to consider in projecting the average cost per trip in SFY 2002. Using a 24-month base period, we found more support for the linear regression model. Using a 24-month base period, we recalculated the projected cost of services for SFY 2002, had the new brokerage model not been implemented. Our projections result in a slightly higher average cost per trip overall; however, we feel comfortable in that projection given some of the forces that affected prices in SFY 2002 (e.g., increased insurance and fuel costs).

Once we established the average cost per trip under the assumption the true brokerage model had not been implemented, we compared our results to the actual SFY 2002 experience. We multiplied the difference between the average monthly costs per trip by the number of trip for each month in SFY 2002 to arrive at overall savings. Our results are displayed in Table 13, following.

Table 13. Estimated Savings from the Pierce County Brokerage Model

Calculation	Amount
Average Cost per Trip without the True Brokerage Model	\$10.73
Average Cost per Trip with the True Brokerage Model	\$8.92
Difference in the Average Cost per Trip	\$1.81
Actual Number of Trips in SFY 2002	717,136
Total Savings (in millions)	\$1.30

The total savings estimated by The Lewin Group is \$1.30 million, which is approximately \$270,000 more than the original savings of \$1.03 million estimated by MAA. While we do not necessarily disagree with MAA's estimate of savings, we would suggest that the State only book cost avoidance through August 2002, at the latest. The true brokerage model was implemented between July and August of 2001. To be consistent with other UCCI programs, cost avoidance should only be counted for 12 months.

2. Unique Transport Program

In addition to implementing a true brokerage model in Pierce County, the Transportation Services Program has developed the Unique Transport Program. The program identifies individuals, who may be seeking a change in the services they are receiving, but for reasons of

transportation, cannot realize their desired changes. Often, the individual could be served in a more cost-effective manner, but the transportation services required to make the change are not covered.

To assist individuals in changing the types of services or the delivery of current services, the Transportation Services Program reviews cases on an individual basis. If the client can be better served in a different environment and the change of environment is cost-effective for the State of Washington, the Unique Transport Program allows the State to pay for typically uncovered transportation services. For example, Lewin was told about a 65-year old man who lived in a Washington State nursing home, which costs approximately \$122 per day. The man had no family in Washington, but he did have family living near a nursing home in Iowa. The man wanted to move to Iowa, but he could not afford the cost of the move. Because the client desired to be closer to family and moving him to the State of Iowa would be cost effective for the State of Washington, MAA provided him with the \$2,000 needed to move to Iowa.

To estimate savings for this program, MAA calculates the difference between the cost of the unique transportation services and the medical expenditures avoided. The cost of providing unique transportation is amortized over a 12-month period, 1/12 of the expense allocated to each month. A monthly cost avoided amount for medical services is also established and booked for each month. The difference between the transportation expenses and the medical costs saved is the savings attributable to each month.

In our review of the savings calculation for this program, we did not find significant differences between our approach and MAA's. However, to be consistent with other programs, MAA should consider booking 100 percent of the transportation costs in the month those expenses are incurred. While it is possible, under this methodology, to realize a monthly deficit due to the program, the overall cost savings will more accurately reflect the time periods in which expenses are incurred. Over time, however, the savings will be the same. To quantify the effect of employing this methodology in SFY 2002, we reallocated the expenses to reflect the entire amount incurred in the month the expenses actually incurred. This lowered the SFY 2002 savings from approximately \$329,000 to approximately \$326,000, a nominal difference. We would not necessarily recommend that MAA change its current UCCI estimates, but rather consider a change in methodology for future calculations.

The Unique Transport program creates one-time savings opportunities. In discussions with MAA staff, we learned that there is no systematic way to identify a person who may participate in this program. Moreover, cases are often presented to MAA by transportation providers in the field, who often identify transportation needs through casual conversations with Medicaid clients. We also learned that MAA does not establish savings goals for this program, as it recognizes the unpredictable nature of the potential savings. Because there is no way to predict the number of cases or the cost savings associated with them, we recommend that MAA not rely on this program for achieving its long-term savings objectives.

IV. DEBRIEFING COST CONTAINMENT ACTIVITIES THAT STALLED BEFORE IMPLEMENTATION

In determining potential cost containment strategies for Washington to pursue in the future, Lewin has evaluated certain activities that stalled prior to implementation or that are moving forward more slowly than expected. To identify these activities, Lewin reviewed background material provided by state staff and conducted follow-up interviews for more information. We have included two major initiatives that have not been completed. In addition to these, we found several strategies were discussed but did not move much beyond the discussion stage.

One common barrier states often encounter in implementing new programs is that there are so many systems that need to be coordinated, it may take several months for the program to be completely functional. An example in Washington was the slow implementation of the premiums for Transitional Medicaid Clients. Although the program was officially started, there was a misunderstanding with the eligibility workers and, as a result, premiums were not collected for several months after the start of the program. Another barrier emerged when Washington tried to enroll the SSI population in managed care, namely, financing the pent up demand from a previously underserved population. Although enrolling this population into managed care was expected to save money, the savings was only realized by the enrollment of the TANF population.

A. Primary Care Case Management

In 2001, Washington had developed a Primary Care Case Management Program (PCCM) to serve a portion of the TANF population in Healthy Options. Eleven counties in Washington were voluntary managed care counties at the time the program was developed, meaning that eligible populations could choose to enroll in either a managed care plan or in the FFS program. Washington had the system developed, documents prepared for CMS, and meetings in the community in early 2001.

Before the PCCM program was implemented, MAA terminated the initiative. MAA ultimately decided that a PCCM program might undermine the effectiveness of the full-risk managed care program, Healthy Options. MAA wanted to create an environment conducive to managed care expansion into these counties, rather than focus resources on developing a PCCM. The existence of a PCCM would not encourage managed care expansion and would place the State in competition with own its managed care contractors. Since the PCCM implementation was cancelled, two mid-size counties in Washington will move to a mandatory full-risk managed care model in 2003.

B. Managed Care for the SSI Population

When Washington began its managed care program, the original plan included enrolling all Medicaid beneficiaries, statewide, into managed care. There was some original concern from the advocacy community that managed care would impair access to specialists, particularly for persons with disabilities. To address this concern, the state implemented an exemption/disenrollment process, meaning that persons with considerable needs would be eligible to disenroll from the managed care program.

In an attempt to better serve persons with disabilities, the state employed exceptional need care coordinators (ENCCs), all registered nurses, to contact all SSI clients within 30 to 45 days of their enrollment to perform an initial needs assessment and develop a care plan. This requirement presented a considerable administrative burden. In addition, the ENCCs uncovered significant pent up demand. This pent up demand increased the cost for the MCOs to serve this population to a point where the MCOs were forced to pull out of the program. Without any MCOs to serve the SSI population, Washington returned these clients to the FFS system.

V. ASSESSMENT OF SAVINGS ASSUMPTIONS FOR CERTAIN COST CONTAINMENT ACTIVITIES

There are several initiatives currently or soon to be underway at MAA that have the potential to generate cost savings. The HIFA and Take Charge programs are waiver programs that require approval from the federal government. The disease management program was recently instituted by MAA to provide additional high quality care to Medicaid recipients with certain diseases. The Medicare eligibility programs are pilot projects in one area of the State and have not yet been approved for statewide implementation. The new brokerage model for delivering interpreter services is a legislatively mandated program that will be implemented in 2003.

Because these programs vary in their scope and their stage of implementation, Lewin will not provide a comprehensive evaluation of cost containment related to these initiatives, but rather an evaluation of the savings assumptions that underlie these programs. Therefore, this section does not contain a bottom line savings estimate for each program, but rather provides areas of consideration for the State as it determines the level of cost savings that each program can achieve.

A. Disease Management

Because the disease management (DM) program is relatively new in Washington State, there are not yet sufficient data to establish the overall savings (or costs) of implementing this program. In order to provide perspective on the potential of achieving the levels of savings predicted by the State, we have provided a list of factors that may either contribute or detract from Washington's ability to meet its cost saving targets for the DM program.

1. *Factors Potentially Contributing to Achieving Savings Targets*

Several factors may contribute to the State's ability to achieve its cost savings targets for its DM initiative. These factors include the methodology used to calculate savings, the population enrolled, the structure of the contract with the vendors, and the level of savings the State has established in its goals.

The State has carefully established its methodology for achieving savings, which may contribute to its ability to achieve desired savings levels. First, in order to calculate savings for the individual DM programs, the State developed the methodology for estimation, rather than allowing the DM vendors to develop their own methodologies. In that way, the State can assure that the measurement of savings is consistent with their expectations for the program. In developing the methodology, the State consulted with its actuaries at Milliman USA, as well as with the Disease Management Purchasing Consortium & Advisory Council, which also lends credibility to the methodology.

Another factor contributing to the State's ability to meet its savings objectives is the way in which it is treating the dually eligible (Medicare and Medicaid) population in the programs. Because DM programs can produce savings in such areas as inpatient hospitalization, the savings for the dually eligible population can be largely realized by Medicare, rather than by Medicaid. However, the State has not included the dually eligible population in either the

enrollee populations or the comparison groups in any meaningful way, thereby eliminating the possibility of booking savings that might be realized by Medicare, rather than by Medicaid.

The methodology employed by the State also allows for adjustments of the savings calculation based on forces outside the control of the DM vendor. For example, the State can change its FFS reimbursement rates without affecting the measurement of savings attributable to the programs. This is particularly important in the evaluation of the end stage renal disease (ESRD) program, as the FFS dialysis rates were lowered significantly, effective September 2002.

The structure of the contracts with the DM vendors may also contribute to the State's ability to meet its savings goals. First, the savings targets appear reasonably modest and achievable, which favors the State in meeting these goals. Secondly, the contract provides the vendors with downside risk, whereby they may lose some or all of their administrative fees if they do not achieve the desired savings levels; however, the contract does not provide the vendors with the corresponding upside risk, the potential to share in savings above the established goals. The State thereby avoids a potentially large area of fiscal risk should the actual savings exceed the estimated savings.

Finally, the DM programs appear to be experiencing success in finding active membership in the program. Current enrollment in each program is progressing well. In addition, McKesson has focused its efforts on the highest risk clients. By initiating participation with the highest risk, and therefore most costly participants, McKesson is targeting areas where the largest potential for savings exists.

2. Factors Potentially Working Against the Achievement of Savings Targets

While the State has been very careful and thoughtful in establishing its savings targets for its DM programs, there are several factors that may work against the achievement of these goals. These factors may lead to less savings in the short term and the potential over- or under-statement of actual savings.

Some of the factors that may work against the achievement of savings goals are specific to the individual programs. For example, in evaluating the ESRD program, we noted that the savings for these individuals are not likely to be realized on dialysis treatments, one of the highest expense categories for this population. In fact, Renaissance should encourage increased compliance with dialysis treatment guidelines and thus the State may experience higher dialysis costs than would occur without the program. The savings for ESRD patients would occur as a result of reduced hospitalizations and emergency department visits; however, these kinds of savings are not likely to be realized in the very near term. This could cause difficulty in meeting near term savings targets. In addition, the population enrolled in Washington's ESRD program is comprised mainly of persons relatively early on in their dialysis treatment, as they are not yet Medicare eligible. In the context of the overall dialysis population, they are relatively healthy, thus limiting the potential for achieving cost savings.

While the methodology for calculating savings is well thought-out, there are several concerns that must be raised in the estimation of savings, to avoid over- or under-estimation. For example, one of the desired effects of a DM program is the lengthening of the participants' average life span. While this is a positive and desired effect of the program, the methodology

for calculating savings does not account for the medical costs associated with additional months/years of survival. The calculation is made on a per-person basis and does not specifically adjust for increases in life span. If the program is clinically successful, increases in longevity may negate cost savings on an aggregate basis.

The savings calculation also does not account for catastrophic cases that may occur in either the enrollee population or in the comparison group. A single catastrophic case, especially in a population as small as the ESRD group, could significantly over- or under-state the true savings. Similarly, the methodology does not consider the degree to which enrolled participants and members of the comparison group are in their last year of life, a period that traditionally accounts for significantly higher medical costs. Finally the methodology does not account for differences in the average health status of those who are entering the program. Differences in the baseline average health status could corrupt savings estimates.

While all of these issues are of concern, protecting against these potentially obfuscating factors can be challenging. It may be useful for the State to conduct an alternative estimation approach to ensure that the original calculation is accurately representing true savings. For example, the State may consider looking at an aggregate progression of Medicaid spending for each disease to consider shifts in care that have taken place over time. While this approach will not estimate savings, it could help to validate the findings of the per capita calculation, as outlined in the contract. In addition, the State can measure the savings calculations against the results of the University of Washington study that will analyze utilization impacts of the DM initiative.

B. HIFA Waiver

In light of a growing deficit, Washington State has submitted a waiver to CMS under the Health Insurance Flexibility and Accountability (HIFA) demonstration initiative, in order to contain costs without eliminating entire eligibility groups or services. The waiver proposes to contain costs and improve utilization through the implementation of cost-sharing (co-payments and premiums), benefit design reductions, and enrollment caps on certain groups. At the time of this report, CMS has not made a decision on whether to approve the waiver application.

1. Implementation of Co-payments

A five dollar (\$5) co-payment will be required for all Medicaid clients who choose a brand-name drug when a generic or preferred drug is available. The co-payment will not apply if the prescribing provider deems the brand-name drug “medically necessary.” A ten dollar (\$10) co-payment will be required for all Medicaid clients who seek hospital emergency room services for non-emergent conditions. Hospitals will be authorized to require clients to contact the Medicaid consulting nurse by telephone to discuss whether or not the condition in question requires emergency room treatment. The State’s consulting actuaries have conducted a preliminary analysis which confirms that the application of targeted brand-name and emergency room co-payments would reduce inappropriate utilization. The State has not projected specific saving amounts at this time.

The co-payment on brand-name drugs should not be expected to create significant revenue due to the other pharmacy-related cost containment activities the State is pursuing at this time. The implementation of a preferred drug list (PDL), along with therapeutic consultation services

(TCS) and Intensified Benefits Management (IBM) consultation services, should be expected to change pharmaceutical prescription and utilization patterns to the point where co-payments on brand-name drugs would not occur very often. The savings due to improved drug utilization should be attributed to these other pharmacy initiatives more so than to the implementation of a co-payment. The co-payment will generate some short-term savings while the PDL and consultation services are being introduced, but should not be expected to generate much savings in the long run. It is possible that the co-pay could increase costs if the payment creates a by-pass of the PDL prior authorization process, or if it gives prescribers additional incentives to deem a non-preferred drug “medically necessary”.

The implementation of emergency room co-payments will require the creation of a 24-hour, 7-day per week nurse consultation service. As part of its recently implemented DM project, nurse consulting services will be made available to aged and disabled persons. This service would be expanded to provide consultation for all other Medicaid clients. The savings generated by improved emergency room utilization and co-payments would be offset by the cost of expanding the nurse consulting services. It is too early to estimate the actual savings that will occur.

2. Implementation of Premiums

Washington’s waiver application proposes premiums on the Medicaid eligibility categories of Categorically Needy (CN) Optional Children, Medically Needy (MN) Aged, Blind, and Disabled, and MN Pregnant Women and Children when family income is above 100 percent of poverty. Premiums would also be imposed on families during the entire 12-month period of their Transitional Medical Assistance eligibility. The premium schedule for these eligibility groups is shown in Table 14 below. The payment of premiums is estimated to generate \$13 to \$14 million per year in revenue for SFYs 2004 and 2005. The waiver would give the State the ability to adjust the premium amounts on an annual basis in accordance with the annual increase in federal poverty level (FPL) without a formal amendment. This flexibility will allow to State to maintain its desired level of savings into the future.

Table 14. Premium Schedule under the Proposed HIFA Waiver

FPL Range		Individual Monthly Premium	Family Maximum
Min	Max		
0%	100%	\$0.00	\$0.00
101%	150%	\$10.00	\$30.00
150%	200%	\$15.00	\$45.00
200%		\$20.00	\$60.00

The method used to estimate premiums has the potential to overstate actual premium revenues. To calculate premium revenue, the estimated average monthly caseload by income level was multiplied by the appropriate monthly premium and then annualized. This method does not take into account the family maximum. A family of four would only pay \$30.00, not \$40.00. If

there are several families of four or more in the data, the premium revenue generated would be less than the amount currently estimated.

The implementation of premiums could create savings beyond that of premium revenues alone. Some persons may elect to drop coverage due to their inability or unwillingness to pay the premium. The savings due to enrollment decreases could exceed those resulting from actual premium collections. At this time, Lewin does not have a basis to accurately estimate the effects that premiums might have on enrollment. However, the savings due to decreased enrollment could be offset by a rise in the complexity of medical care. People may choose to delay enrollment until a major medical problem arises, or they may drop coverage when immediate medical care is not necessary. Under this scenario, the State would face higher medical costs per episode and would lose the benefits of preventative medicine and continuity of care.

3. Optional Adult Benefit Design Reduction

The HIFA waiver would allow for the elimination of non-emergent dental, routine vision, and routine hearing benefits for adults in categories of Optional CN Medicaid “Buy-in” and MN Aged, Blind and Disabled, and Pregnant Women. It is estimated that these benefit reductions will reduce the State’s Medicaid expenditures by \$1.3 to \$1.4 million per year for SFYs 2004 and 2005. The methodology employed to estimate savings for this proposal follows the methodology that Lewin would use. In addition, we reviewed the trend assumptions in this section and find them to be reasonable. Therefore, we believe the \$1.3 to \$1.4 million in savings to be reasonably achievable.

4. Enrollment Freeze

The waiver also would allow an enrollment freeze in categories of CN Optional Children, Medically Needy Aged, Blind, and Disabled, MN Pregnant Women and Children, and SCHIP Children when expenditures for the entire Medical Assistance program are projected to exceed the forecasted level in the annual appropriations. The enrollment freeze would only be applied to new enrollees, and not persons transferring from one eligibility group to another nor persons in continuing MN certification periods.

The enrollment freeze would constrain potential growth but not necessarily reduce costs; it would help the State maintain expenditures within the budgeted amount. One potential problem with the enrollment freeze is that those persons on the waitlist could develop more complicated medical problems while the freeze is in place. Once the freeze is lifted and these persons become eligible, their medical care could be more costly than if they had received adequate care when they first applied. Also, the State must consider potential premium revenue decreases, as fewer persons would be eligible than estimated.

C. Medicare Eligibility

The State is currently undertaking two pilot projects to facilitate the enrollment of eligible Medicaid recipients into Medicare. The programs focus on Medicaid recipients with ESRD and or those who are considered Disabled Adult Children. By expediting the enrollment of eligible participants into the Medicare program, the State may avoid paying for services for which

Medicare is ultimately responsible. To evaluate the potential of these programs to achieve cost containment, we have outlined several areas of consideration for the State.

1. End Stage Renal Disease

In order to determine which Medicaid recipients may be eligible for Medicare, MAA identified any patient who is on dialysis and who does not have evidence of Medicare eligibility in the MMIS. In interviews with the State, we learned that about 400 such patients exist currently. However, there appears to may be a backlog of individuals for whom Medicare eligibility has not yet been discerned; once this backlog is fully addressed, the ongoing stream of dialysis patients that might be Medicare eligible is likely to be only 10-15 persons. State staff are now working to address the backlog and assure that dialysis patients obtain the Medicare ESRD Program coverage to which they are entitled at the earliest appropriate juncture (90 days after the onset of dialysis). This effort began in September 2002 and it is anticipated that the backlog-related work effort will extend through June 2003.

It appears that substantial Medicaid cost savings opportunities exist related to this backlog, with the greatest challenge being to get the applications for the ESRD program submitted and approved in a timely fashion. However, Medicare has no reason to delay or deny the applications.

In order to provide an estimate of the level of savings the State may realize by expediting the eligibility process, Lewin derived projected per member, per month (PMPM) savings. These projections are outlined in Table 15. These figures are based on published Medicare costs for dialysis patients under age 65 who are already on ESRD Medicare, and Lewin estimates of the Medicaid costs that will be avoided when the patient is converted to dual eligible status from Medicaid-only status.

Table 15. Estimated PMPM Savings Of Expedited Medicare ESRD Enrollment

Service	Medicare PMPM Costs, Dialysis Patients Age 45-64 ¹³	Estimated Medicaid Cost Factor ¹⁴	Estimated Risk Factor for Pre-ESRD Persons in First Year of Dialysis	Estimated PMPM Medicaid Costs Avoided Through Expedited Application
Dialysis	\$1,128	0.75	1.00	\$846
EPO/iron/vitamins	\$556	0.75	1.00	\$417
All Other Services	\$2,768	0.75	0.75	\$1,557
Total	\$4,452			\$2,820

Table 16 estimates the level of savings that will occur at various levels of expedited enrollment for the backlog population. Based on the State's initial work in this arena, Lewin does not

¹³ Source: United States Renal Data System, 2002 Annual Data Report, Table K.7.

¹⁴ Assumes Medicaid prices are 15 percent below Medicare; another 10 percent is removed to reflect anticipated level of cost sharing for which Medicaid will still be responsible after enrollee becomes enrolled in Medicare ESRD.

anticipate that, on average, more than 30 percent of this population will be converted to Medicare. Our best estimate, shown in bold in Table 16, is that an evaluation of all 400 backlog cases will yield a 20 percent reduction in Medicaid-only dialysis patients. This creates monthly savings of \$225,000 and an annual savings of \$2.7 million. However, this is simply a one-time savings related to the backlog. The annual savings thereafter, given the vastly reduced population of Medicaid-only dialysis patients post-backlog, will be less than \$100,000.

Table 16. Estimated One-Time Annual Savings Of Expedited Medicare ESRD Enrollment

Assumed Number of Medicaid Only Patients on Dialysis	Persons Becoming Dually Eligible	Annual Savings Per Person (\$2,820 x 12)	Total Annual Savings
400 (baseline)	0		
360 (10% reduction)	40	\$33,840	\$1,353,600
300 (20% reduction)	80	\$33,840	\$2,707,200
200 (30% reduction)	120	\$33,840	\$4,060,800

Please note that the savings estimates above do not contain the offsetting administrative expenses associated with the State's work to expedite the eligibility process for recipients with ESRD.

2. Disabled Adult Children

The State suspects that many developmentally disabled persons on Medicaid-only coverage are eligible for Medicare. To confirm its theory, the State undertook a pilot project to determine how many disabled adult children have the potential to be Medicare eligible. The pilot project confirmed that many of these enrollees are eligible for Medicare immediately, and many others are on track for future Medicare eligibility. MAA has identified approximately 975 developmentally disabled adult children receiving only Medicaid coverage, who are potentially Medicare eligible. As with the dialysis patients in the previous section, this subgroup represents a backlog of potentially Medicare eligible persons. An MAA staff person has been assigned to assess each of these cases, and it is anticipated that all cases will have been assessed by the end of calendar 2003. Once the backlog is addressed, the ongoing disabled adult child cases that might warrant assessment for Medicare eligibility may be fewer than 25 persons.

Working with Medicaid claims data from another state (California) as a starting point, average PMPM costs for disabled adult children were estimated as shown in Table 17.

Table 17. PMPM Savings Estimate of Obtaining Medicare Coverage for Disabled Adult Children

Service	Estimated Medicaid PMPM Costs ¹⁵	% Of Medicaid Costs Estimated To Be Averted By Obtaining Medicare Coverage	PMPM Savings
Pharmacy	\$250	0%	\$0
Inpatient Hospital	\$150	90%	\$135
All Other Services	\$200	80%	\$160
Total	\$600		\$295

In working through the estimated backlog of 975 Medicaid-only disabled adult child cases, Table 18 estimates the monthly and annual savings that will occur at various levels of Medicare coverage for this population. Based on the State’s initial pilot work in this arena, which found that 22 percent of the adult children were immediately eligible for Medicare coverage, Lewin anticipates that, on average, 20 percent to 40 percent of this population will be converted to Medicare. Our best estimate, shown in bold in Table 18, yields a one-time annual savings of \$1.0 million. The ongoing annual savings from continuing to assess Medicare eligibility after the backlog issues are evaluated will be much smaller – probably below \$50,000 per year.

Table 18. Estimated Annual Savings Of Obtaining Medicare Coverage for Disabled Adult Children

Assumed Number of Medicaid Only Patients	Persons Becoming Dually Eligible	Annual Savings Per Person (\$295 x 12)	Total Annual Savings
975 (baseline)	0		
780 (20% reduction)	195	\$3,540	\$690,300
683 (30% reduction)	292	\$3,540	\$1,033,680
585 (40% reduction)	390	\$3,540	\$1,380,600

Please note that the savings estimates above do not contain the offsetting administrative expense associated with the State’s work to expedite the eligibility process for disabled adult children. In determining the potential levels of cost containment that can be achieved through this program, the State needs to consider the associated administrative costs.

D. Take Charge Waiver

The Take Charge Waiver program offers family planning services to persons with income up to 200 percent of the Federal Poverty Level (FPL), who are not eligible for full Medicaid benefits. The program encompasses both women who previously received family planning services after a Medicaid-sponsored birth and those who were not previously eligible for Medicaid-sponsored family planning services. Prior to Take Charge, women who were Medicaid-eligible by virtue of their pregnancy (and meeting income requirements) could receive family planning services for 10 months after their post-partum Medicaid eligibility ended. These services were paid for

¹⁵ Source: Approximate PMPM costs of Medicaid-only disabled persons in California.

on a state-only basis, with no federal financial participation. In addition to women who previously received state-only services after a Medicaid-sponsored birth, Take Charge also offers family planning services to women and men who are not eligible to receive other Medicaid benefits, due to income and other eligibility limitations.

In order to create the Take Charge program, MAA requested a waiver from CMS. As required in the waiver application process, MAA created budget neutrality worksheets demonstrating that over a five-year period, the Take Charge program would not cost more than the current program. MAA predicted significant savings from the Take Charge program. In order to evaluate the potential savings, Lewin reviewed the assumptions made in the budget neutrality calculations. The following analysis provides the results of our review, as well as suggestions for MAA to consider in future evaluation of the program.

Savings from family planning waiver programs like Take Charge result from two different populations. First, many of the women to whom family planning services are delivered under these programs would be Medicaid-eligible if they were to become pregnant.¹⁶ By averting these pregnancies, the Medicaid program does not incur the cost of prenatal care, delivery, post-partum care, and any other medical expenses a pregnant woman may incur during her pregnancy. Secondly, the children of mothers who are in the Medicaid program are generally eligible to receive Medicaid themselves. By reducing the number of births, the Medicaid program does not incur the ongoing costs of covering these children.

Family planning waivers offer the additional advantage of increased federal financial participation, with the federal government providing 90 percent of the funding for family planning services. This enhanced match is particularly advantageous to the State of Washington, which had previously established a state-only 10-month family planning extension in its Medicaid program; 100 percent of the funding for these services was provided by the State of Washington, with no federal financial participation. Under the Take Charge waiver, these women now continue to receive family planning services, but the federal government assists the State by providing 90 percent of the funding. In addition, the State can extend family planning services to a previously uncovered population and contribute only 10 percent of the funding.

While Take Charge has the potential to save medical costs based on avoided pregnancies, the net savings amount must be considered in light of the additional cost of providing family planning services. Particularly challenging is demonstrating that the provision of family planning services is budget neutral to the federal government, as it provides a majority of the funding. Table 19 below outlines the potential costs and savings associated with the Take Charge waiver, as estimated by the State in its original waiver application to CMS.

¹⁶ In Washington, a woman is eligible for Take Charge if her income is below 200 percent of FPL, while she would be eligible for Medicaid coverage if she were pregnant and her income were below 185 percent of FPL.

Table 19. State and Federal Costs and Savings Anticipated from Take Charge (in millions)¹⁷

	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006	Total
Costs/(Savings) to the State	(\$2.3)	(\$10.4)	(\$17.1)	(\$23.6)	(\$29.2)	(\$82.7)
Costs/(Savings) to the Federal Government	\$4.2	\$2.9	\$0.6	(\$2.5)	(\$5.5)	(\$0.4)
Total Costs/(Savings)	\$1.9	(\$7.5)	(\$16.5)	(\$26.1)	(\$34.8)	(\$83.0)

As noted in the table above, the Take Charge Waiver is anticipated to save \$83.0 million in state and federal funds over 5 years, from SFY 2002 to SFY 2006. In order to evaluate these cost savings estimates, Lewin took two approaches. First, from the original waiver application, we reviewed the major assumptions that drove the resultant cost and savings estimates. Secondly, since the waiver application was completed on a prospective basis, we reviewed some of the original assumptions against Take Charge's actual experience. Based on the actual experience data, we constructed three scenarios that demonstrate possible budget implications for the state and federal government. The results of our analysis are below.

1. Original Take Charge Assumptions

MAA provided us with the budget neutrality calculations from the original waiver application. To assist us in understanding the assumptions incorporated into this analysis, we conducted a conference call with staff from DSHS' Division of Research and Data Analysis (DRDA). They provided an overview of the assumptions in the analysis and provided insight into the many dynamics that take place in family planning programs, like Take Charge.

Our review of the original waiver focused mainly on the assumptions related to the number of unintended births that would be avoided as a result of increased family planning service utilization. From the target population of 395,900 persons, the waiver assumed that, without the Take Charge program, 27,436 births would occur annually.¹⁸ This is equivalent to an annual birth rate of 69.3 per 1,000 persons. The waiver calculations also assume that 50 percent of these births are unintended. For each state fiscal year, the number of avoided unintended births was assumed to increase as the program matures and additional persons receive family planning services. Table 20 outlines basic with and without waiver assumptions included in the original budget neutrality calculations.

¹⁷ Total numbers may not add due to rounding.

¹⁸ 27,450 births were assumed in SFY 2002. This number of births still translates to approximately 69.3 births per 1,000 persons.

Table 20. Take Charge Birth Rate Assumptions

	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006
Number of Births Without the Waiver	27,450	27,436	27,436	27,436	27,436
Number of Births With the Waiver	27,175	25,378	24,281	23,458	22,909
Percentage Reduction in Unintended Births	2.0%	15.0%	23.0%	29.0%	33.0%
Percentage Reduction to Overall Number of Births	1.0%	7.5%	11.5%	14.5%	16.5%
Number of Persons Assumed to Participate in Take Charge	14,590	34,624	46,949	56,197	62,365

The assumed number of avoided unintended births is clearly one of the major drivers of overall savings and costs. This assumption drives not only the avoided pregnancy-related care but also drives the total avoided costs for children who would enter Medicaid, if born to mothers in the Medicaid program. In order to review the avoided unintended pregnancy assumptions, we calculated the number of avoided births that must occur in the Take Charge population for the *entire* population's birth rate to drop to the "with waiver" assumed number of births. Table 21, following, summarizes the results of our analysis.

Table 21. Analysis of Take Charge Birth Rate Assumptions

	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006
A Total Target Population	395,900	395,900	395,900	395,900	395,900
B Assumed Take Charge Population	14,590	34,624	46,949	56,197	62,365
C Target Population Outside of Take Charge (A – B)	381,310	361,276	348,951	339,703	333,535
D Birth Rate for Target Population Outside of Take Charge (per 1,000 persons)	69.3	69.3	69.3	69.3	69.3
E Expected Number of Births of Population Outside of Take Charge (C × D)	26,425	25,036	24,182	23,541	23,114
F Total Number of Births Assumed (With Waiver)	27,175	25,378	24,281	23,458	22,909
G Number of Births Within the Take Charge Population (F – E)	750	342	99	(83)	(205)
H Birth Rate (per 1,000 persons) Within the Take Charge Population $([G \div B] \times 1,000)$	51.4	9.9	2.1	N/A	N/A
I Percentage Decrease in Birth Rate as a Result of Take Charge Participation	25.8%	85.7%	97.0%	N/A	N/A

In conducting this analysis, we noted that the assumptions of the number of unintended avoided births for SFYs 2005 and 2006 indicate that the birth rate for the Take Charge population would need to drop to less than zero, which is not possible. Alternatively, to

achieve the same number of avoided unintended births, the birth rate in the non-Take Charge population would need to decrease from the current level of 69.3 births per 1,000 persons; however, this population would not receive any additional intervention in order to reach that target. These assumptions make achieving the original cost savings estimates very difficult.

2. Actual Take Charge Experience

Given our concern with the original assumptions, we decided to incorporate alternative assumptions in the second portion of our review. In this section, we have generated several scenarios that demonstrate potential outcomes that result from changes in the number of assumed avoided unintended births. Other assumptions utilized in this section's analysis, including the per capita cost of family planning services and the actual number of Take Charge participants, reflect actual experience from SFY 2002.

To assist us in conducting the second portion of our review, staff from DRDA provided data on actual per capita costs and take-up rates in the Take Charge program. In the first year of the program, per capita family planning costs were significantly less than were assumed in the original waiver application. The original waiver application assumed SFY 2002 per capita costs of \$419.56, while claims data for services delivered in SFY 2002 indicate that the actual per capita cost was approximately \$234.45. Lewin asked DRDA staff why the actual per capita costs were significantly less than the costs assumed in the waiver application. Lewin was informed that there may be two reasons for the decrease in costs. First, the \$234.45 represents a year of claims data with only two months of run-out, and DRDA felt that the number may not be complete due to outstanding provider claims. Secondly, MAA suggests that the original waiver estimate of \$419.56 was designed to account for a more expensive mix of family planning services than was actually realized upon implementation.

In addition to the lower than anticipated per capita costs, the Take Charge waiver program also experienced a much higher than anticipated participation rate. In the first year of the program, the budget neutrality calculations assumed that 14,590 persons would participate in Take Charge. DRDA staff found that 73,108 persons (69,995 women and 3,113 men) actually had paid claims for family planning services through the Take Charge program in SFY 2002.

Given that the actual results in SFY 2002 varied significantly from the assumptions in the original Take Charge waiver, Lewin chose to incorporate these results into the budget neutrality calculations and provide estimates of the impact under three different scenarios. In all three scenarios, we assumed a per capita cost of \$246.79 for SFY 2002 for family planning services.¹⁹ In addition, we used a Take Charge user count of 73,108, the actual number of users in SFY 2002. Because the actual user count in SFY 2002 is similar to the anticipated user rate in SFY 2006 from the original waiver application, we assumed no growth in the number of users from SFY 2002 to 2006. In addition, we assumed a shift in the number of avoided unintended pregnancies, with more pregnancies avoided in the earlier years due to the high initial take-up rate.

¹⁹ We assumed a 5 percent higher per capita cost to adjust for the potential of incomplete data due to claims lag. For SFYs 2003 to 2006, we trended the SFY 2002 figure of \$246.70 forward at the same trend rate assumed in the original waiver, 2 percent.

Incorporating the assumptions above, the following are the three scenarios we modeled in our analysis.

1. Take Charge achieves the same number of *total* avoided unintended births as was assumed in the original waiver application.
2. Take Charge achieves the number of *total* avoided unintended births needed to maintain budget neutrality.
3. Take Charge achieves *half* of the number of avoided unintended births as was assumed in the original waiver application.

The following three sections outline the results of each scenario. It is important to note that these scenarios are not Lewin’s predictions for the actual costs and savings resulting from the Take Charge program. The scenarios are designed to demonstrate some potential outcomes, given limited information on Take Charge’s first year experience.

a. Scenario 1

Under scenario 1, Lewin assumed that the Take Charge waiver would achieve the same total number of avoided unintended pregnancies as in the original Take Charge budget neutrality calculation; however, these avoided births were assumed to take place earlier within the five-year span. Table 22, following, outlines our assumptions and the resulting costs and savings under scenario 1.

Table 22. Scenario 1 Results: Achieving the Same Total Number of Avoided Unintended Births

	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006	Total
Number of Avoided Unintended Births in WA’s Original Waiver Application	275	2,058	3,155	3,978	4,527	13,993
Number of Avoided Unintended Births - Scenario 1 ²⁰	824	3,292	3,292	3,292	3,293	13,993
Difference in Number of Avoided Unintended Births	(549)	(1,234)	(137)	686	1,234	0
Net Costs/(Savings) – State and Federal	\$8.6	(\$16.7)	(\$21.6)	(\$26.5)	(\$30.8)	(\$86.9)
Federal Costs/(Savings)	\$12.3	(\$0.4)	(\$2.7)	(\$5.0)	(\$7.0)	(\$2.7)
State Costs/(Savings)	(\$3.7)	(\$16.3)	(\$18.9)	(\$21.5)	(\$23.8)	(\$84.3)

Under scenario 1, the shift of avoided unintended births to earlier fiscal years caused the program to realize greater savings across the five year period than in the original waiver application. Our analysis shows savings of \$86.9 million (total state and federal) over 5 years, as compared to \$83.0 million in the original application. From a budget neutrality perspective, the federal savings reached almost \$2.7 million over the 5-year period. From the State’s perspective, should the higher than anticipated number of program participants realize more

²⁰ We assumed that the number of avoided unintended births in SFY 2002 was one-fourth of the number in subsequent fiscal years. The Take Charge program began on July 1, 2002. Assuming a nine-month gestation period, the first avoided unintended birth would occur three quarters of the way through the first year, thus reducing the potential number of avoided unintended births to one-quarter of the potential in subsequent years.

avoided unintended births earlier than originally anticipated, the savings results are positive. The revised assumptions result in first year savings of \$3.7 million for the State, with a cost of \$12.4 million to the federal government. Under the waiver’s original assumptions, the State would realize \$2.3 million in savings while the federal government would realize \$4.2 million in costs.

In order to achieve the results of this scenario, the Take Charge program would need to reduce the birth rate of 69.3 births per 1,000 by 16.0 percent in SFY 2002. The birth rate in subsequent fiscal years would need to be 65 percent lower than the original 69.3 per 1,000 rate. Table 23 outlines the result the assumed reductions in birth rates under this scenario.

Table 23. Analysis of Take Charge Birth Rate Assumptions Under Scenario 1

		SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006
A	Total Target Population	395,900	395,900	395,900	395,900	395,900
B	Assumed Take Charge Population	73,108	73,108	73,108	73,108	73,108
C	Target Population Outside of Take Charge (A – B)	322,792	322,792	322,792	322,792	322,792
D	Birth Rate for Target Population Outside of Take Charge (per 1,000 persons)	69.3	69.3	69.3	69.3	69.3
E	Expected Number of Births of Population Outside of Take Charge (C × D)	22,369	22,369	22,369	22,369	22,369
F	Total Number of Births Assumed (With Waiver)	26,626	24,144	24,144	24,144	24,144
G	Number of Births Within the Take Charge Population (F – E)	4,257	1,775	1,775	1,775	1,775
H	Birth Rate (per 1,000 persons) Within the Take Charge Population $[(G \div B) \times 1,000]$	58.2	24.3	24.3	24.3	24.3
I	Percentage Decrease in Birth Rate as a Result of Take Charge Participation	16.0%	65.0%	65.0%	65.0%	65.0%

b. Scenario 2

Under Scenario 2, Lewin has calculated the point at which the assumed number of avoided unintended births will cause the Take Charge program to be budget neutral from the federal perspective. As mentioned earlier, with the movement of state-only populations into the shared federal/state program and the 90 percent federal financial participation, budget neutrality is most difficult to maintain from the federal perspective. Table 24, following, provides the results of scenario 2, the “break-even” point for the federal government over the five-year waiver period.

Table 24. Scenario 2 Results: Break Even Point for Federal Budget Neutrality

	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006	Total
Number of Avoided Unintended Births in WA's Original Waiver Application	275	2,058	3,155	3,978	4,527	13,993
Number of Avoided Unintended Births in Scenario 1	799	3,192	3,192	3,192	3,193	13,568
Difference in the Number of Avoided Unintended Births	524	1,134	37	(786)	(1,334)	(425)
Net Costs/(Savings) – State and Federal	\$8.9	(\$15.7)	(\$20.4)	(\$25.1)	(\$29.3)	(\$81.7)
Federal Costs/(Savings)	\$12.4	\$0.1	(\$2.1)	(\$4.3)	(\$6.2)	\$0.0
State Costs/(Savings)	(\$3.6)	(\$15.8)	(\$18.3)	(\$20.9)	(\$23.1)	(\$81.7)

The break-even point for federal budget neutrality under this scenario is achieved when the number of avoided unintended births reaches approximately 97 percent of the total assumed under scenario 1. Under scenario 2, total savings would decrease by \$0.3 million over the 5-year period from the amount calculated in the original waiver application. However, if the number of avoided unintended births in this scenario were realized, Washington would still achieve substantial savings of \$81.7 million over five years, with first year savings exceeding the original waiver projection by \$1.3 million.

In order to achieve the results of this scenario, the Take Charge program would need to reduce the birth rate of 69.3 births per 1,000 by 15.5 percent in SFY 2002. The birth rate in subsequent fiscal years would need to be 63 percent lower than the original 69.3 per 1,000 rate. Table 25 outlines the result the assumed reductions in birth rates under this scenario.

Table 25. Analysis of Take Charge Birth Rate Assumptions Under Scenario 2

		SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006
A	Total Target Population	395,900	395,900	395,900	395,900	395,900
B	Assumed Take Charge Population	73,108	73,108	73,108	73,108	73,108
C	Target Population Outside of Take Charge (A – B)	322,792	322,792	322,792	322,792	322,792
D	Birth Rate for Target Population Outside of Take Charge (per 1,000 persons)	69.3	69.3	69.3	69.3	69.3
E	Expected Number of Births of Population Outside of Take Charge (C × D)	22,369	22,369	22,369	22,369	22,369
F	Total Number of Births Assumed (With Waiver)	26,651	24,244	24,244	24,244	24,244
G	Number of Births Within the Take Charge Population (F – E)	4,282	1,875	1,875	1,875	1,875
H	Birth Rate (per 1,000 persons) Within the Take Charge Population $[(G \div B) \times 1,000]$	58.6	25.6	25.6	25.6	25.6
I	Percentage Decrease in Birth Rate as a Result of Take Charge Participation	15.5%	63.0%	63.0%	63.0%	63.0%

c. Scenario 3

Under scenario 3, we assumed that the State would only achieve 50 percent of the original number of avoided unintended births. However, in this analysis, we continued to assume that the per capita family planning costs are lower and the take-up rate is higher than originally projected in the waiver application. Table 26, following, demonstrates the result of this scenario.

Table 26. Scenario 3: Achieving Half of the Total Number of Avoided Unintended Births

	SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006	Total
Number of Avoided Unintended Births in WA's Original Waiver Application	275	2,058	3,155	3,978	4,527	13,993
Number of Avoided Unintended Births in Scenario 1	412	1,646	1,646	1,646	1,647	6,997
Difference in the Number of Avoided Unintended Births	137	(412)	(1,509)	(2,332)	(2,880)	(6,996)
Net Costs/(Savings) – State and Federal	\$12.5	\$0.0	(\$2.3)	(\$4.6)	(\$6.6)	(\$1.0)
Federal Costs/(Savings)	\$14.3	\$8.1	\$7.1	\$6.1	\$5.3	\$40.9
State Costs/(Savings)	(\$1.8)	(\$8.1)	(\$9.4)	(\$10.7)	(\$11.9)	(\$41.9)

Under scenario 3, achieving only half of the assumed total number avoided unintended births, the Take Charge program is no longer budget neutral from the federal perspective. The program would continue to be an overall savings of \$1.0 million; however, the federal

government would experience costs of \$40.9 million. Washington would continue to realize savings, but only about half of the total amount calculated in scenarios 1 and 2.

In order to realize the results under this scenario, the Take Charge program would need to reduce the birth rate of 69.3 births per 1,000 by 7.9 percent in SFY 2002. The birth rate in subsequent fiscal years would need to be 32.5 percent lower than the original 69.3 per 1,000 rate. Table 27 outlines the result the assumed reductions in birth rates under this scenario.

Table 27. Analysis of Take Charge Birth Rate Assumptions Under Scenario 3

		SFY 2002	SFY 2003	SFY 2004	SFY 2005	SFY 2006
A	Total Target Population	395,900	395,900	395,900	395,900	395,900
B	Assumed Take Charge Population	73,108	73,108	73,108	73,108	73,108
C	Target Population Outside of Take Charge (A – B)	322,792	322,792	322,792	322,792	322,792
D	Birth Rate for Target Population Outside of Take Charge (per 1,000 persons)	69.3	69.3	69.3	69.3	69.3
E	Expected Number of Births of Population Outside of Take Charge (C × D)	22,369	22,369	22,369	22,369	22,369
F	Total Number of Births Assumed (With Waiver)	27,038	25,790	25,790	25,790	25,790
G	Number of Births Within the Take Charge Population (F – E)	4,669	3,421	3,421	3,421	3,421
H	Birth Rate (per 1,000 persons) Within the Take Charge Population ((G ÷ B) × 1,000)	63.9	46.8	46.8	46.8	46.8
I	Percentage Decrease in Birth Rate as a Result of Take Charge Participation	7.9%	32.5%	32.5%	32.5%	32.5%

Scenarios 1 and 2 demonstrate great potential for cost savings, should the higher than anticipated number of participants in the early stages of the program avoid more unintended births than was originally forecasted. However, these results should be viewed with caution. Because budget neutrality is measured over a five-year cumulative period, the result of not meeting the anticipated number of avoided unintended births could cause significant fluctuations in overall budget neutrality, as demonstrated in scenario 3. For example, if the State did not realize at least 97 percent of the 13,993 assumed avoided unintended births (under the revised assumptions), the program would no longer generate cost savings to the federal government. If the State only reaches half of the predicted number of avoided unintended births, the program would cost the federal government \$40.9 million, with an overall savings of just \$1.0 million.

While it is difficult to predict the potential for Washington to achieve its targeted reduction in births, many other states have reported success with similar family planning waiver programs. For example, as a result of a study conducted by the University of California, San Francisco, evaluators reported to the California legislature that the state's PACT (Planning, Access, Care and Treatment) program prevented 50,000 unintended births for 749,572 clients in its first

year.²¹ An evaluation of the State of Rhode Island's RIte Care program, which includes the State's family planning waiver extension program, reported a 50 percent reduction in three years of the number of women who have had a subsequent Medicaid-sponsored birth within 9 months of a prior birth.²²

3. Factors Influencing Washington's Ability to Achieve Cost Savings Targets

As the final part of our analysis of the Take Charge program, we have provided items for consideration as the State conducts its own evaluation of the program's cost savings. We have outlined several factors that may either contribute to or detract from Washington's ability to realize its projected savings goals, as well as to maintain budget neutrality from the federal perspective.

The State's original waiver application projected a total savings of \$83.0 million in state and federal funds over the 5-year waiver period. Given the assumptions utilized in the original application, reaching the projected cost savings amount could be difficult. However, the actual experience of Take Charge in SFY 2002 is a factor that may contribute to Washington's ability to meet its savings goals and maintain budget neutrality. The lower than anticipated per capita family planning costs reduce the "cost" side of the with-waiver calculation. In addition, the higher than anticipated take-up rate provides the opportunity to avoid more unintended births, both in total and in earlier stages of the waiver program. However, the budget neutrality calculation is heavily dependent upon the assumed number of avoided unintended births. In determining the cost savings generated by Take Charge, this number should be carefully scrutinized.

As mentioned above, achieving a high number of avoided unintended pregnancies is key to realizing significant cost savings and maintaining federal budget neutrality. Another factor that may lead the Take Charge program to realize a high number of avoided unintended births is the program's approach to ensuring effective contraceptive use. The Take Charge program not only provides financial access to family planning services, but also provides training to providers to promote client-centered practice. Based on several research studies, the Take Charge program has developed a conceptual model, designed to increase the successful use of family planning services through client-centered provider behavior that promotes client self-efficacy.²³ Including this component in the overall program design may assist Washington in meeting the number of avoided unintended pregnancies needed to effect the desired cost savings.

While the Take Charge program has several factors that may contribute to the achievement of cost savings goals, we are concerned that the additional volume of family planning recipients may be somewhat misleading. In our research, we learned that many Take Charge participants are notified of their potential eligibility for the program while they are seeking family planning services in a clinic or other provider setting. For example, DRDA staff informed us that 12,362

²¹ University of California, San Francisco News Release. <http://www.ucsf.edu/pressrel/2000/07/072101.html>.

²² Kaiser Family Foundation. "Medicaid Coverage of Family Planning Services: Results of a National Survey." <http://www.kff.org/content/2001/2216/2216.pdf>.

²³ Information on Take Charge's conceptual model provided by Dr. Laurie Cawthon in the Take Charge Evaluation Design.

of the Take Charge enrollees had claims at Title X clinics. This suggests that at least some Take Charge participants likely received some sort of family planning services through other means *prior* to the beginning of the program. To some degree, Take Charge could be creating a Medicaid payment mechanism for visits that otherwise would have occurred and may not be creating nearly as many additional visits as the high take-up rate implies. If this is the case for a sizeable portion of the added family planning visits, it will be extremely difficult to achieve the birth rate reduction necessary for the program to prove budget neutral.

4. Considerations for Future Evaluation of Cost Savings

As Washington undertakes its evaluation of the Take Charge program, we would suggest that evaluators consider changes at the clinic level. While administrative data can provide aggregate counts of utilization and cost, individual clinics can provide valuable insight into the change in the delivery of family planning services. For example, the clinics can provide information on changing volume of services and the type of payer through whom individuals are receiving services. This kind of evaluation may shed light on the concerns that this program may shift payment of services rather than actually affecting the birth rate.

In addition, the estimation of the potential cost savings associated with the Take Charge program does not include the additional costs and savings that may be associated with some of unintended consequences of the waiver program. In our discussions with DRDA, we learned that approximately 100 women per month seeking family planning services discover they are pregnant and enroll in Medicaid. While it is unknown whether all or some of these women may have sought family planning services regardless of the waiver, as discussed earlier, the discovery of their pregnancies likely impacts Medicaid's costs. For example, had the women not sought family planning services at clinics participating in the Take Charge program, they may not have been aware of state-funded pregnancy terminations available to them. In addition, some women may have discovered their pregnancies earlier than they would have otherwise, had they not sought family planning services. This could increase the amount of prenatal care utilization in the Medicaid program. However, the earlier detection of the pregnancies and the subsequent prenatal care may offset high-cost Medicaid births in the future, had these women not received prenatal care earlier in their pregnancies because of successful outreach under the Take Charge program. While the cost neutrality calculations do not factor in these items, the State should consider them in the context of overall cost savings.

Finally, MAA has been considering the potential for this waiver to contain costs as part of the UCCI. The methodology for calculating cost avoidance over time for the Take Charge waiver is not consistent with the methodology employed in other areas of the UCCI. Cost avoidance in other UCCI programs is generally booked for a 12 month period after the initial cost avoidance. In Take Charge, cost avoidance can be accrued over multiple fiscal years, potentially up to a five-year period. For example, for an avoided unintended birth in SFY 2002, savings generated through not covering the child in the Medicaid program can be booked in each of SFYs 2003 to 2006. To be consistent with other UCCI initiatives, the State must carefully consider the length of time for which Take Charge cost avoidance can be booked under UCCI to ensure comparability of all savings projections.

E. Interpreter Services - Efficiencies

In the 2002 Supplemental Budget, the legislature anticipated that MAA would establish a brokerage system for the delivery of interpreter services by January 1, 2003. The development of this model is an alternative to eliminating these services altogether. For SFY 2003, the new model is anticipated to save MAA \$1.75 million, while realizing the entire DSHS savings of \$2.55 million. The estimates for these savings were developed by legislative staff and were incorporated into the 2002 Supplemental Budget.

Because the new brokerage model has not yet been implemented, we chose to provide an evaluation of the factors that may contribute to the interpreter services brokerage model meeting its savings targets, as well as the factors that may work against realizing these savings.

1. Factors Potentially Contributing to Achieving Savings Targets

Savings targets for the new interpreter services brokerage model are significant, but several factors will assist Washington in meeting these targets. Specifically, both Washington's extensive experience in developing and maintaining brokerage models, as well as the payment structure that has been developed for the interpreter services model will contribute to the State's ability to meet these aggressive targets.

First, MAA, specifically the Transportation Services Program, has significant experience in developing and managing brokerage programs. The non-emergency transportation brokerage model has been successfully implemented since 1988. The State plans to draw upon its experience from this program, which should allow for more efficient implementation and the ability to meet its savings targets. The State will also draw upon its purchasing power to negotiate more competitive rates from providers. MAA is largest purchaser of interpreter services in the State. Leveraging its market share through the brokerage model should contribute to its ability to meet its savings targets.

MAA's methodology for establishing its overall expenditures will assist the DSHS in meeting its savings goals. In order for MAA to meet its savings objectives, it must remain within its overall budget, which is the forecasted expenditures less the anticipated savings detailed in the budget notes. To live within this budget, MAA projected its overall utilization of services for the year and divided the overall budget by that amount to reach a maximum hourly payment limit of \$28 per hour. The hourly limit reflects the most that any provider can charge for one hour of service, but it is not necessarily the amount the provider will charge. One advantage of the brokerage model is that the maximum hourly rate can be changed quickly if, for example, utilization exceeds the original projections.

In addition to the flexibility of the brokerage model and MAA's global approach to reaching its savings target, the brokerage model has established its utilization measures on an encounter basis, rather than on an hourly basis. The encounter system should help to limit the amount of overbilling within the program by paying for services based on the type of service, rather than

by the amount of time spent by the provider.²⁴ While an encounter system does not completely eliminate the potential for overbilling, it will allow MAA to more closely control utilization.

2. Factors Potentially Working Against the Achievement of Cost Savings Targets

While MAA has several factors potentially contributing to its success in meeting its savings targets in for the end of SFY 2003 and beyond, there are some concerns that may cause the program to fall short of its targets.

A brokerage model for the delivery of interpreter services is experimental. In interviews with MAA, Lewin learned that MAA was unaware of any other model in the country for brokering interpreter services. While this model has served the non-emergent transportation program well, its adoption into the interpreter services program may produce unintended consequences. Without experience in other states, it is difficult to determine what aspects of interpreter services, if any, may not be well-suited to this model. In addition, this model was mandated as part of the 2002 supplemental budget, with an implementation date of January 1, 2003. Therefore, there was not a great deal of time allotted for the development and implementation of this experimental program. Time constraints could provide additional pressures that may affect a successful implementation.

As mentioned above, the maximum hourly charge for services in this program was established based on the total budget and the anticipated utilization of services. If either of those factors changes significantly, overall savings could be jeopardized. For example, should utilization of services increase dramatically, MAA may not be able to adjust its maximum hourly rate to meet the increase in demand. MAA will not be able to reduce its hourly rate to levels substantially below market rates to achieve its savings targets. Should utilization be significantly higher than originally anticipated, such that it demands a more significant decrease in rates than the market can bear, MAA could encounter cost overruns. Also, in interviews with MAA staff, we learned that the interpreter services program has been allowed to go over budget in the past. Funds from other areas have supplemented interpreter services costs. Should the program be allowed to continue to go over budget, overall cost savings may not be realized.

F. Alternative Payers – Clark County Pilot

In addition to the UCCI initiative to obtain VA coverage for the pharmaceutical costs generated by veterans in VA nursing homes (discussed above), Washington is considering expanding its efforts to move appropriate medical costs to the VA. It is currently working through logistical concerns to expand VA pharmaceutical coverage to all veterans in nursing homes, not just those residing in VA nursing homes. It is also exploring other military-related benefits for Medicaid recipients, such as TRICARE and CHAMPUS.

These pilot projects are exploring multiple ways in which to move medical costs from Medicaid to the VA for those who are eligible to receive veterans' benefits. To assist the State as it undertakes these kinds of analyses, we researched some of the issues the State may encounter as it tries to expand VA coverage on a wider basis. We explored these issues in the context of the

²⁴ MAA assumes an average of approximately 1.7 hours per encounter.

Clark County pilot project, where a concerted effort is being made to discern Medicaid enrollees who are jointly eligible for VA coverage.

1. Eligibility for Veterans Services

As the State has already encountered in its Clark County pilot projects, determining eligibility for veterans' benefits is complicated. The administrative data collected by the State does not directly capture eligibility for veterans' benefits. For example, the State can generally identify Medicaid clients who receive VA pensions; however, only a portion of veterans who are eligible for VA medical benefits also receive a VA pension. Some initial Clark County findings suggest that there are far more (perhaps 2 to 3 times more) persons who are eligible for both Medicaid and VA benefits than those who are registered in the Medicaid eligibility system as being veterans. Because data are not readily available, significant administrative resources could be devoted to determining eligibility for VA benefits.

In a larger scale initiative, the State must consider: first, whether its pharmaceutical pilot project in Clark County is cost effective; and secondly, whether the remaining claims for veterans outside of nursing homes are worth pursuing in light of the additional administrative burden. Moreover, the State has spent significant resources in identifying veterans in VA nursing homes, a population that is more likely to be aware of the potential for VA coverage. It has not yet been determined whether this pilot project is cost effective. Identifying clients outside of nursing homes may prove more administratively difficult than in the Clark County pilot, and MAA must consider this issue, in light of the cost effectiveness in Clark County, as it looks to expand VA coverage. In addition, pharmaceuticals accounted for approximately 70 percent of Medicaid claims for veterans in the Clark County project. In terms of overall cost effectiveness, the State should consider whether to pursue total medical coverage for veterans through the VA or limit its pursuit to the coverage of pharmaceuticals, where the bulk of expenditures lie.

2. Encouraging the Use of VA Services

The VA health system is available for veterans to use on an *optional* basis. In an interview with a VA staff member who specializes in patient billings, she indicated that many veterans who are eligible for care at the VA do not elect to receive services from the VA because they are comfortable with their own providers and do not wish to change. VA health coverage responsibility generally corresponds only to those situations where a veteran chooses to obtain care at a VA facility by VA employed medical professionals. It appears that sizable savings could be realized by Medicaid if the VA system were accessed more fully by Medicaid veterans. However, the veteran must be willing to change providers and receive services at the VA facility.²⁵

While the VA has no legal means of turning away eligible veterans, there are issues that may impede Medicaid-eligible veterans from receiving services through the VA. For example, the VA is currently experiencing serious capacity constraints due to high demand for prescription

²⁵ The VA is generally not responsible for services provided by non-VA providers. The VA will only pay for limited services provided by non-VA medical professionals in special circumstances that include 100 percent service-connected disability and the inability to travel to the nearest VA facility.

medication coverage among Medicare-eligible veterans. According to our interviews with VA staff, current waiting lists run into the thousands, even in smaller communities. While veterans with low-incomes, including Medicaid-eligible veterans, have priority on VA waiting lists, veterans may still experience a delay in receiving care that they may not experience if they accessed Medicaid providers. This delay could discourage veterans from accessing care through the VA.

In addition, the State's efforts to cost shift to the VA find a potentially troubling precedent in the relationship between Medicaid and the Indian Health Services (IHS). Like the VA, IHS is entirely federally-funded, is a federally-run provider, and it may not turn away eligible participants, including eligible participants on Medicaid. In response to a budget crisis in the 1980s, the State of Arizona attempted to divert Medicaid-eligible Indians to IHS, and it attempted to deny Medicaid funds to IHS for the resulting Medicaid claims. IHS subsequently sued the State of Arizona and prevailed in federal court, blocking the state from actively pursuing these cost-shifting strategies.

3. *The Potential for Savings*

If the State chooses to expand its initiatives to maximize the medical services provided by the VA, it must take great care in determining the potential savings that can actually be achieved. If the State chooses to make the Clark County program its model for estimating savings, some care must be taken in extrapolating these figures to a statewide amount. Clark County has 5.8 percent (336,268 persons, per 1999 Census data) of the State's population. However, Clark County residents have excellent geographic access to the Portland VA Medical Center in Oregon – both to the main campus and to a campus in Clark County itself. Thus, veterans in Clark County may be particularly likely to utilize the VA health system, and may even be disproportionately likely to reside in Clark County. Thus, our initial sense would be that savings from VA-related COB activities in Clark County are likely to be higher in proportion to what can, on average, be achieved in the rest of the State. In addition, it is unclear how many veterans may be willing to access care at the VA, given that they have not accessed it to this point.

Additionally, in calculating the savings from the Clark County pilot, it will also be important to track the administrative costs that were incurred to undertake the pilot project. As mentioned above, it is difficult to determine which Medicaid recipients are eligible for veterans benefits. It is possible that the administrative burdens associated with this effort will outweigh the savings that can be achieved.

VI. CONCLUSION

In conclusion, we are very impressed by the State of Washington's effort to measure the financial effects of its Medicaid cost containment strategies. The State, and MAA in particular, have been careful and thoughtful in their approach to measuring cost savings.

While we applaud these efforts, we suggest some modifications to current methodologies. Specifically, we suggest that cost recoveries only be booked when the actual amount is received and that this practice be instituted throughout all cost containment programs at MAA. We also suggest that MAA re-examine its cost avoidance methodologies to ensure consistent application of the 12 months' rule.

We also suggest that MAA carefully consider all of the potential forces that may act upon its larger scale initiatives, such as Take Charge and the HIFA waiver to ensure that cost savings expected from these programs actually may be realized.

We again would like to thank the many Washington State employees from MAA, DSHS, the Legislature and OFM for their thoughtful input and feedback. We especially would like to thank the many staff members who provided data for this project and assisted us in understanding the many intricacies of their programs. We look forward to continuing to work with them as we conduct the third and final report in this series.