

Massachusetts Medicaid: Innovative Fiscal Strategies

The Public Partnership Model



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We are pleased to share our report, *Massachusetts Medicaid: Innovative Fiscal Strategies, The Public Partnership Model*, with you. This report provides a snapshot of the innovative programs UMass Medical School's Center for Health Care Financing has initiated and conducted on behalf of the Commonwealth of Massachusetts.

You will see in the following pages how we have been able to generate revenue and achieve cost avoidance totaling \$26 billion over the past 15 years. And while the numbers are impressive, especially in increasingly difficult fiscal times, the more important story is what can be accomplished when the family of state agencies in Massachusetts collaborate and combine their strengths to better serve the public.

The public partnership model offers states the flexibility to adapt their programs in changing times, administrative efficiencies that optimize resources, and an environment where innovation is achievable. The considerable cost savings achieved by working with a public partner provides states with additional funds to improve the lives of its citizens, especially those who are most vulnerable and in need of support.

We are proud of our accomplishments, and we believe they affirm our ongoing commitment to public service and fulfill our vision of providing underserved populations access to quality health care.

Best regards,

A handwritten signature in cursive script that reads 'Thomas Manning'.

Thomas D. Manning, M.A., CAGS
Deputy Chancellor, Commonwealth Medicine

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A Powerful Public Partnership for Flexibility and Innovative Solutions

Health care today is more complex than ever. Whether it's understanding the ramifications of health care reform, developing care strategies for special populations, synthesizing research into effective policy, or adapting to new fiscal realities, organizations of every shape and size are struggling to make sense of the changes sweeping through the system — all while containing costs and providing the highest level of care. Like every state, Massachusetts spends a substantial portion of its state budget — this year nearly 30 percent — providing essential health services to about a quarter of its residents, particularly the sickest and poorest residents. For over 25 years, the University of Massachusetts Medical School (University) has provided wide-ranging supports and services to agencies within the Executive Office of Health and Human Services (EOHHS) through a collection of centers and programs, now known as Commonwealth Medicine.

Commonwealth Medicine understands these challenges, and knows what it takes to navigate the changing face of health care. A division of the Chancellor's office at the University of Massachusetts Medical School, Commonwealth Medicine provides a broad spectrum of clinical, fiscal, policy, research, and administrative consulting services to both public- and private-sector clients, working with them to develop and implement innovative solutions to some of today's most pressing health care issues. Our experts truly understand the health care system — because they're part of it. We bring all the experience, global reach, and thought leadership of a world-class academic health sciences center to our work. From our unmatched performance in Medicaid cost savings and revenue recovery, unique in the nation, to a pharmacy management program that achieved one of the highest rates of generic drug usage among Medicaid programs in the country, our reputation for excellence is evident.

We understand the health care issues that disproportionately impact vulnerable populations, and through our unique public university partnership model, we work collaboratively with state agencies to help improve health care delivery, manage costs, and maximize revenue.

Why the Public Partnership Works

State managers regularly need the flexibility to redirect resources to real-time priorities or unexpected and urgent programmatic and policy developments. This constant need to adjust priorities and focus is the norm for state executives, and those that have the tools to be agile in the face of new challenges do it best. Private vendors are obligated to provide services only to the precise terms of a contract, the scope of which is typically multi-year where parties did their best, years earlier, to anticipate the scope of services needed for years into the future. When faced with resource needs for an unanticipated current problem, states must negotiate even the willingness to make scope changes with a private vendor. With a public partner, however, there exists a perpetual and inherent obligation to move resources wherever they are needed and to respond cooperatively and collaboratively where the interests of the Commonwealth drive all requests for changes. Moreover, these resources are under the direct management of the Commonwealth.

Utilization of private contractors may indeed be most efficient in program areas that remain stable and relatively unaffected by fiscal and policy fluctuations or rapid evolution in clinical science or health care related technologies, in which core contract responsibilities are steady and predictable. But many government responsibilities require management agility, fiscal flexibility, and long-term commitment to the public interest, with or without monetary gain.

Center for Health Care Financing: No Parallel Nationally

Medicaid expenditures currently consume about one-third of a state's budget and are likely to grow under health care reform; and thus, it is essential that a state be able to apply extensive and coordinated resources to assure the fiscal integrity of its programs. But securing adequate resources is daunting. State Medicaid agencies are challenged to fulfill this critical need, because fluctuations and limitations in their administrative budgets make it difficult to maintain sufficient staff resources and technology tools to meet their savings and revenue targets, let alone invest in new revenue and savings initiatives. Many states try to address this challenge, by contracting with private firms under a performance-based contingency rate, to help fulfill their core savings and revenue functions; those core functions arise from federal mandates issued by Medicaid's federal oversight agency. The result, in many states, is an inefficient dependency on non-state staff working under the



management of private companies to carry out essential public tasks.

In Massachusetts, a unique combination of public resources supplemented by private contractors is used to perform these mandated fiscal functions. Recognizing that the Commonwealth needed a consistent, well-resourced, in-house staff of experts to conduct critical Medicaid financing functions if it were to meet ambitious cost savings and revenue targets, the state's Medicaid agency supported the founding of the Center for Health Care Financing (Center) at the University in 1996. In the 15 years since its formation, the Center, in collaboration with the state's Medicaid agency (MassHealth), EOHHS, and other agencies within EOHHS, has made available to state government a Medicaid cost savings and revenue recovery resource that has no parallel nationally.

The Center affords the Commonwealth a high-performing and less expensive option across a broad range of third-party liability, benefit coordination, federal revenue maximization, program integrity, and revenue operations activities than is available from the private sector. There is no single vendor, or combination of vendors, that performs the scope of savings and revenue projects that the Center manages and conducts on behalf of the state. Both the University and EOHHS maintain competitively procured qualified vendor lists of pre-approved vendors to facilitate the involvement of private vendors when needed.

Advantages of University-Agency Public Partnerships

As the state's public medical school, the University partners with EOHHS in the same manner that numerous other state agencies do. Public agency relationships established to provide services by one agency to another are common in Massachusetts and are generally known as interdepartmental service agreements (ISAs). Among the agencies within the EOHHS Secretariat alone, such relationships are valued in the hundreds of millions of dollars annually. The Commonwealth has invested substantial public resources in its medical school. And like all public university assets, the University is regularly called upon to meet state and public needs; the most familiar example is meeting the state's workforce training needs. The Center provides similar cost-effective, enhanced value in managing a growing spectrum of financial and fiscal integrity responsibilities of the EOHHS agencies, focusing on federal financial operations, opportunities, and innovative benefit coordination systems.



Working with a public partner affords EOHHS an enhanced ability to conduct core Medicaid savings and revenue functions utilizing experienced public employees. This gives the state flexibility to co-design and adapt programs and projects to the state's pressing needs and shifting interests — instead of being bound by the strict terms of a contract awarded by virtue of a public procurement. The Center also serves EOHHS and MassHealth (the state's Medicaid agency) as a fiscal watch to help it assure that all Medicaid payments are appropriate, that the state's fiscal administration of the Medicaid program is in compliance with federal and state law, and that both providers and the federal government are meeting their Medicaid program and payment obligations.

The Contracting and Compensation Structure

All of the Center's work with state agencies and offices is performed under ISAs; however, with very few exceptions, the compensation is earned on a performance-based contingency fee. Such contingency fee-based compensation is allowed only under the terms of state laws, which grant authority to the Office of the Comptroller to enter into contingency-based contracts and to regulate the use of this compensation method. The state legislature has further directed the use of this compensation structure specifically in ISAs between the University and EOHHS annually in outside budget section language.

The Comptroller's regulations specify the criteria to be applied to ISAs using performance-based reimbursement and the requirements to which EOHHS and the University must adhere.

Those requirements include the need for EOHHS to justify the choice of the University to perform the work described in the ISA and also to describe the costs and net benefits to the state associated with the selection of the University to either perform or manage the work. A proposed ISA is submitted to the Comptroller for review, comment, and approval; in the case of a renewal of an ISA, the Office of Administration and Finance has the explicit authority to review, comment, and approve an ISA. In practice, that office routinely reviews all ISAs.

Financial Advantages

Through a transition of core functions and staff to the University, EOHHS has sought and achieved administrative efficiencies, the integration and consolidation of savings and revenue activities, and the enhancement of performance — while maintaining administrative cost neutrality for these financial services to the



extent practicable. Over time, various surveys conducted regarding vendor costs for particular Medicaid savings and revenue projects in other states have consistently revealed that the University is a less expensive option for the Commonwealth.

One example of the many units whose services are made available to state government at lower cost is the Center's Public Provider Reimbursement (PPR) unit, which is responsible for revenue billing at 20 public health care institutions and four community-based programs sponsored by a dozen agencies within the EOHHS Secretariat. This function was transferred to the Center in 2004 as part of a broader reorganization of billing staff at agencies within the Secretariat and houses about 40 percent of the Center's staff. The ISA's performance-based rate (1.25 percent) is intended to be near the University's actual cost for the operation; this cost is far lower for the state than a private-sector option for which a comparison is available.

For example, in July 2010, the Center assumed direct operational responsibility for billing at several Department of Mental Health sites and programs, replacing a private vendor. The vendor who had historically performed this service proposed a cost of \$1.127 million for fiscal year 2011; the Center proposed a cost of \$541,000, less than half the vendor's cost. Since the transition, revenue recovery is similar across the sites and programs but with significant improvement: the Center identified missed billing opportunities that were costing the state several hundred thousand dollars in revenue.

In other cases described in this document, the consolidation of fiscal functions has allowed the state to transition to the Center other activities that had been performed by the private sector at higher cost, generating further administrative savings. The financial model reflected in the ISAs also creates an incentive for the University to innovate and bring new savings and revenue projects to the Commonwealth. In the Center's brief history, numerous new savings and revenue activities have been developed under this model, generating hundreds of millions of dollars in benefits to the state as well as the federal Medicaid program. Many of the projects developed are conducted by few, if any, other state Medicaid programs. Over the years, the Center has been able to invest in literally dozens of small projects (generating \$50,000–\$300,000 in savings and revenue) for which no outside vendor could be secured given the low savings/revenue base. Finally, because a portion of the incentive payments the University receives is re-invested in the Center's program staff and resources to further enhance the capacity available to state government, state funds remain within the state and are applied to public purposes.



Program Benefits

Benefit Coordination

Shortly after the Center's formation, two key federally mandated revenue recovery functions transitioned to the University. In 1997, the Casualty (Accident) Recovery unit became part of the Center to help satisfy the state's desire for administrative cost efficiency and better performance. The existing vendor was not dedicating sufficient resources to the project, in the state's view. This initiative allows the Medicaid program to recover expenditures it makes that are the result of a tort resulting in injury.

Under the Center's management, the project has been staffed by paralegals instead of clerks, and concurrently, financial recoveries have accelerated. Other key innovations have been introduced over time: an attorney referral system, an audit process to ensure compliance by insurance companies with line collection, and in 2005, in collaboration with the Department of Revenue, a Payment Intercept Program was launched that allowed for the interception of payments that would otherwise have been beyond Medicaid's reach. In 2008, operations expanded to the Health Safety Net program, further expanding the base of collections. Since the University assumed operational responsibility for the project, more than \$125 million has been returned to the Commonwealth.

Also in 1997, the Estate Recovery function transitioned to the Center because bids received from the private sector to run the program were exorbitant. As with casualty recovery, performance enhancement and innovation have been the hallmarks of the Center's tutelage. The Commonwealth's estate recovery program is graded in national surveys as one of the best performing among all state Medicaid programs. To date, the program has returned approximately \$400 million to the state's coffers.

An innovation introduced in 2009, years ahead of a federal mandate, expanded the scope of possible recoveries through a unique Lifetime Lien process, designed to ferret out real estate, stock, and other valuable assets held by Medicaid recipients and applicants. Also in 2009, as a result of University investments, new case management tracking systems were developed for both the casualty and estate programs, saving the state hundreds of thousands of dollars in annual licensing and use costs that had been spent on private-sector systems.



Other Coordination Innovations

Once benefit coordination became a support responsibility for the University on behalf of EOHHS, program innovations soon followed. In 1999, the Center developed a new program called Enhanced Coordination of Benefits in which staff are co-located with acute hospital discharge staff in hospitals in Massachusetts to coordinate available insurance benefits for high-cost cases. Hospitals with neonatal level II and III units are targeted, though other high-cost conditions, such as cancer and trauma, are addressed.

This program is the first and only one of its kind in the country. Since its inception, it has cost-avoided approximately \$250 million for the Commonwealth. With expansion occurring in 2008 and 2009, the program now saves the state nearly \$50 million annually. In 2005, the program was honored with an Innovation in Government award from the Pioneer Institute.

In 2004, various coordination-of-claims activities transitioned to the Center from the state. Enhancements have been introduced since, including greatly expanded re-pricing techniques to assure that the Medicaid payment made is at the lowest available rate, saving the state well over \$100 million annually.

In addition, Center staff helped develop, manage, and maintain the state's Medicaid Management Information System third-party liability matrix, the state's most important tool for cost avoidance. The Center also administers the important Medicare Savings Programs (Part A and Part B buy-in) for the state at cost; these projects ensure that federal Medicare benefits are available to nearly 225,000 Medicaid recipients who are eligible for both programs. Finally, the Center's Premium Assistance program ensures that available commercial insurance coverage is maintained for over 50,000 covered lives.

In 2009, the Center identified a systemic nationwide flaw in SSA's system that resulted in a national settlement with states valued at over \$250 million; Massachusetts' share of the settlement was nearly \$11 million.

Program Benefits

Federal Benefit Eligibility

As a result of years of University research and development investments promoting a greater understanding of the Social Security Administration (SSA) and its influence on state Medicaid programs, the Center has developed a unique set of projects for Massachusetts that are performed by no other vendor. These projects now allow Massachusetts to begin to answer the questions of who on Medicaid's rolls could or should be eligible for Medicare, not merely who are. By asking these questions and developing approaches to answering them, the Center has helped many Massachusetts residents establish their eligibility for federal benefits; and in so doing, the Center has saved the state tens of millions of dollars.

For example, in 2009, the Center identified a systemic nationwide flaw in SSA's system that resulted in a national settlement with states valued at over \$250 million; Massachusetts' share of the settlement was nearly \$11 million. Two other national settlements are underway by the SSA as a direct result of the Center's work which should bring millions in credits to Massachusetts.

Other systemic flaws in SSA's systems and processes have been identified over time, permitting the Center to audit and perform quality control activities on the Medicare program's monthly charges to the state. These quality control activities save the state millions of dollars annually. Also, the Center is the lead technical support to a 33-state national coalition seeking a \$4 billion net settlement to address the impact on states' coffers of a systemic flaw in SSA's processes that originated in 1973. Massachusetts is in line to receive \$160 million if the settlement occurs. These innovations represent the leading edge of Medicare identification activities nationally. As the SSA has developed repairs to its systems to prevent a recurrence of problems the Center has identified, these projects generate ongoing savings to Massachusetts.



Maximizing Savings

Our mission is to enhance federal benefit eligibility for residents of the state as a pathway to maximizing savings for the Commonwealth. The Center offers free hands-on assistance to help state residents navigate the SSA application process, by developing the capacity to audit and analyze SSA and federal Medicaid files at a detailed level and by coordinating with University clinical staff to identify residents who may be eligible for federal benefits. Our ability to appropriately target potentially eligible individuals is reflected in the fact that more than 90 percent of clients for whom the Center provides help are converted to federal Supplemental Security Income and Medicare benefits; in a portion of these cases, individuals have been found eligible for the federal Supplemental Security Disability Income (SSDI) program. The SSDI program provides them with a richer cash benefit and also relieves the Commonwealth of the need to make a monthly state supplemental payment.

The Center is the lead technical support to a 33-state national coalition seeking \$4 billion in net settlement to address the impact on states' coffers of a systemic flaw in SSA's processes that originated in 1973.

Program Benefits

Municipalities

Municipal government also benefits from the Center's activities in numerous ways. The Center serves as the statewide manager for the Medicaid school-based claiming program, which returns well over \$100 million annually in federal funds to municipal coffers. The Center also provides billing services to over 100 municipalities; many of those communities would not be able to take advantage of this revenue opportunity, if not for the Center, because the base of their potential claim is not large enough to attract private vendors.

The University has developed technology tools that it makes freely available to all municipalities to facilitate their participation in the program, and has provided EOHHS with key technology resources as well. The Center's low rates for school billing services have caused dramatic reductions — as much as 75 percent — in the cost of vendor services for municipalities.

Pioneering Programs

In 2009, at the request of and in collaboration with the Department of Public Health, the Center created a billing system that allowed municipalities to secure reimbursement from private health care plans for H1N1 and seasonal flu vaccine services provided to health plan members by municipalities, a first for the Commonwealth's cities and towns. Hundreds of thousands of dollars have been received by municipalities, and an expanded list of 100 communities is participating in 2010. The Center was honored with a DPH Public Health Hero award for 2009 for its work.

As well, the Center has developed claiming programs related to the Food Stamp Program that makes available federal financial support to community organizations that are providing employment, training, and food stamp outreach services to municipal residents. To our knowledge, such a claiming opportunity exists in only two other states.



Program Benefits

Federal Claiming

The Center provides EOHHS with a core Federal Claiming operations and consulting function to support a number of activities. Consulting activities are provided at no cost to the state. This unit also develops new savings or revenue strategies annually by carefully reviewing changes at the federal level and applying those opportunities to the Commonwealth. Recently, the unit developed a project for enhanced claiming under the Children's Health Insurance Program that could bring the Commonwealth more than \$40 million in 2011. In 2008, it developed a project, isolating an opportunity for certain qualified Medicare beneficiaries, that has yielded nearly \$10 million in new revenue to date.

Maximizing Revenue Flow

This Federal Claiming unit has also developed the most comprehensive array of projects of any Medicaid program to access enhanced federal revenue for family planning services. The unit provides the staffing and resources to prepare Healthy Start claims to secure enhanced federal funding for those expenditures. A key role is played by the unit in maximizing the flow of revenue available to state-owned hospitals. Staff also calculate the amount of uncompensated care, calculate Medicare upper payment limits, and provide technical assistance for reimbursement methodologies for public nursing facilities, all at no cost to the state.

Finally, over the last two years, this unit has developed an integrated suite of new technology tools for EOHHS that will allow for automation of all federal draw, expenditure, reporting, and reconciliation functions that support the Medicaid program — tools that will significantly transform how Medicaid's finances are tracked and managed.



New Administrative Cost-Savings Initiatives

The Center is constantly preparing new opportunities for EOHHS that offer the state considerable administrative savings compared to its current level of expenditures for operational activities. On an annual basis, the Center proposes a number of new initiatives for EOHHS consideration. These projects arise from many sources: analysis of both the federal and state budgets; changes in rules and regulations governing federal entitlement programs; judicial decisions affecting the program; and innovations arising from Center research and development efforts.

New projects that may be implemented or finalized during SFY 12 include:

- Assumption of state administrative responsibility for the State Supplement Program. This would cause the transition of the program from federal to state administration at an annual administrative cost savings of \$15 million, or 60 percent less than its current cost. Importantly, the program's current benefit structure will be maintained, allowing for a seamless transition for beneficiaries of the state supplement.
- Expansion of the Public Provider Reimbursement unit's billing activity to include additional state-owned hospitals at an annualized savings of \$500,000.
- Opportunities to capture additional outreach-related expenditures for the Food Stamp Program.
- Implementation of the Special Disability Workload settlement to rectify SSA errors that can be traced back as far as 1973. A national settlement currently in progress could bring as much as \$160 million in net revenue to the Commonwealth.



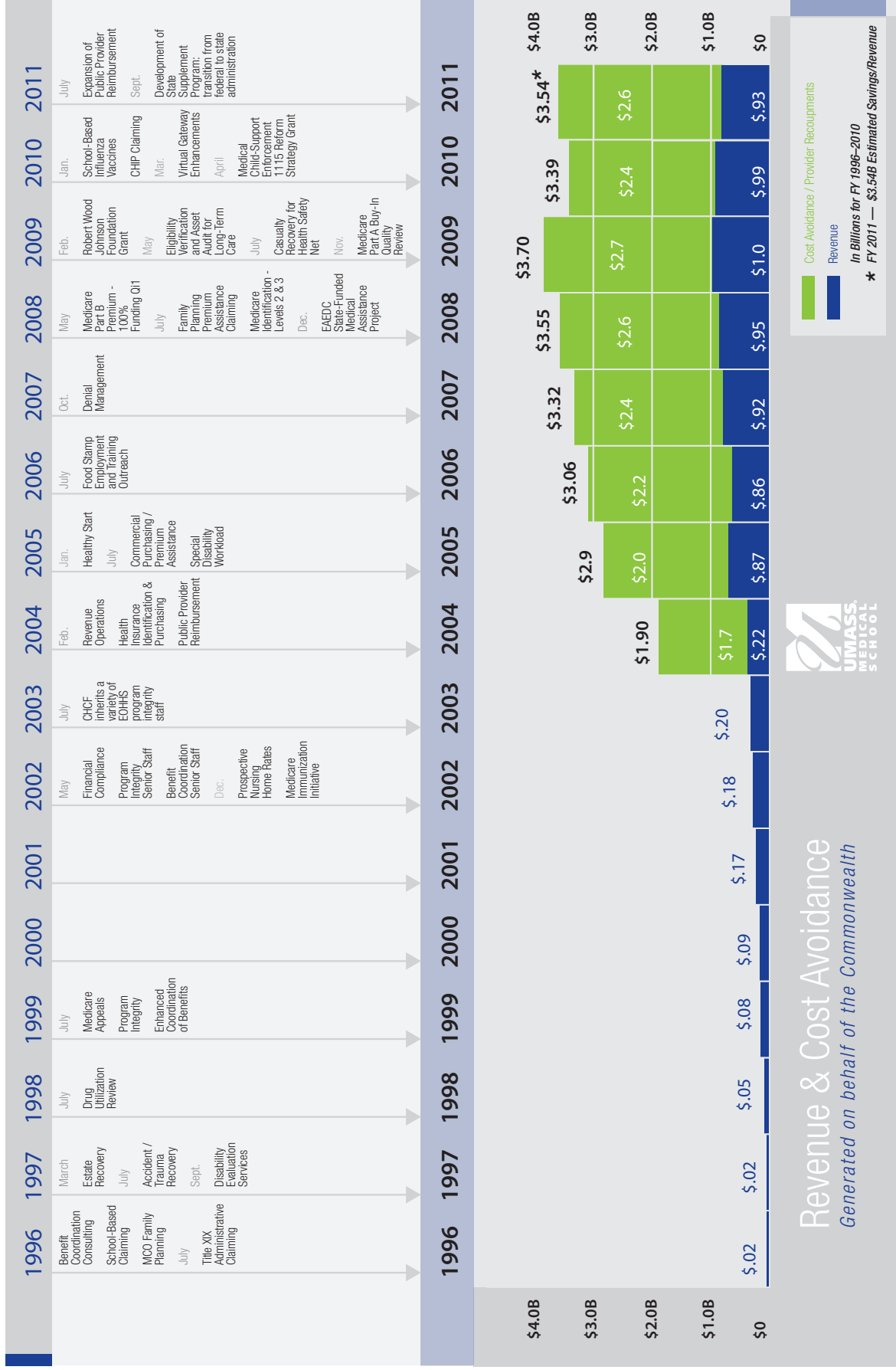
Conclusion

The chart that follows, reflective of the Center's performance in its 15 years of existence, tells a number of important stories. One is the achievement of over \$25 billion in cost savings and revenue recovery activity for the Commonwealth since 2004. Although we are proud of our accomplishments, they should not mask the true success story reflected in the unprecedented collaboration between the health and human services Secretariat and the public university system in generating those results. That partnership has achieved consensus support over many gubernatorial administrations, multiple legislatures, and several changes in leadership at both the Secretariat and University levels. In the process, a new model for the administration of government services has been created, a model that has attracted interest from states across the country seeking to bring administrative and programmatic innovations to their own states. As Massachusetts has become the national leader in ensuring health care coverage for all its citizens, so it is also now recognized as a leading example of the value of collaboration among state entities.



Center for Health Care Financing

Milestones & History



Revenue & Cost Avoidance
Generated on behalf of the Commonwealth

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