

FINAL REPORT

**REVIEW OF IOWA'S
MEDICAL ASSISTANCE PROGRAM
STUDY COMMITTEE**

**Presented to the Legislative Council
and the Iowa General Assembly
January 1993**

Prepared by the Legislative Service Bureau

FINAL REPORT

REVIEW OF IOWA'S MEDICAL ASSISTANCE PROGRAM STUDY COMMITTEE

January 1993

AUTHORIZATION AND APPOINTMENT

The Review of Iowa's Medical Assistance Program Study Committee was established by the Legislative Council for the 1992 Interim and was charged with identifying cost-containment measures and other efficiencies which can be instituted in Iowa's Medical Assistance (Medicaid) program. The Committee was also charged with making a recommendation by September 1992 to the Legislative Council regarding the best mechanism for conducting an audit of Iowa's Medical Assistance program. The members of the Study Committee were:

Senator Elaine Szymoniak, Co-chairperson
Representative Johnie Hammond, Co-chairperson
Senator Mark Hagerla
Representative Joan Hester

COMMITTEE PROCEEDINGS

The Study Committee was authorized two meeting days. The meetings were held on September 2 and September 3, 1992. During the meetings, the Study Committee received testimony from a variety of interested parties. The presentations and discussions are summarized as follows:

Mr. Don Herman, Administrator of the Medical Services Division of the Department of Human Services, provided information regarding the history and an overview of the operations and coverage of the federal Medicare and the federal-state Medical Assistance (Medicaid) programs.

Ms. Susan Bredman, President, Iowa Physician Assistant Society, discussed reimbursement policies by third-party payors and the effect on physician assistants (PAs), and suggested the following: an evaluation of the Medicaid rate structure to ensure that payment is sufficient to cover the costs of care; review of supervision requirements for physician and PA practices; improving the MediPASS system by removing certain restrictions on the use of PAs or nurse practitioners in providing

treatment; designing limitations on the number of Medicaid visits so as not to create barriers to the seeking of primary care; and requiring that utilization review for drugs, number of visits, and the MediPASS program be performed by practitioner peers of those reviewed.

Mr. Tom Temple, Executive Vice President, Iowa Pharmacists Association, provided information regarding the cost-containment strategies which currently exist and recommended the following additional cost-containment and administrative cost-containment measures:

1. Expand commitment of funding to retrospective drug utilization review.
2. Implement an electronic claims transmission and prospective drug utilization review system.
3. Expand the use of pharmacists-legend class of drugs which would increase the number of prescription drugs that a pharmacist can dispense without the necessity of a physician's prescription.
4. Expand the provider lock-in program in which clients who have a pattern of overutilization of physician services or drugs are locked into use of a particular provider.
5. Reimburse pharmacists directly for conducting drug regimen reviews in long-term care facilities in place of the current practice of paying for this service within the general reimbursement for the patient care at the facility.

Mr. Martin Ozga and Mr. Tom Krause, Attorneys with the Legal Services Corporation of Iowa, identified the following recommendations for improvement in the Medicaid program:

1. Expansion and improvement of the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program.
2. Simplification of eligibility categories, through federal waivers to allow demonstration projects which would eliminate various categorical eligibility requirements.
3. Allowing a "buy-in" for the medically needy spend down by allowing eligibility to occur when the individual has paid the regularly occurring expense amounts to the state rather than first paying them out and then becoming eligible.
4. Expansion of the eligibility of the SSI-related individuals with incomes less than 100 percent of the federal poverty level.

Mr. Paul Romans, Iowa Health Care Association, discussed the effects of the federal Omnibus Budget Reconciliation Act (OBRA) of 1987 on nursing homes and suggested that the General Assembly enact legislation to provide direction to state surveyors in implementing the Act, and suggested that implementation standards of federal requirements often exceed those required by the federal Act.

Ms. Betty Grandquist, Director, Department of Elder Affairs, discussed the Medical Assistance waiver program intended to provide in-home care for frail elderly persons to reduce nursing home placements.

Mr. Gary Pedersen, Co-chairperson, Pharmaceutical Manufacturers Association Task Force of St. Louis, Missouri, discussed federally required drug manufacturer rebates to states, raised concerns regarding Iowa's prior authorization program (enacted during the 1992 second special session) as a restrictive formulary which he believes is not cost-effective, and discussed the topic of "me-too" drugs in which very similar drugs are marketed as separate products.

Mr. Larry Breeding, Executive Director, Iowa Association for Home Care, provided the following six recommendations to the Study Committee:

1. That the Iowa Foundation for Medical Care (IFMC) be directed to determine the appropriateness of community-based noninstitutional services, including home health care and hospice, for all nursing facility residents prior to admission to a nursing home and every 30 days thereafter.
2. The IFMC review of inpatient hospital Medicaid clients should include noninstitutional community-based services in order to raise the awareness level of hospital personnel as they perform discharge plans of care for hospital patients.
3. Amend Iowa law to require insurance companies selling long-term care insurance to provide the home health care benefit prior to nursing facility benefits.
4. Pursue implementation of the Robert Wood Johnson Foundation concept of providing Medicaid or state-backed, private long-term care insurance in which the state guarantees long-term care benefits to any person who purchases a private policy.
5. Pursue implementation of the "Nursing Home Without Walls" case management system used by New York State.
6. Direct an entity such as the Health Data Commission to compile, on a county-level basis, all information relative to the availability of community-based noninstitutional health care services and regularly provide this information to other state agencies such as the Health Facilities Council.

Ms. Peggy Huppert, Iowa Citizens Action Network (ICAN) and Iowa State Council of Senior Citizens, and Mr. Paul Stanfield, ICAN and Iowa Human Needs Advocates, expressed the need for fundamental health care reform, expressed concern regarding proposals which involve rationing of health care, and expressed concern that cost control measures not result in limited access to health care.

Ms. Linda Goeldner, Iowa Hospital Association, provided data to the Study Committee regarding Medicaid expenditures and analyses of various factors including increases, percentage changes, and comparisons of expenditures among

states. Ms. Goeldner also discussed third-party payors of health care charges and the DRG system.

Mr. Paul Peitzsch, President, Health Policy Corporation of Iowa (HPCI), provided the Study Committee with nine recommendations adopted by the HPCI Board of Directors as follows:

1. Reform Medicaid through broadening and simplifying categories of eligibility and reform payment structures through new methods such as participating in community and private sector collective purchasing initiatives and demonstration projects.
2. Expand the Scott County HMO purchasing model and add similar models in other parts of the state.
3. Provide strong incentives and information to encourage enrollment in organized care.
4. Join other public and private group health insurance sponsors in assisting enrollees to become better consumers and accept responsibility for their own health.
5. Support the development of integrated claims and information systems to improve services and reduce administrative costs and time, and collect quality outcomes of care and management information.
6. Support and actively participate in developing and using the Iowa Health Data Commission in order to fully utilize the benefit of information.
7. Support changes in reimbursement so that reimbursement to providers in rural areas is fair and equitable.
8. Consider use of special managed care approaches for both inpatient and outpatient mental health and substance abuse services.
9. Consider various approaches to reducing prescription drug costs through purchase techniques.

Ms. Elizabeth Powell, American Association of Retired Persons (AARP), noted that the AARP supports incremental changes to increase eligibility for Medicaid up to the federal poverty line, to require all states to include the medically needy program option, and to require that provider reimbursements are adequate to ensure the availability of care. Ms. Powell also stressed the importance of ensuring availability of care to rural areas; noted AARP support of cost-containment strategies which address both price and volume increases, assure quality, collect data, and investigate appropriateness and efficacy of care; and stressed that efforts to control costs should include the implementation of reimbursement rates that are uniform across all payors.

Ms. Elizabeth Momany and Mr. Peter Damiano, Public Policy Center at the University of Iowa, presented a written evaluation of the MediPASS Managed Care Demonstration Project. The major findings of the evaluation and recommendations are as follows:

1. Effectiveness of MediPASS expenditures.
2. Continued monitoring of the availability of patient managers which have been overstated.
3. Continued monitoring of and improvement of physician satisfaction.
4. Further research to determine the reasons for perceived difficulty in accessing care.
5. Continued communication with and monitoring of Maternal Health Centers and recipients' use of enhanced prenatal services.

Ms. E.J. Rohlwing, Executive Director, Association for Retarded Citizens/Metro-Polk County, discussed the importance of community-based services and living arrangements, stressed the importance of optional services coverage under the Medicaid program, and expressed strong support for implementation of the federal home- and community-based services waiver for persons with mental retardation.

Kenton Moss, M.D., Representative of the Iowa Medical Society, suggested the following cost-savings measures for the Medicaid program:

1. Identify specific treatment alternatives which should not be reimbursed by Medicaid.
 2. Collect and disseminate information on the costs of specific treatment alternatives to physicians in local communities to enable physicians and their patients to consider cost as one factor in deciding on a treatment regimen.
 3. Consider options to help reduce inappropriate utilization of the hospital emergency room as a source of primary care.
 4. Strengthen the recipient utilization review and education program to control costs resulting from overutilization.
 5. Increase the number of primary care physicians in the state as suggested in many national health care plans and in accordance with studies which have demonstrated more cost-effective care with the use of primary care providers.
- Dr. Moss also provided information regarding the issue of physician referral to physician-owned ancillary health services, noted the AMA ethical guidelines which address self-referral, and expressed the belief that this type of physician referral or investment is not a serious problem in Iowa as it may be in other states.

Following the providing of testimony and proposals by the above presenters, the Study Committee discussed various potential recommendations and directed that a report to the Legislative Council be drafted. The draft report was unanimously approved via telephone poll of the members and submitted to the Legislative Council on September 22, 1992. The report contained the following findings and recommendations:

1. The Study Committee finds that expenditure growth in the Medical Assistance (Medicaid) program reflects the general growth in health care inflation and increases in the number of persons eligible for coverage under the program.
2. The Study Committee finds that many of the increases in the number of eligible persons are due to federal provisions, implemented over the past several years, requiring that new types of persons be covered. An example is the coverage requirement for children who are eight years of age and younger with incomes of not more than 100 percent of the federal poverty level. This coverage requirement increases by one year of age, annually.
3. The Study Committee finds that no indication of fraud or misuse of funds has been evidenced in connection with the Medical Assistance program. Therefore, it is recommended that an audit of the program is unnecessary. However, the Study Committee recommends performing an analysis of potential cost savings in certain areas of the program as explained in item #4.
4. The Study Committee heard various suggestions for savings strategies during its two days of hearings and finds that additional analysis is needed to determine whether actual savings would result from implementing the suggestions. The Study Committee observes that staff resources in the Medical Assistance program are severely strained at present, which would restrict or eliminate ability to conduct the needed analysis. Therefore, the Study Committee recommends that private sector assistance, such as loaned executives, be solicited to assist in providing the needed analysis. Suggestions received include implementing utilization review on nursing facility care and developing an inventory of noninstitutional care sources.
5. The Study Committee heard testimony from the Department of Human Services, Iowa Physician Assistant Society, Iowa Pharmacists Association, Legal Services Corporation of Iowa, Iowa Health Care Association, Department of Elder Affairs, Pharmaceutical Manufacturers Association Task Force, Iowa Association for Home Care, Iowa Citizen Action Network (ICAN), Iowa State Council of Senior Citizens, Iowa Human Needs Advocates, Iowa Hospital Association, Health Policy Corporation of Iowa, American Association of Retired Persons (AARP), University of Iowa Public Policy Center, Association of Retarded Citizens/Polk County, Iowa Governor's Planning Council for Developmental Disabilities, and the Iowa Medical Society. In addition, the Study Committee received extensive written testimony from the presenters and background materials from the Legislative Service Bureau.
6. The Study Committee members intend to further review the testimony received and, if possible, to review the Department of Management Study of the Medical Assistance program. The Committee requests an additional meeting day to develop final recommendations after these reviews are completed.

The Legislative Council approved an additional meeting of the Study Committee at the September 22, 1992, meeting of the Legislative Council and amended the charge of the Study Committee as follows: "In addition, that the Study Committee be charged to review child support fees and rebates as described in the report of the Legislative Fiscal Committee and if testimony is invited, then single parent child support obligees and fathers' rights groups should be included."

The members of the Study Committee agreed to forego a third meeting and to include the DOM Medicaid Task Force Report and recommendations to the Legislative Council and the General Assembly as part of this report in addition to the initial recommendations made by the Study Committee. The report of the DOM Medicaid Task Force is attached to this report.

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***MEDICAID
TASK FORCE***

FINAL REPORT

Iowa Department of Management

December 1992

TABLE OF CONTENTS

- ◆ Executive Summary i
- ◆ Process and Acknowledgments 1
- ◆ Introduction 8
- ◆ Recommendations:

Managed Care

- Managed Health Care Plan Models 17
- "Hassle Factors" Which Prevent Participation in Managed Care Plans 21
- Cost/Use of Pharmaceuticals 24
- Contracting for Durable Medical Equipment and Supplies 28

System Simplification

- Medical Malpractice Reform 29
- Efficiency of Billing and Reimbursement System 31

Long-Term Care

- Transfer of Assets 33
- Long-Term Care Insurance 35
- Residential Care Facilities (RCF)/Assisted Living 37
- Integrated Case Management for the Frail Elderly 38
- Case Mix Reimbursement 40

Regulation

- Fiscal Impact of Federal Nursing Home Requirements/OBRA 87 42
- Reimbursement Rates/Calculation of the Capital Cost Component of the Inpatient Reimbursement Methodology 44
- Reimbursement Rates/Outpatient Hospital Charges Reimbursed Under the Retrospective Methodology 45
- Reimbursement Rate/DRG Calculation 46
- Inappropriate Patient Access/Emergency Room Use 47
- Other Issues 49

Federal Funds Maximization

- Leveraging Existing State Funds to Enhance Health-Related Programs or Offset General Fund Expenditures 50

EXECUTIVE SUMMARY

Introduction

The Iowa Medicaid program provides a wide variety of health care services to eligible indigent persons. Like most other states, Iowa is experiencing an unacceptably high rate of growth in the cost of its jointly-funded state/federal Medicaid program. Program growth is being driven by overall growth in health care spending, program expansions mandated by the federal government and a growing elderly population in need of long-term care services. The number of Iowans eligible for Medicaid stood at 210,000 in fiscal year 1992, an increase of 78,000 since fiscal year 1986. State appropriations to the program in fiscal year 1992 were \$250 million, having risen nearly \$120 million from fiscal year 1986. Both the number of eligibles and the costs of the program are projected to continue to increase at alarming rates. By fiscal year 1995 the number of eligibles is projected to increase to 255,000 and state appropriations to \$387 million.

The slow pace of federal efforts to address health care and Medicaid reform coupled with severe budget constraints has led states to begin developing their own solutions. In response to the alarming rate of Medicaid spending growth in Iowa, the General Assembly passed legislation (Senate File 2355) which required the Department of Management to utilize a task force to study Medicaid and make recommendations for reining in program costs.

The Department of Management established the Medicaid Task Force in September along with five subcommittees to assist the Task Force in its work. Each subcommittee was assigned a focus area (managed care, long-term care, system simplification, regulation and federal funds maximization) within which it was to review Medicaid and identify courses of action for improvement. The Task Force reviewed the courses of action and developed recommendations based on consensus support. The Task Force recommendations are organized around the focus areas of managed care, long-term care, system simplification, regulation and federal funds maximization.

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TASK FORCE***

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Executive Summary

Iowa Department of Management

December 1992

Introduction

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RECOMMENDATIONS: MANAGED CARE

TBD = To be determined

Managed Health Care Plan Models

	FY 94 General Fund (Savings)/Cost
1. Establish risk-based managed care plans in urban and rural settings with existing medical facilities (hospital or clinic) which have or could develop established physician relationships. Similar to the Iowa Leadership Consortium proposal, these plans should result in an integrated delivery system, organized to provide or coordinate all or most services.	(\$1,200,000) / \$200,000 Totals for recommendations 1, 2, 3, 4, 7 & 8
2. Expand HMO contracting to other geographic areas and expand HMO contracting to other services such as pharmacy.	See recommendation 1
3. Explore rural PPO opportunities with appropriate parties.	See recommendation 1
4. Establish a community-based model of service delivery similar to the plan under development by the Cedar Rapids Leadership Council or the Central Iowa Project.	See recommendation 1
5. Contract for selected medical services (such as heart transplants and other high cost major procedures) at centers of excellence which can demonstrate quality and cost-effectiveness.	(\$34,680)
6. Place a state-funded Medicaid physician in an existing rural health care facility, to provide services to Medicaid patients.	TBD
7. Expand relationships with HMOs that utilize a managed care model for mental health and chemical dependency services.	See recommendation 1
8. Contract with existing organizations on a capitated basis for mental health and chemical dependency services and use the state substance abuse appropriation as a source of Medicaid match.	TBD

"Hassle Factors" Which Prevent Participation in Managed Care Plans

FY 94 General Fund (Savings)/Cost

- | | |
|--|-----|
| 1. Dedicate staff in local DHS offices to provide enrollment and education services to persons eligible for managed care (MediPASS) and to serve as liaison between enrollees and providers. | \$0 |
| 2. Provide staff or resources (contract staff) to educate/recruit managed care plans to participate with Medicaid, provide ongoing liaison function and to educate DHS staff as necessary to ensure success and cooperation. | \$0 |
| 3. Direct DHS to identify an existing advisory body to address the detailed issues surrounding "hassle factors " | \$0 |
| 4. Promote the following at the federal level (a and b are part of a proposal already under discussion in Washington): | TBD |
| a) Legislation to allow six month lock-in to a managed care plan. | |
| b) Legislation that provides for additional month of eligibility after normal cancellation if the person is enrolled in a managed care plan. This allows for continuity if eligibility is regained within the extended eligibility period. | |
| c) HCFA examination of the effect of the newly developed standards for risk-based Medicaid managed care plans Quality Assurance Reform Initiative (QARI) to determine the willingness of plans to participate. | |

Cost/Use of Pharmaceuticals

	FY 94 General Fund (Savings)/Cost
1. Expand retrospective drug utilization review (DUR) and implement a program of prospective DUR.	(\$336,000) / \$31,650
2. Expand the list of Medicaid covered (when prescribed by a physician) over-the-counter drugs.	(\$389,350)
3. Expand the prior authorization program for prescription drugs.	(\$461,600)
4. Apply for a federal waiver for use of formulary (allowance for substitutes for prescribed drugs by therapeutic class) for prescription drugs.	TBD
5. Establish, on a voluntary basis, a mail order drug program for maintenance drugs needed by aged, disabled or nursing home medicaid recipients.	(\$532,600)
6. Establish selective contracting for dispensing fees.	TBD
7. Direct DHS to work with the Department of General Services to examine the legalities of state wholesale purchase of drugs for Medicaid.	TBD

Contracting for Durable Medical Equipment and Supplies

	FY 94 General Fund (Savings)/Cost
1. Explore volume purchasing of medical equipment and supplies; bids based on discount from manufacturers' published price.	(\$105,000)
a) Create a network run by the state purchasing agency (in Iowa this would be General Services) which purchases items, such as wheelchairs, for not only Medicaid, but all of the state's political subdivisions	
<i>or</i>	
b) Include Medicaid in the purchasing network of a private entity such as a major hospital.	

RECOMMENDATIONS: SYSTEM SIMPLIFICATION

Medical Malpractice Reforms

	FY 94 General Fund (Savings)/Cost
1. Establish uniform practice parameters such that conformance with these parameters is defense against allegations that a provider did not comply with accepted standards of practice in the community absent clear and convincing evidence to the contrary.	\$0
2. Amend the statute of limitations for minors' medical liability claims to increase access to prenatal, obstetrical and pediatric care.	\$0
3. Transfer punitive damages from malpractice awards to the state in order to provide expanded health care.	(\$373,400)

Efficiency of Billing and Reimbursement System

	FY 94 General Fund (Savings)/Cost
1. Implement a point of sale claims processing system in FY 94 (90/10 federal financial participation) for pharmacy claims. Implement a similar processing system within a year after for all other Medicaid providers.	(TBD) / \$22,739
2. Evaluate and implement the use of on-line eligibility verification for Medicaid recipients as well as evaluate the use of permanent or smart cards.	TBD
3. Investigate the use of electronic fund transfer for the payment of claims.	TBD
4. Integrate Medicaid payments into the Community Health Management Information System (CHMIS) when it becomes operational.	\$0

RECOMMENDATIONS: LONG-TERM CARE

Transfer of Assets

	FY 94 General Fund (Savings)/Cost
1. Expand from 30 to 60 months the look back period to determine if an applicant transferred resources for less than fair market value in order to qualify for Medicaid.	TBD
2. Require authentication of income and assets for individuals seeking to receive Medicaid coverage in a nursing facility.	TBD
3. Implement legislation to allow DHS the right to recover from the transferee the value of resources transferred for the purpose of qualifying for Medicaid.	TBD
4. Require routine audits of income and assets by the local county human services departments.	TBD

Long-Term Care Insurance

	FY 94 General Fund (Savings)/Cost
1. Direct the Insurance Division of the Department of Commerce to develop a plan to implement a Robert Wood Johnson Foundation long-term care insurance model similar to that adopted in Connecticut. The plan should include provisions for Medicaid exclusions for the amount of assets protected by long-term care insurance policies as individuals qualify for participation in the Medicaid program.	\$0
2. Provide a full or partial tax credit for individual payments of premiums for the purchase of long-term care insurance from approved companies.	TBD

Residential Care Facilities (RCF)/Assisted Living

FY 94 General Fund (Savings)/Cost

1. Expand the Residential Care Facility (RCF) program. Reduce the rules and restrictions to which RCFs are subject and increase reimbursement which they receive as first steps to expanding the program. TBD
2. Develop standards to allow assisted living care settings to qualify for state supplementary assistance reimbursement. \$0

Integrated Case Management for the Frail Elderly

FY 94 General Fund (Savings)/Cost

Provide funding to expand integrated case management for the frail elderly to each of the four Area Agencies on Aging (AAA) not currently served by the program and increase funding for the program in each of the AAAs currently providing the program. (TBD) / \$320,000

Case Mix Reimbursement

FY 94 General Fund (Savings)/Cost

1. Modify the intermediate level of care reimbursement for Medicaid recipients in accordance with a case mix strategy. The reimbursement rate for those individuals meeting the "heavy care" special care status should be a flat amount of \$4.00 per resident per day in excess of the current reimbursement rate. The reimbursement rate for "lighter care" residents would be a flat amount of \$4.00 per resident per day lower than the current reimbursement. (\$215,030)

**FY 94 General Fund
(Savings)/Cost**

2. By March 1, 1993, establish a study committee composed of Area Agency on Aging, Iowa Foundation for Medical Care (IFMC) and appropriate state agency representatives to review current Medicaid admission criteria for nursing facility care. This group should consider the appropriateness of including psycho/social factors in evaluating level of care needs and the most appropriate role for the IFMC in determining whether a consumer should be admitted to a nursing facility.

\$0

RECOMMENDATIONS: REGULATION

Fiscal Impact of Federal Nursing Home Requirements/OBRA 87

**FY 94 General Fund
(Savings)/Cost**

1. Evaluate the cost/benefits of Nursing Home Reform by comparing the cost and quality of care in Iowa nursing facilities that do not participate in the Medicaid program with the cost and quality of care in participating facilities.
2. Promote congressional review of the cost benefits of various provisions of Nursing Home Reform.

\$0

TBD

**Reimbursement Rates/Calculation of the Capital Cost Component of Inpatient
Reimbursement Methodology**

**FY 94 General Fund
(Savings)/Cost**

Modify the methodology to require that capital costs greater or less than standard deviations of the mean capital cost will be reduced or increased to within 1 standard deviation of the mean and allow no more than 80 percent of capital costs from the hospital's cost report.

(\$920,500)

Reimbursement Rates/Outpatient Hospital Charges Reimbursed Under Retrospective Methodology

**FY 94 General Fund
(Savings)/Cost**

Direct DHS to conduct a study of outpatient hospital charges and develop a new reimbursement methodology that would take outpatient charges from a cost basis methodology to one that is more efficient and cost effective.

(TBD) / \$50,000

Reimbursement Rate/DRG Calculation

**FY 94 General Fund
(Savings)/Cost**

Require DHS to contract with an accounting firm to:

TBD

- a) perform audits on the cost reports submitted by hospitals, on a sample basis
- b) review Medicare cost reporting standards and where applicable develop Iowa Medicaid program standards of allowable costs.

Inappropriate Patient Access/Emergency Room Use

**FY 94 General Fund
(Savings)/Cost**

1. Eliminate the guideline allowing emergency room (ER) payment if physician referral was made and develop a system to allow for payment of non-emergency treatment.
2. Expand the system of identifying abuse and misuse and regulating outliers through the Recipient Lock-In program.
3. Strengthen incentives and disincentives to reduce emergency room use.

(\$235,650)

TBD

TBD

RECOMMENDATIONS: FEDERAL FUNDS MAXIMIZATION

Leveraging Existing State to Enhance Health-Related Programs or Offset General fund Expenditures

	FY 94 General Fund (Savings)/Cost
1. DHS should continue to work with the Federal Health Care Financial Administration (HCFA) to obtain \$24,700,000 in additional federal funds for Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) provisions. A representative work group should be established to develop a plan for allocation of these federal funds.	See Footnote a.
2. Direct the Departments of Education, Public Health, Management and DHS to develop an implementation plan to deliver EPSDT services in Iowa public schools and to include the use of existing federal, state and local resources.	See Footnote b.
3. Direct the Department of Public Health and University of Iowa Child Health Specialties Clinics (CHSC) to work with DHS to apply for federal funding for public health consultants and CHSC nurse consultants.	(\$28,800)
4. Direct the Department of Public Health to work with DHS to apply for additional federal funds for immunization marketing.	See Footnote c.
5. Direct the Department of Public Health to review its administrative activities and pursue opportunities for utilizing federal funding to pay for administrative staff for the Well Elderly Clinic (WEC) Program.	See Footnote d.
Total (Savings) / Cost All Recommendations:	(\$4,037,210) / \$653,180

(a)	\$24,700,000	in enhanced services
(b)	\$652,080	in enhanced services
(c)	\$10,170	in enhanced services
(d)	\$25,000	in enhanced services
	\$25,387,250	Total enhanced services

PROCESS AND ACKNOWLEDGMENTS

Senate File 2355, enacted by the General Assembly in 1992, directed the Department of Management to utilize a task force to study Iowa's Medical Assistance Program, more commonly referred to as Medicaid. Senate File 2355 mandated that the study consider:

- Reimbursement rates,
- Accuracy and improvement of fiscal projections,
- Scope of covered services,
- Cost containment,
- Relative program growth,
- The relationship with other health coverages.

A 15 member Medicaid Task Force, which included state agency, legislative, provider and consumer representation, was established in early September along with five subcommittees to assist the Task Force in its work. The subcommittees were structured around the areas of regulation, managed care, long-term care, system simplification and federal funds maximization. Each of the Task Force members, except the chair, also served as a member of a subcommittee, most as co-chairs. Subcommittee membership was rounded out with additional state agency, provider and consumer representatives. A staff person was also assigned to each subcommittee to assist in their efforts. Membership listings of the Task Force, each of its subcommittees and staff can be found at the end of this section. The scope of issues which the Task Force directed each subcommittee to analyze and possibly develop courses of action for is shown here. In some cases, discussion which occurred during the course of Task Force meetings altered the course of direction as to the issues which subcommittees focused on.

Regulation

- Utilization Review, Second Opinions - how effective has this strategy been? Can it be strengthened? What works best?
- Certificate of Need - do we need to strengthen this?
- Use of Data - how effectively is health care data being used in the Medicaid Program? How can its value be enhanced?
- Standards - are they too high?
- Reimbursement Methodologies

Managed Care

- Purchasing Pools, Mail Order Drugs - to what extent can the state save money through volume purchasing?
- Clinics - do Medicaid clinics make sense? Where might they be feasible? Is there applicability to Medicaid?
- Capitation (pre-payment on a per enrollee basis) - how far can this concept be taken in Iowa? How fast?
- MediPASS.

Long-Term Care

- Asset Transfer
- Alternatives to Institutionalization - what can be done to develop the infrastructure and strengthen the use of home- and community-based alternatives to institutionalization?
- Long-Term Care Insurance - what are the impediments to development of the long-term care insurance industry? What can be done to encourage the growth and development of this industry? Should the state subsidize premiums?

System Simplification

- Insurance - should (can?) the state increase its role in the purchase of private health insurance for individuals who are "borderline" eligible for Medicaid?
- Private Insurance Comparisons - what administrative practices are used in the private insurance industry that could help streamline the administration of the Medicaid Program?

Federal Funds Maximization

- Are there activities currently 100 percent state-funded that could qualify for Medicaid funding?
- How can the state maximize its disproportionate share funds in FY 1994? (e.g. MHIs)

Medicaid Task Force

Gretchen Tegeler, *Chair*
Department of Management
Des Moines, Iowa

William K. Appelgate
The Western Home
Cedar Falls, Iowa

Christopher G. Atchison
Department of Public Health
Des Moines, Iowa

Julie Beckett
Child Health Specialty Clinics
Iowa City, Iowa

Paul Carlson
Department of Management
Des Moines, Iowa

Betty Grandquist
Department of Elder Affairs
Des Moines, Iowa

Mark Hagerla
State Senator
West Burlington, Iowa

Johnie Hammond
State Representative
Ames, Iowa

David J. Lyons
Department of Commerce
Des Moines, Iowa

David Millage
State Representative
Bettendorf, Iowa

Charles Palmer
Department of Human Services
Des Moines, Iowa

Janet Phipps
Department of Management
Des Moines, Iowa

Stephanie Seemuth, D.O.
Northwood Family Care Center
Northwood, Iowa

Elaine Szymoniak
State Senator
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INTRODUCTION

National Overview

At both the national and state levels policymakers are searching for answers about how to rein in health care costs. U.S. spending on health care has risen from about \$230 billion in 1980 to about \$600 billion in 1990. As a percentage of gross domestic product, health care costs have risen from 9.2 in 1980 to 12 percent in 1990. According to the Congressional Budget Office (CBO), states spent approximately \$100 billion on health care in 1991. This figure includes spending for Medicaid, public health hospitals, clinics and other public health services. CBO projections indicate that states' health care spending could increase to \$244 billion by the turn of the century, with Medicaid accounting for most of this increase.

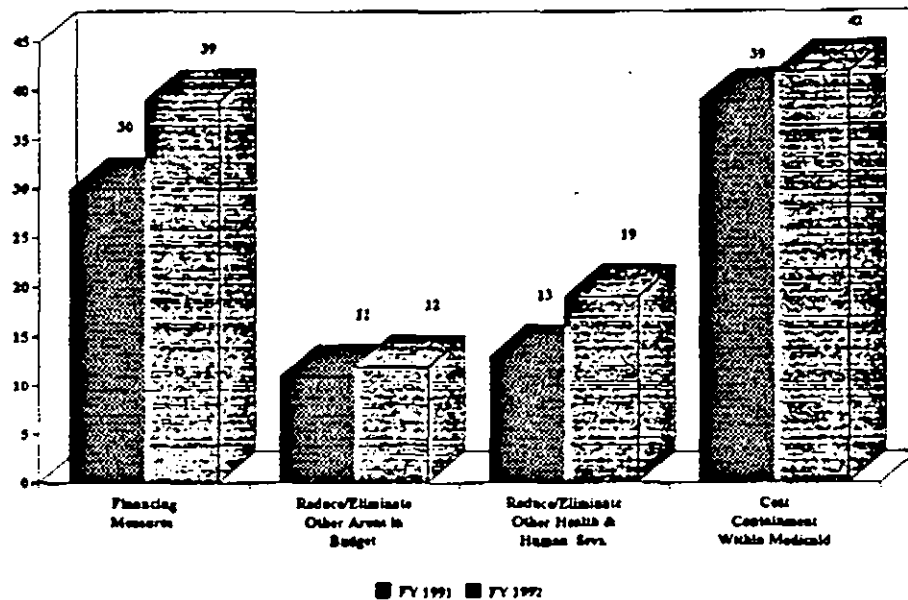
Since the joint federal-state Medicaid program was established in 1965 to provide health care for the poor, it has grown into one of the major health care programs in the U.S. Total Medicaid expenditures have grown from \$1.3 billion during the first year of the program to \$75.2 billion in 1990.

Medicaid expenditures have grown to represent an increasing portion of states' budgets over time, going from less than 3 percent of states' budgets during the first year of the program to 14.8 percent in 1990. The National Association of State Budget Officers (NASBO) projects that Medicaid will represent an average of 17 percent of states' budgets by 1995. The growth in state Medicaid spending is attributable to several factors, including the overall growth in health care spending, program expansions mandated by the federal government and a growing elderly population in need of Medicaid funded long-term care.

A NASBO report issued in March 1992 reviewed approaches which states took in fiscal years 91 and 92 to balance their Medicaid budgets and indicated that the most common approach involved combining cost containment and financing mechanisms. Reductions or eliminations in other health and human service programs and reductions in other budget areas were also utilized to free up funds to pay for Medicaid. Commonly used cost containment strategies included case management, managed care, prior authorization and pursuit of third party payers. Commonly utilized financing mechanisms included provider taxes and recipient

co-payments. Some of the health and human services program cuts came in the areas of mental health, mental retardation, public health and general assistance and medical programs. Reductions to other areas of the budget came in the way of across-the-board cuts.

Overall Strategies to Balance or Control the Medicaid Budget Fiscal Years 91 and 92



Source: NASBO

States will find it increasingly difficult to finance Medicaid without increasing taxes, eliminating optional services, closing public clinics or cutting spending for other state programs.

The Medicaid Program in Iowa

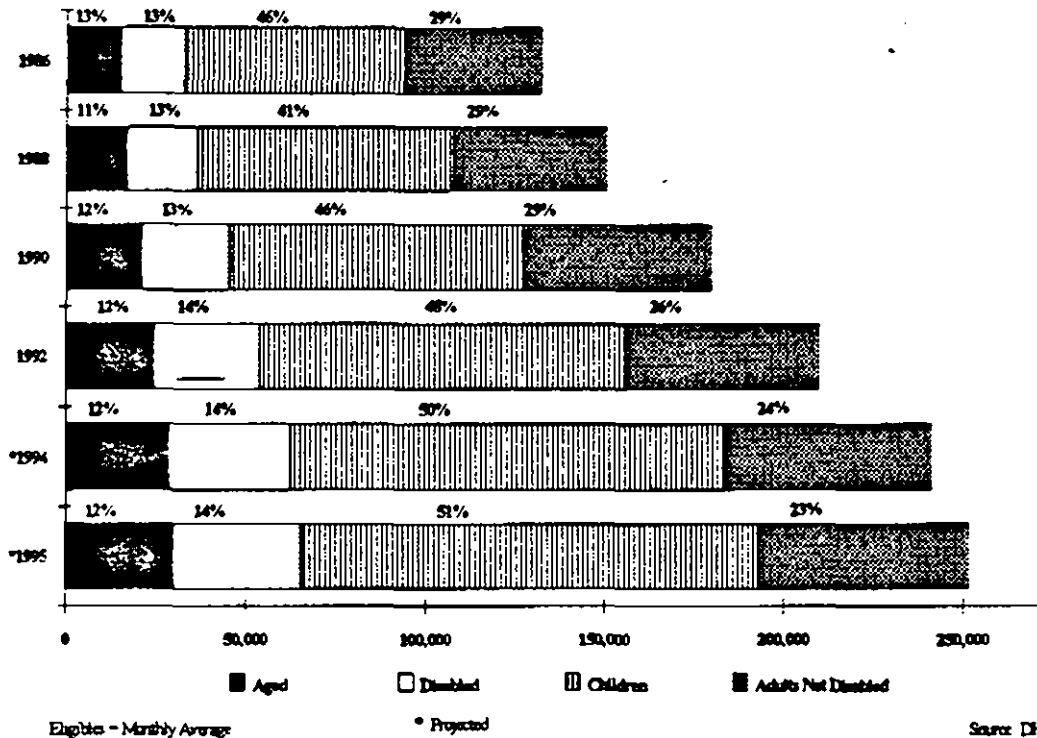
Who the Program Serves

Iowa's Medicaid program provides a wide range of health care services to persons who are financially disadvantaged. The number of Medicaid eligibles in Iowa stood at 210,000 in fiscal year 1992 and is projected to rise to 255,000 by fiscal year 1995. In general, eligibles fall into one of four groups:

- Aged - persons 65 and over
- Disabled - persons 0-64 who are disabled according to Social Security disability requirements
- Children - persons 0-20 who are not disabled
- Adults not disabled - persons 21-64

Children currently represent the largest group of eligibles, followed by adults not disabled, disabled, and aged. The proportion of total eligibles in each group has not shifted significantly over the past several years. However, projections indicate the children's group will have grown 5 percent from 1986 to 1995, while the adults not disabled group will have decreased by 6 percent during the period.

Total Eligibles/Percent of Total by Group



The percentage of total state funds devoted to each group varies greatly from one group to another. For example, in fiscal year 1992:

- The aged group represented 12 percent of eligibles and accounted for 24 percent of costs
- The disabled group represented 14 percent of eligibles and accounted for 20 percent of costs
- The children group represented 50 percent of eligibles and accounted for 23 percent of costs
- The adults not disabled group represented 24 percent of eligibles and accounted for 27 percent of costs

While it is expected that the proportion of eligibles in the aged group will remain stable, the group will account for an increasingly greater proportion of the state's future Medicaid costs.

Why Costs are Increasing

Not unlike other states, Iowa has felt the budgetary impact of the rapidly escalating cost of Medicaid and these costs have, likewise, been driven by overall growth in health care spending, increasing federal mandates and a growing elderly population in need of long-term care services. Some of the federal mandates which have led to escalating costs in Iowa's Medicaid program include:

- The Omnibus Budget and Reconciliation Act of 1987 (OBRA 87) - New coverage groups and Nursing Home Reform.
- The Medicare Catastrophic Coverage Act of 1988 - Phase-in of qualified Medicare beneficiaries, implementation of spousal impoverishment protections and mandatory coverage of pregnant women, infants, and children.
- The Family Support Act of 1988 - Mandatory coverage of persons leaving the AFDC Program and mandatory coverage of persons who are in the AFDC Unemployed Parent Program.
- Increases in the required coverage of pregnant women, infants, and children; mandatory Medicaid buy-in for qualified Medicare beneficiaries (1989).
- Increases in the required purchase of treatments identified as necessary under the Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) provisions. (1989).

Outside of mandated coverages, Iowa has chosen to provide a wide range of services which the federal government classifies as optional under Medicaid. The increased cost of providing these services has also contributed significantly to the escalating costs of Iowa's Medicaid program. States providing optional services are able to draw federal funding for these services at the same rate (38 percent for Iowa in fiscal year 93) as for services which are mandatory. Twelve optional services are currently provided under Iowa's program, including prescription drugs and dental care. The legislature has previously considered and rejected cuts in some of these optional categories.

The state spent \$39 million in general fund dollars in fiscal year 1992 to fund these twelve optional services. The projected state general fund cost for providing these services in fiscal years 1993 and 1994 are \$45 million and \$65 million respectively.

**Optional Medicaid Categories of Service
(General Fund Expenditures)**

	FY 92	FY 93 Projected	FY 94 Projected
Ambulance	\$216,105	\$288,600	\$497,700
Chiropractors	470,317	516,554	623,100
Clinics (excludes RHC & FDHCs)	568,000	725,777	945,900
Dental	5,791,600	6,372,996	8,226,200
Enhanced Services	3,196,270	2,860,000	3,194,131
Hospice	218,904	360,000	607,000
Medical Supplies	2,575,700	3,143,800	5,454,400
Optometric	1,278,000	1,405,900	1,827,400
Podiatrists	309,000	372,300	572,300
PMIC	4,162,800	4,880,200	7,197,700
Prescribed Drugs	18,666,737	22,707,219	34,687,800
Psychiatric (includes community mental health center and independent psych)	1,052,500	1,153,500	1,413,900
Total	\$38,506,533	\$44,786,846	\$66,057,831

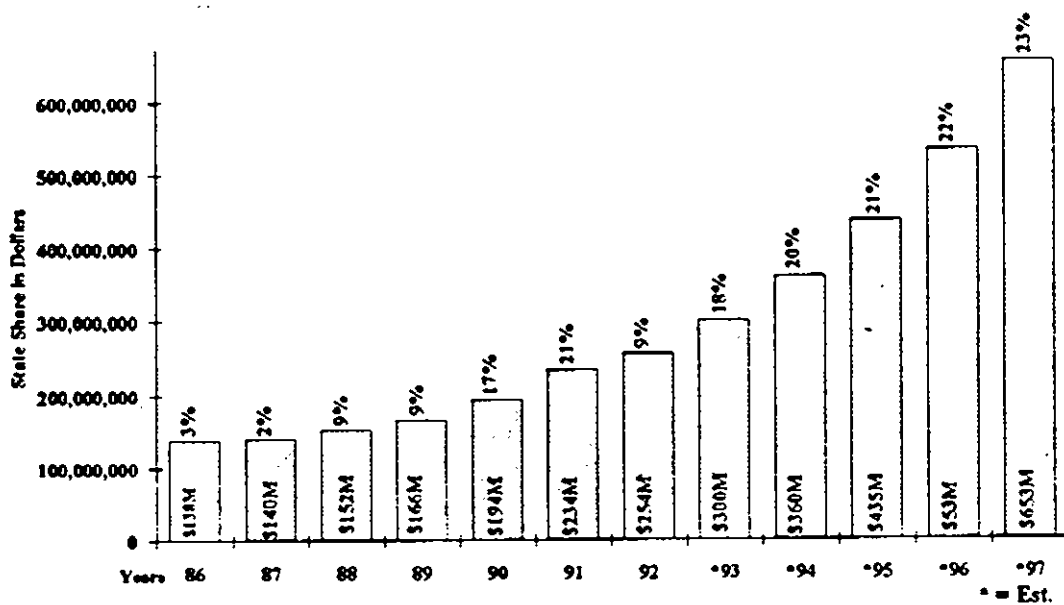
Source: DHS

State Budget Impact

Iowa began to experience double digit increases in state funding for Medicaid in fiscal year 1990. Absent reforms in the state's Medicaid program, double digit increases are likely to continue.

Over \$250 million in general fund dollars were devoted to Medicaid in fiscal year 1992, nearly double the \$132 million in general fund dollars devoted to the program in 1986. If Iowa follows national trends, state government's share of Medicaid spending is projected to grow to \$300 million in 1993 and to \$386 million by 1995.

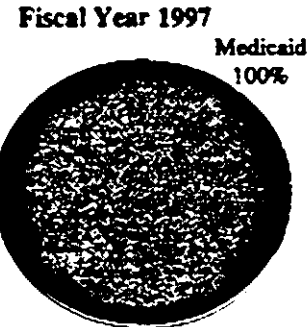
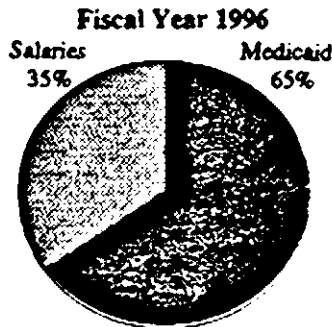
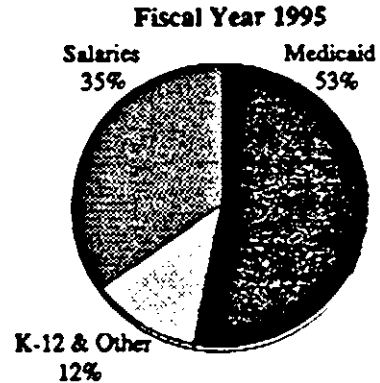
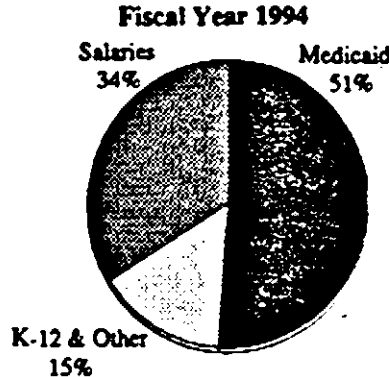
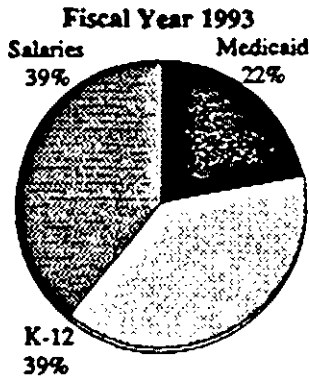
Total General Fund Expenditures and Annual Percentage Increases



Source: Department of Management

In fiscal year 1992, 7.6 percent of the state general fund budget was devoted to Medicaid. The percentage is projected to increase to 8.7 percent in fiscal year 1993 and to 17.1 percent by fiscal year 1997. Medicaid is expected to consume an increasing share of the state's expected revenue growth over the next several years, crowding out available new funding for education and other programs by 1997.

**Percent of Total Annual Increase in Resources
Devoted to Medicaid, Employees Salaries
and K-12 School Aid
(Projected, Without Medicaid Reforms)**



* Excludes GAAP and ending balance
Source: Iowa Department of Management
As of July 1992

Cost Containment Mechanisms

In an effort to keep program growth down, a variety of Medicaid cost containment mechanisms have been put in place within the last several fiscal years and additional mechanisms are scheduled to be utilized during fiscal year 1993. The net state savings realized from Medicaid cost containment mechanisms in fiscal year 1992 was nearly \$14 million and projections are that new initiatives for fiscal year 1993 will generate nearly \$1 million in additional net savings.

Medicaid Cost Containment Mechanisms

	Gross State Savings (FY 92)	State Cost	Net State Savings
Hospital Pre-Admission Review	\$2,948,224	\$100,718	\$2,847,506
Outpatient Hospital Review (PRO)	32,303	14,168	18,135
Pre-procedure Review (PRO)	632,458	83,757	548,701
Nursing Facility Admission Review (PRO)	768,690	223,412	545,278
Lock-In/RHEP (PRO)	259,548	15,883	243,665
Ambulatory Review (Fiscal Agent)	515,011	48,919	466,092
Drug Utilization Review (IPA)	636,660	73,200	563,460
Third Party Liability	2,546,640	147,733	2,398,907
Health Insurance Premium Payment Program (HIPP)	459,810	351,968	107,842
Drug Rebates	3,237,000	17,330	3,219,670
MediPASS	3,027,337	571,956	2,455,381
HMO (est.)	305,324	60,537	244,787
Co-payments	949,946	-0-	949,946
Other Limitations	Unknown		
Total FY 92	\$16,318,951	\$1,709,581	\$14,609,370

New Initiatives

	Gross State Projected Savings (FY 93)	State Cost	Net State Savings
Immunization Project	\$338,568	\$40,026	\$298,542
Prior Authorization of Prescription Drugs (3 quarters of savings)	508,749	120,000	388,749
Physician Related Visits (3 quarters of savings)	Unknown		
MediPASS Expansion	435,877	147,149	288,728
Total New Initiatives FY 93	\$1,283,194	\$307,175	\$976,389

Source: DHS

Summary

This section has focused on providing a snapshot of the current and future scope of state general fund spending for Medicaid, along with an understanding of why those increases have occurred. While current cost containment mechanisms are producing very positive results, much remains to be done to control the rise in state spending for Medicaid.

Implementation of the recommendations which follow will help to stem the growth in Medicaid spending, but it is essential that comprehensive reform of the entire health care system remain a top priority. In the long run, comprehensive health care reform will offer the most permanent solution to the dilemmas facing Medicaid.

MANAGED CARE

Issue:

Managed Health Care Plan Models

Background:

Managed health care plans, such as health maintenance organizations (HMOs) and preferred provider organizations (PPOs) are based on the concept that by capping payment for group care or paying physicians to monitor patients' care, physicians will be motivated to keep patients healthy by emphasizing preventive measures and avoiding more expensive care at later stages of intervention. Managed care plans have been utilized for decades by many private and public sector employers who provide for employee health care. The relationship between managed care plans and Medicaid, however, is more recent.

Seven states, including Iowa, have been granted waiver approval by HCFA to operate Medicaid managed care models.

Arizona administers the most expansive Medicaid managed care model. Since implementing its Medicaid program in 1982, Arizona has required nearly all persons participating in Medicaid to enroll in a managed care plan. The state's program receives great praise from providers, recipients and government officials. A 1989 federal evaluation of Arizona's program found that costs were 40 percent lower during the first five years of the program than could have been expected under a traditional Medicaid program. Quality of care was found to be at least as good as would be expected in a traditional program. Unlike Arizona, none of the other six states is operating a Medicaid managed care model statewide. It is important to note that the waiver authority under which Arizona's statewide plan operates is unique and difficult to qualify for.

Iowa has contracted with the Heritage National Healthplan HMO to serve Medicaid recipients in Scott County since 1986. Approximately 8,900 Medicaid recipients are enrolled in the Scott County model. The contracting arrangement with Heritage has been viewed as a major success.

The Medicaid Patient Access to Service System (MediPASS) is another form of managed care serving some Iowa Medicaid recipients. Under MediPASS, a recipient is assigned to a physician who manages the overall health utilization of the recipient. Implemented in fiscal year 1991, the program operates in seven counties (Black Hawk, Jackson, Linn, Muscatine, Polk, Pottawattamie and Scott) and has an enrollment of more than 39,000. In fiscal year 1993, the program will be expanded to include an additional 27,000 recipients.

When looking at any of the models recommended here policymakers need to consider the following:

- Administrative feasibility dictates that managed care programs enroll only ADC and ADC-related eligibles at this time. Aged, blind and disabled Medicaid recipients are not included in Iowa's current managed care programs.
- There are a variety of managed care models. Models need to be community specific. What may work in an urban setting may not work in a rural setting. Caution should be used when developing provider managed care contracts and conducting oversight.
- Provisions for transportation services may need to be built into the models, especially in rural areas, to increase recipient access.
- There is a need to promote recipient behaviors which ensure their long-term health (e.g. prenatal care).

Recommendations:

- 1. Establish risk-based managed care plans in urban and rural settings with existing medical facilities (hospital or clinic) which have or could develop established physician relationships. Similar to the Iowa Leadership Consortium proposal, these plans should result in an integrated delivery system, organized to provide or coordinate all or most services.**

If a limited-risk based plan or any other form of managed care plans is pursued, it would not be necessary to obtain waivers from HCFA to require enrollment of the ADC and related population in the seven counties where MediPASS is in place. Waiver application is unnecessary since waiver authority allowing for MediPASS would also allow for other forms of managed care for the ADC and related population. However, extension of managed care plans to other

categories of eligibles would require a waiver, as would implementation of a similar plan in an area where MediPASS does not exist. Typically, HCFA has not granted waivers if more than one capitated plan or one capitated plan and MediPASS do not exist.

Financial Impact: General fund savings of \$1,200,000 for recommendations 1, 2, 3, 4, 7 and 8. The administrative cost of implementing recommendations 1, 2, 3, 4, 7 and 8 is estimated at \$200,000.

2. Expand HMO contracting to other geographic areas and expand HMO contracting to other services such as pharmacy.

In order to implement this recommendation there must be HMOs willing to contract with Medicaid or expand existing contracts. The issue of "hassle factors" explained later may impact the state's ability to contract with HMOs.

Financial Impact: See financial implication for recommendation 1.

3. Explore rural PPO opportunities with appropriate parties.

HMOs provide a full range of services to patients while PPOs generally provide physician or physician and hospital services. Because of dispersed population bases in rural areas, it may be more practicable to explore PPO agreements than to explore HMO agreements.

Financial Impact: See financial implication for recommendation 1.

4. Establish a community-based model of service delivery similar to the plan under development by the Cedar Rapids Leadership Council or the Central Iowa Project.

Financial Impact: See financial implication for recommendation 1.

5. Contract for selected medical services (such as heart transplants and other high cost major procedures) at centers of excellence which can demonstrate quality and cost-effectiveness.

A federal waiver which would limit free choice of provider would probably be necessary to implement this recommendation.

Financial Impact: \$34,680 in general fund savings.

- 6. Place a state-funded Medicaid physician in an existing rural health care facility to provide services to Medicaid recipients.**

It is unknown whether there are enough recipients to keep a full time physician busy in a rural area, and transportation becomes an issue if Medicaid recipients are able to receive medical services in one place only.

Financial Impact: TBD

- 7. Expand relationships with HMOs that utilize a managed care model for mental health and chemical dependency services.**

Currently, the use of mental health and chemical dependency services in an unmanaged fee-for-service environment, without centralized services to coordinate and direct care, is a costly system. Additionally, it is difficult for managed care providers such as MediPASS's patient managers to oversee these areas of service. There are several organizations already operating in Iowa who specialize in managing these services. The relationship which the state has with the Heritage HMO model in Scott County includes coverage for these services.

Financial Impact: See financial impact for recommendation 1.

- 8. Contract with existing organizations on a capitated basis for mental health and chemical dependency services and use the state substance abuse appropriation as a source of Medicaid match.**

DHS currently certifies some mental health and chemical dependency units through the Iowa Foundation for Medical Care (IFMC).

Financial Impact: See financial impact for recommendation 1.

MANAGED CARE

Issue:

"Hassle Factors" Which Prevent Participation in Managed Care Plans

Background:

The term "hassle factors" relates to substantive and procedural barriers which may inhibit providers from becoming involved in managed care systems. A number of "hassles" are inherent to medical practice (utilization review, payers wanting accountability) while others are inherent when dealing with a public payer (reimbursement). Some things considered "hassles" are, by physicians' own accounts, "good ideas"; however, the results are burdensome (OB high risk assessment).

In discussing perceived "hassles" relating to managed care plans, it was determined that some issues have been handled under existing policy or clarified through education.

Some physicians perceive "hassles" to be fewer when contracting with a managed care plan as opposed to contracting directly with the state.

Movement from micro-management and utilization review to case management and outcome measures (holding providers accountable for outcomes) seem to be logical guiding principles to follow.

Recommendations:

- 1. Dedicate staff in local DHS offices to provide enrollment and education services to persons eligible for managed care (MediPASS) and to serve as liaison between enrollees and providers.**

A sense of frustration exists among providers and persons enrolled or eligible to enroll in MediPass over a perceived lack of information available in some

local DHS offices. While local DHS offices are currently providing these services in the course of other duties, specific staff are not dedicated for these purposes. Dedication of staff to specifically provide education and liaison services may help to address this concern.

Financial Impact: \$0

- 2. Provide staff or resources (contract staff) to educate/recruit managed care plans to participate with Medicaid, provide ongoing liaison function and to educate DHS staff as necessary to ensure success and cooperation.**

Before managed care contracting can occur, education and recruitment of managed care plans and providers is necessary. DHS has discovered that many misconceptions exist about contracting with Medicaid for managed care services. Ongoing recruitment and education efforts will be necessary to attract plans to participate and ongoing liaison functions will be important to the continued success of these relationships. Staff in this position would be responsible for not only initial recruitment but ongoing assessment of the needs of the plan and concerns which need to be addressed about the contractual relationship. Reporting recommendations to policy staff and thorough follow-up will be necessary.

Financial Impact: \$0

- 3. Direct DHS to identify an existing advisory body to address the detailed issues surrounding "hassle factors."**

This body would be charged with the responsibility to examine the reasons and needs for procedures and requirements which are considered "hassles." The group would need to comprehensively review issues and balance needs such as quality assurance and cost containment against the level of aggravation for the provider.

Financial Impact: \$0

4. Promote the following at the federal level (a and b are part of a proposal already under discussion in Washington):

- a) Legislation to allow six month lock-in to a managed care plan.**
- b) Legislation that provides for additional month of eligibility after normal cancellation if the person is enrolled in a managed care plan. This allows for continuity if eligibility is regained within the extended eligibility period.**
- c) HCFA examination of the effect of the newly developed standards for risk-based Medicaid managed care plans to determine the willingness of plans to participate.**

Financial Impact: \$0

MANAGED CARE

Issue:

Cost/Use of Pharmaceuticals

Background:

State fiscal year 1992 marked the first year in the history of Iowa's Medicaid program that spending for pharmaceuticals exceeded spending for physician services. Over the past ten years Medicaid has experienced a three-fold increase in its expenditures for prescription drugs. This increase is due to three factors:

- Manufacturer cost - 53 percent of the increase,
- Recipient use - 31 percent of the increase, and
- Pharmacist fees - 16 percent of the increase.

Several other factors have contributed to increased cost in the Medicaid drug program, such as:

- The growing percentage of elderly patients requiring more extensive drug therapy.
- The shift in institutional care to outpatient care, with greater reliance on pharmaceuticals which were previously used in institutional settings.
- The availability of biotech drugs and other new therapies to treat schizophrenia, rejections from organ transplants, AIDS, etc.

It is also important to recognize the following cost containment mechanisms have already been put in place to keep pharmaceutical costs down:

- Use of generic drug products
- Drug utilization review
- Manufacturer drug rebates
- Restrictions in pharmacist fee reimbursement
- Patient cost sharing-co-payment
- Prior authorization for selected drugs

There are additional opportunities to utilize current pharmaceutical cost containment mechanisms and to institute new cost containment initiatives to reduce Medicaid pharmaceutical costs.

Recommendations:

1. Expand retrospective drug utilization review (DUR) and implement a program of prospective DUR.

Four thousand, eight hundred drug profiles are currently reviewed under retrospective DUR. This number could be expanded to 7,200 if an additional physician were added to the DUR Commission along with the addition of one professional staff person and one support staff person at the Iowa Pharmacists Association. The positions with the Pharmacists Association would be funded through a contract with DHS. The Pharmacists Association staff would conduct reviews, perform research and establish educational programs, including a pilot program of academic detailing. Research could include focus studies centering on lipid lowering agents, or Nonsteroidal anti-inflammatory agents, or Histamine (H2) blockers or antibiotics.

Financial Impact: \$336,000 in state general fund savings. Additional state funds of \$36,150 would be needed to fund the Commission member and costs of the contract with the Pharmacists Association.

2. Expand the list of Medicaid covered (when prescribed by a physician) over-the-counter drugs.

A physician's prescription is necessary for Medicaid to pay for any drug, legend or non-legend. The savings realized by expanding the list of non-legend drugs that are payable would depend on the physician making the decision to prescribe the non-legend drug.

The following list of examples was provided by the Iowa Pharmacists Association.

PRESCRIPTION PRODUCTS

NON-PRESCRIPTION PRODUCTS

ANTI-ULCER AGENTS

Zantac 300 mg \$2.61/tab
Zantac 150 mg \$1.47/tab

Rulox tablets \$.02/tab
Rulox Suspension \$.09/15ml
generic for Maalox

LAXATIVES

Lactulose \$.68/15 ml

Milk of Magnesia \$0.09/15 ml
Ducosate sodium \$0.02/capsule
Natural Vegetable Powder
\$.11/dose/(generic Metamucil)

CORTICOSTEROID CREAMS

Synalar 0.01% \$8.70/15 Gm
Diprolene 0.05% \$19.51/15 Gm

Hydrocortisone 1/2% \$1.77/30 Gm

ACNE PRODUCTS

Retin A 0.025% \$22.44/20 Gm

Benzoyl Peroxide Gel 5% \$2.85/45 Gm

Financial Impact: \$394,000 in state general fund savings.

3. Expand the prior authorization program for prescription drugs.

The prior authorization for certain prescription drugs became effective October 1, 1992. The program focuses on evaluating the prescribed use of targeted prescription drugs for medical necessity. No additional staff would be necessary to implement this recommendation.

Financial Impact: Total estimated general fund savings of \$388,700 are projected for fiscal year 1993. Expansion of the program in fiscal year 1994 could generate \$461,600 in additional savings.

4. Apply for a federal waiver for use of formulary (allowance for substitutes for prescribed drugs by therapeutic class) for prescription drugs.

Federal law currently requires Medicaid to cover payment for all prescription drugs. The Federal prohibition against formulary will expire in October 1994.

Financial Impact : TBD

- 5. Establish, on a voluntary basis, a mail order drug program for maintenance drugs needed by aged, disabled or nursing home Medicaid recipients.**

Maintenance drugs are those used on a continuous, long-term basis. Currently, pharmacists dispense all drugs in nursing homes by unit dose packaging. Implementation of this recommendation would allow for maintenance drugs to be purchased via mail and dispensed in monthly dose packaging. There may be additional opportunity for participation by in-home Medicaid clients who use maintenance drugs.

Financial Impact: \$539,000 in state general fund savings.

- 6. Establish selective contracting for dispensing fees.**

In addition to reimbursing pharmacies for product costs under Medicaid, pharmacists are paid a professional fee of \$4.02 or \$6.25 depending on the drug dispensed.

Financial Impact: TBD. The experience of one managed care plan was that \$2.00 per prescription was saved.

- 7. Direct DHS to work with the Department of General Services to examine the legalities of state wholesale purchase of drugs for Medicaid.**

General Services currently contracts directly with manufacturers to purchase drugs at discount for use by residents in state institutions. Economies of scale might be realized if Medicaid drugs were purchased in conjunction with these drugs purchased for use in state institutions.

Financial Impact: TBD

MANAGED CARE

Issue:

Contracting for Durable Medical Equipment and Supplies

Background:

Selective contracting for certain equipment and supplies has been studied by DHS in the past. Other states have used this method of contracting with varying degrees of success. A 1991 DHS report, "Survey of State Medicaid Contracting Practices," indicated a satisfactory contract for durable medical equipment and supplies would be difficult to accomplish due to:

- 1) The large number of products and product specifications.
- 2) Provider resistance due to potential loss of market in a competitive environment.
- 3) Statewide distribution.

Minnesota's experience with one selected item, wheelchairs, shows a discount of 25-50 percent.

Recommendations:

1. Explore volume purchasing of medical equipment and supplies; bids based on discount from manufacturers' published price.
 - a) Create a network run by the state purchasing agency (in Iowa this would be General Services) which purchases items, such as wheelchairs, for not only Medicaid, but all of the state's political subdivisions
 - or*
 - b) Include Medicaid in the purchasing network of a private entity such as a major hospital.

Financial Impact: Maximum potential savings from a wheelchair purchase program were estimated at \$105,000 state dollars in fiscal year 1994. Potential for other equipment and supplies purchases is unknown.

SYSTEM SIMPLIFICATION

Issue:

Medical Malpractice Reform

Background:

Medical liability is a key issue in the area of expanded use of managed care. Physicians and other providers perceive that an increased role in the cost/quality determination under managed care may increase the likelihood of conflict with patients, based on the perception that available care was denied because it was too expensive. Managed care relies upon capitated or bundled payment schemes requiring the provider to assume some financial risk for delivering cost-effective care. While Iowa may wish to expand the use of managed care for Medicaid, without malpractice reform it may be difficult to find providers willing to contract.

Recommendations:

- 1. Establish uniform practice parameters such that conformance with these parameters is defense against allegations that a provider did not comply with accepted standards of practice in the community absent clear and convincing evidence to the contrary.**

This concept has been developed in Minnesota under the MinnesotaCare statute. Following Minnesota's example, Iowa could significantly improve the quality of care through the approval of practice parameters, while increasing the predictability and, arguably, fairness of the medical liability system for both providers and patients.

Practice parameters, based on outcomes research, are very complimentary in concept to both managed care and the increasing prevalence of practice guidelines in the medical community at large.

Financial Impact: There would be some time lag to review and approve appropriate practice parameters, so savings would not be immediate, but would be long lasting and permanent while simultaneously improving the quality of care.

2. Amend the statute of limitations for minors' medical liability claims in order to increase access to prenatal, obstetrical and pediatric care.

This change is essential if the state is to pursue an aggressive managed care program. Such a change will improve access and costs for all segments of the population, not just Medicaid. It is an especially pressing need for rural Iowa, and other under-served populations, where the perception of this liability problem leads to early retirement of general practitioners from the obstetrical portion of their practice. A change in the statute of limitations to the prevalent adult rule of 6+2 would complement efforts to encourage allied professionals to provide the same services.

Financial Impact: The state and local communities will incur lower costs to train and recruit physicians by retaining existing physicians in practice longer and by making practice in rural Iowa more attractive to new physicians.

3. Transfer punitive damages from malpractice awards to the state to provide expanded health care.

Currently a portion of punitive damage awards are directed to the state civil reparation fund under Chapter 668A. Claims are rarely made to draw from this fund.

Consideration should be given to expanding the portion of punitive damage awards directed to the state. All such funds directed to the state, including those currently set aside, could be redirected to increase access to health care, especially in instances where the state may be able to leverage additional federal funding for Medicaid. The increased portion of punitive damage awards directed to the state would not be drawn from contingency fees directed to attorneys.

Financial Impact: Approximately \$373,400 exist in this account presently from malpractice and all other civil suits, so fiscal year 94 savings will equal or exceed that number. However, the source of such funds (punitive damage awards in private civil actions) is highly unpredictable and remains TBD for future years.

SYSTEM SIMPLIFICATION

Issue:

Efficiency of Billing and Reimbursement System

Background:

Medicaid utilizes a fiscal agent who is responsible for maintaining the computer system, data entry, provider relations, provider audit, medical review, drug prior authorization and check writing for claims payment. On-line claims processing and eligibility determination are not currently possible, nor is electronic funds transfer, but implementation of technology to accomplish these purposes would improve the system.

Recommendations:

- 1. Implement a point of sale claims processing system in FY 94 (90/10 federal financial participation) for pharmacy claims. Implement a similar processing system within a year after for all other Medicaid providers.**

Implementation of this recommendation would require an initial expenditure but would allow Medicaid claims processing to be more flexible and improve turnaround time. Administrative costs might be reduced and payment data might be accessed in a more timely manner.

Financial Impact: General fund savings TBD. A general fund appropriation of \$22,739 will be necessary in fiscal year 94.

- 2. Evaluate and implement the use of on-line eligibility verification for Medicaid recipients as well as evaluate the use of permanent or smart cards.**

While remittance statements would still need to be sent out, check writing could be reduced by 100 percent, or nearly that. Many remittance statements could also be sent electronically.

Financial Impact: General fund savings and cost TBD.

3. Investigate the use of electronic fund transfer for the payment of claims.

On-line eligibility will eliminate the necessity for monthly mailing of medical cards. Other states have found that there are numerous lost cards, up to 50 percent per month.

Financial Impact: TBD

4. Integrate Medicaid payments into the Community Health Management Information System (CHMIS) when it becomes operational.

The Health Policy Corporation of Iowa has received a grant from the Hartford Foundation to develop a statewide Community Health Management Information System (CHMIS). In addition, the Health Management Information Center (HMIC) has just recently completed a report for the Health Data Commission on the feasibility of developing and implementing CHMIS in Iowa. A steering committee established by HMIC found implementation of CHMIS to be technologically feasible, but the Committee could not offer an assessment on financial feasibility at this time.

CHMIS could provide a totally electronic claims processing system, for all providers and all payers, and the Medicaid program could be one of the major beneficiaries. Many hospitals and clinics already process claims electronically, but CHMIS would provide a common standard and expand the system to other hospitals and to all physicians. CHMIS has the additional promise of dramatically improving the quality of data available to both purchasers and providers of health care. This knowledge can improve the quality of clinical care and reduce the cost of care by informing both providers and purchasers. While implementation of CHMIS is several years away, the system would be consistent with implementation of the three preceding Task Force recommendations.

Financial Impact: No state appropriations will be needed in fiscal year 93. Future state appropriations and savings TBD. CHMIS offers administrative savings to all and better information for decision making. The administrative costs of claims payment could be reduced through increased use of electronic claims processing and could save both state and private dollars.

LONG-TERM CARE

Issue:

Transfer of Assets

Background:

A growing number of middle class elderly are divesting themselves of assets or sheltering their assets by means of trusts or other legal methods so that Medicaid pays their nursing home costs. These persons get Medicaid-assisted care, and their children inherit the money. Medicaid, originally designed for the poor, increasingly is being asked to support all of the elderly, poor or not, who need care.

Recommendations:

- 1. Expand from 30 months to 60 months the look back period to determine if an applicant transferred resources for less than fair market value in order to qualify for Medicaid.**

Current federal law limits the look back period to 30 months. A federal waiver request is being pursued to allow this recommendation to be implemented.

Financial Impact: TBD

- 2. Implement legislation to allow DHS the right to recover from the transferee the value of resources transferred, for the purpose of qualifying for Medicaid.**

In instances where an applicant or recipient of Medicaid nursing facility assistance has transferred resources for less than fair market value for the purpose of qualifying for assistance, DHS should be allowed to recover the uncompensated value of the transferred resources from the person who

received the resources. The right to recover assets would cover a five-year look-back period.

Financial Impact: TBD

- 3. Require authentication of income and assets for individuals seeking to receive Medicaid coverage in a nursing facility.**

This recommendation would require applicants to provide their income tax returns covering the period for transfer of assets. This would allow Income Maintenance Workers to more thoroughly examine the eligibility criteria for applicants applying for medical assistance.

Financial Impact: TBD

- 4. Require routine audits of income and assets by the local county human services departments.**

Implementation of this recommendation would help ensure that information submitted for eligibility is not fraudulent and that all assets and resources have been considered. Requiring audits of documents which list applicants' resources and assets may require additional time to certify eligibility.

Financial Impact: TBD

LONG-TERM CARE

Issue:

Long-Term Care Insurance

Background:

Long-term care insurance can provide for a wide range of medical and support services to individuals who have lost capacity to function independently and are likely to require services over a prolonged period because of a chronic illness or condition. Since nursing home care can cost more than \$25,000 a year, financing for long-term care services has become a major problem for those in need, their families and the Medicaid program.

Recommendations:

- 1. Direct the Insurance Division of the Department of Commerce to develop a plan to implement a Robert Wood Johnson Foundation long-term care insurance model similar to that adopted in Connecticut. The plan should include provisions for Medicaid exclusions for the amount of assets protected by long-term care insurance policies as individuals qualify for participation in the Medicaid program.**

The Robert Wood Johnson Foundation model of private/public partnership for long-term care insurance encourages the development of a statewide system of community-based care services to prevent premature placement in a nursing facility.

Financial Impact: The Division can develop this plan using existing staff. Future savings TBD.

2. Provide a full or partial tax credit for individual payments of premiums for the purchase of long-term care insurance from approved companies.

Availability of a tax credit for the purchase of long-term care insurance by some portion of Iowa's elderly population may reduce the movement from private pay to Medicaid over the years. Thirty percent of the current Medicaid residents in nursing levels of care have converted from private payers to the Medicaid system. The increased use of long-term care insurance is likely to reduce that percentage.

Financial Impact: TBD.

LONG-TERM CARE

Issue:

Residential Care Facilities (RCF)/Assisted Living

Background:

An Iowa Foundation for Medical Care study indicates that as many as 900 individuals currently in intermediate levels of care in Iowa may not meet standard medical criteria which would qualify them for that level of care. Lack of other alternatives, the social appropriateness of living with their spouse, psychological criteria, or the inability to handle routine activities of daily living, more than medical needs, have provided for placement in intermediate care. It may be appropriate to find less medically focused and restrictive environments for responding to their needs.

Recommendations:

- 1. Expand the Residential Care Facility (RCF) program. Reduce the rules and restrictions which RCFs are subject and increase reimbursement which they receive as first steps to expanding the program.**

Financial Impact: TBD

- 2. Develop standards to allow assisted living care settings to qualify for state supplementary assistance reimbursement.**

Financial Impact: No savings are anticipated, but implementation of this recommendation should allow expansion of the service system at little if any additional cost to the state. The basic cost of residential care is currently about half the cost of nursing facility care; however, persons moved or diverted from nursing facility to residential care or to assisted living settings will likely require special services which will have an added cost. Additionally, it is anticipated there would be expanded utilization of residential and assisted living services if funding were increased.

LONG-TERM CARE

Issue:

Integrated Case Management for the Frail Elderly

Background:

Integrated Case Management for the Frail Elderly is a comprehensive system in which a plan of care is developed by a team of providers, the client and/or their family. The team assists clients to gain access to supportive resources to reduce the risk of institutionalization. This system may include the following functions:

- screening,
- assessment,
- interdisciplinary case conferences,
- a written plan of care,
- information about and referral to services,
- case monitoring,
- reassessment to assure proper placement within services,
- evaluation of outcomes of services and exit planning.

Adult day care is also an important element in the integrated case management system. The federal Title 19 Home and Community Based Services Waiver, available where the case management program exists, offers a payment mechanism for specified services, including adult day care, for clients who meet guidelines and who are participating in case management. The waiver was developed through the cooperative efforts of DHS and the Departments of Public Health and Elder Affairs.

The Integrated Case Management Program for the Frail Elderly is now available in 14 counties in nine of the 13 area agencies on aging (AAAs). In fiscal year 1992, 3,089 persons had contact with the program. Eight hundred eighty-one persons were determined to need and received case management services. Of those, 368 were determined by the Iowa Foundation for Medical Care to meet Medicaid's medical necessity criteria for intermediate level of care in a nursing facility.

Recommendation:

Provide funding to expand integrated case management for the frail elderly to each of the four Area Agencies on Aging (AAAs) not currently served by the program and increase funding for the program in each of the AAAs currently providing case management.

Implementation of this recommendation would allow expansion of the Medicaid Home and Community-Based Waiver which helps to prevent seniors at risk from being prematurely institutionalized. This waiver provides a package of services, including adult day care, for persons who would otherwise require care in a nursing facility at a cost which cannot exceed the cost of nursing facility care.

Financial Impact: An appropriation of \$50,000 is suggested for each of the four AAAs not currently providing integrated case management and an additional appropriation of \$120,000 is suggested to bring the other nine AAAs' integrated case management programs up to a \$50,000 funding level. Total general fund cost of this expansion would be \$320,000.

No overall state savings are anticipated from this recommendation; however, waiver program savings would help offset the cost of expanded case management. A significant but undetermined amount of additional federal dollars could be attracted for home- and community-based service expansion.

LONG-TERM CARE

Issue:

Case Mix Reimbursement

Background:

An Iowa Foundation for Medical Care study released in June 1992 reported that of 18,302 Medicaid recipients under review at the end of the fourth quarter of 1990, 14 percent met specialized criteria to qualify for intermediate level of care. In the fourth quarter of 1991, 18,506 Medicaid recipients were under review, with 2,128, or 11 percent meeting specialized criteria to qualify for intermediate level of care. This represents a comparatively heavy care cohort within the intermediate level of care program. Additionally, the Iowa Foundation for Medical Care found in 1991 that 2,523 or 18 percent had minimal care needs. This group is a lighter care segment of Medicaid recipients at this level of care.

Recommendations:

1. Modify the intermediate level of care reimbursement for Medicaid recipients in accordance with a case mix strategy. The reimbursement rate for those individuals meeting "heavy care" special care status should be a flat amount of \$4.00 per resident per day in excess of the current reimbursement rate. The reimbursement rate for "lighter care" residents would be a flat amount of \$4.00 per resident per day lower than the current reimbursement.

Financial Impact: The financial implications of the strategy would be dependent upon the number of individuals certified at each of these two levels of care, "heavy" and "light." Based on current figures and given that there are more light care than heavy care individuals, total savings are estimated to be \$584,000 (400 residents x \$4.00 per day x 365 days per year = \$584,000). State general fund savings would be \$215,030. More importantly, if

implemented, this recommendation would act as a disincentive to premature placement of lighter care residents to intermediate care facilities.

- 2. By March 1, 1993, establish a study committee composed of Area Agency on Aging, Iowa Foundation for Medical Care (IFMC) and appropriate state agency representatives to review current Medicaid admission criteria for nursing facility care. This group should consider the appropriateness of including psycho/social factors in evaluating level of care needs and the most appropriate role for the IFMC in determining whether a consumer should be admitted to a nursing facility.**

Financial Impact: \$0

REGULATION

Issue:

Fiscal Impact of Federal Nursing Home Requirements/OBRA 87

Background:

The Nursing Home Reform provisions of OBRA 87 have presented Iowa nursing facilities with a significant increase in requirements and costs. Questions are beginning to be raised as to whether the benefits to residents and to states are reasonably related to the cost.

OBRA 87 -- Major requirements:

- 1) Physicians visits are required every 30 days the first 90 days and every 60 days thereafter. This requires 2 more visits per year more than formerly required for all Medicaid residents. This increases by \$235,520 the state share of physician visits.
- 2) All residents are required to have preadmission screening and annual resident review, including private pay residents, for mental illness and mental retardation. This sounds good in theory but does not work well in practice. The added state cost related to this requirement is approximately \$100,000 per year.
- 3) Staffing increases in many facilities were required in order to provide 24 hour licensed nurses with services of a registered nurse 8 hours a day 7 days a week. Iowa facilities have had difficulty hiring registered nurses.
- 4) A 75 hour nurse aide training program and competency testing which is substantially different from the prior state program.
- 5) On October 1, 1990, all nursing facilities (HFs) were required to have a medical director. Skilled Nursing Facilities (SNFs) were required to have a medical director prior to October 1, 1990. In rural areas, the medical director

may be the only physician in the community making it unnecessary to coordinate medical care.

The cost associated with meeting requirements 3 through 5 plus other requirements not listed is at least \$22,500,000 per year (\$8,284,500 state share). Meeting these added requirements has increased the average Medicaid payment rates to Iowa nursing facilities by at least \$3.75 per patient per day.

Recommendations:

- 1. Evaluate the cost/benefits of Nursing Home Reform by comparing the cost and quality of care in Iowa nursing facilities that do not participate in the Medicaid program with the cost and quality of care in participating facilities.**

Financial Impact: \$0

- 2. Promote congressional review of the cost benefits of various provisions of Nursing Home Reform.**

Financial Impact: TBD. However, up to \$8,284,500 in state general fund savings could be realized if the major requirements of OBRA were rescinded.

REGULATION

Issue:

Reimbursement Rates/Calculation of the Capital Cost Component of Inpatient Reimbursement Methodology

Background:

Medicaid utilizes a Diagnostic Related Group (DRG) methodology to determine reimbursement for inpatient hospital care. Included in this methodology is an allowance for capital replacement. The methodology for calculating the capital allowance creates wide variations among hospitals and does not necessarily reflect actual costs.

Recommendations:

Modify the methodology to require that capital costs greater or less than standard deviations of the mean capital cost will be reduced or increased to within 1 standard deviation of the mean and allow no more than 80 percent of capital costs from the hospital's cost report.

Financial Impact: State general fund savings of \$920,500.

REGULATION

Issue:

Reimbursement Rates/Outpatient Hospital Charges Reimbursed Under Retrospective Methodology

Background:

Outpatient hospital charges in Iowa are reimbursed under a retrospective methodology. A 1986 Center for Health Policy Studies report reviewed Iowa's Medicaid payment and delivery systems and recommended the state wait for further evidence on the effectiveness of the system-wide reform options that were being discussed at that time. The system reforms are now in place and the utilization of outpatient services has increased.

Recommendation:

Direct DHS to conduct a study of outpatient hospital charges and develop a new reimbursement methodology that would take outpatient charges from a cost basis methodology to one that is more efficient and cost effective.

Financial Impact: \$50,000 to perform the study. Savings TBD.

REGULATION

Issue:

Reimbursement Rates/DRG Calculation

Background:

Currently, there is no in-depth review of cost reports that are submitted by hospitals for hospital Diagnosis Related Group (DRG) calculations. The Iowa Medicaid Program uses Medicare cost reporting regulations. These may or may not reflect the type of reporting regulations that should be used in Iowa's Medicaid program.

Hospitals submit cost reports to DHS and these reports are used in the development of hospital DRGs. The reports are audited by Medicare auditors under contract by the Medicaid program in accordance with Medicare cost reporting standards.

Nursing homes also submit cost reports to DHS; however, these reports are audited by a private sector accounting firm.

Recommendation:

Require DHS to contract with an accounting firm to: (a) perform audits on the cost reports submitted by hospitals, on a sample basis; and, (b) review Medicare cost reporting standards and where applicable develop Iowa Medicaid program standards of allowable costs.

Financial Impact: TBD

REGULATION

Issue:

Inappropriate Patient Access/Emergency Room Use

Background:

Many Medicaid recipients access medical care at a level which is unnecessary and/or more costly than alternatives. Unnecessary use of the emergency room (ER) to obtain primary care is the most recognized example of the inappropriate access to medical care by Medicaid recipients. The Medicaid program has guidelines in place that limit Medicaid payment for the use of the ER. The current rules state that payment will be approved for a fee for use of an ER providing at least one of the following conditions is met:

- The patient is evaluated or treated for a medical emergency, accident, or injury. Medical emergency is defined as a sudden or unforeseen occurrence or combination of circumstances presenting a substantial risk to an individual's health unless immediate medical treatment is given.
- The patient is referred by a physician.
- The patient is suffering from an acute allergic reaction.
- The patient is experiencing acute, severe respiratory distress.

The only charge denied is the actual fee for using the ER (usually a \$40 charge). The hospital has the right to bill the Medicaid recipient for this charge; however, the recipient generally disregards paying this fee; the hospital absorbs the cost.

Recommendations:

- 1. Eliminate the guideline allowing emergency room (ER) payment if physician referral was made and develop a system to allow for payment of non-emergency treatment.**

Payment would no longer be made for the use of the ER room based solely on a physician referral. A reduced rate would be developed to pay for the use of an ER in a non-emergency.

Financial Impact: DHS estimates that in one quarter, they could normally expect to deny about 8,000 claims that had a physician referral but did not have an emergency diagnosis. If the average ER payment was \$40, this would result in a cost savings to the program of \$320,000 per quarter. Assuming this payment would be \$20, the cost savings per quarter would drop to \$160,000. The estimate of total annual savings is \$640,000 with a state general fund savings of \$235,650.

- 2. Expand the system of identifying abuse and misuse and regulating outliers through the Recipient Lock-In program.**

The Recipient Lock-In program is designed to control the utilization of health care of recipients who have developed a pattern of misuse or over-utilization. The program was instituted in the 1970s and expanded on July 1 each of the last two years. The success of the program has led to a greater number of recipients receiving counseling and education on how to appropriately utilize health care.

Financial Impact: TBD

- 3. Strengthen incentives to reduce emergency room (ER) use.**

While the ER fees which recipients are required to pay for ER use are generally not paid and, therefore, absorbed by hospitals, it is possible that these fees and any other co-payments which might be instituted could be deducted from other assistance payments which a recipient might receive from the state, e.g. ADC. This would be but one incentive to reduce ER use.

Financial Impact: TBD

REGULATION

In addition to the preceding issues identified and recommendations developed in relation to regulation, other issues which may require monitoring or future development include:

- Assuring that a continuum of care provides for appropriate care modality and flexibility to move between levels of care as a result of personal or external factors. This could include the development of a system for short-term care and home maintenance. Current regulations may actually prevent individuals from being served at the lowest level of care or returning to a lower level if their condition changes.
- Assuring that inappropriate referrals to ancillary services do not occur. This concerns provider ownership of referral services.
- Maintaining effectiveness of the Certificate of Need (CON) program. There were significant changes in the Code regarding CON a year ago. Other states have demonstrated that eliminating CON has impacted the health care system negatively in the cost arena.
- Additional staff may be needed in the Medical Division to improve oversight of the Medicaid system and to better analyze the data available. It was felt that the amount of data collected is sufficient.
- Eliminating duplication in government regulation or procedures. One example is the dual licensure in hospital-based substance abuse programs.
- Maintaining an appropriate supply of trained professionals. This pertains to primary care physicians, especially in the rural areas.

FEDERAL FUNDS MAXIMIZATION

Issue:

Leveraging Existing State Funds to Enhance Health-Related Programs or Offset General Fund Expenditures

Background:

The Task Force inventoried and reviewed all state funded (in whole or part) health-related activities (non-DHS) to identify opportunities for new or additional federal funding under the Medicaid program. Programs could either be expanded by leveraging existing state general fund moneys to qualify for additional federal funding or state general fund moneys could be saved by replacing them with federal funds, with no decline in program service levels.

Opportunities were identified in the areas of Child Welfare, Education (school nurse), Public Health Consulting, Immunization Marketing and Well Elderly Clinics.

Recommendations:

- 1. DHS should continue to work with the Federal Health Care Financial Administration (HCFA) to obtain \$24,700,000 in additional federal funds for Early and Periodic, Screening, Diagnostic and Treatment (EPSDT) provisions. A representative work group should be established to develop a plan for allocation of these federal funds.**

Historically, Child and Family Services have been funded largely by the state with minimal federal funding for foster care services and adoption subsidy. A number of the child and family services (i.e. group care, treatment family foster care, family centered services and family preservation) are eligible for Medicaid reimbursement under the EPSDT provisions. EPSDT is a federally mandated health screening program for children. By using the current state appropriation as match, it is estimated that \$24.7 million in new federal dollars

could be generated on an annualized basis to provide child and family services. DHS is working with the HCFA for approval to implement this "refinancing" concept. The DHS appropriation for Fiscal Year 94 reflects this Medicaid opportunity.

Financial Impact: \$24,700,000 in enhanced services.

- 2. Direct the Departments of Education, Public Health, Management and DHS to develop an implementation plan to deliver EPSDT services in Iowa public schools and to include the use of existing federal, state and local resources.**

It may be possible to enroll additional school districts as EPSDT providers in the Medicaid program. The Des Moines School District is the only district enrolled as a Medicaid provider. There are over 297 school districts in Iowa that employ school nurses, making them potentially eligible for Medicaid matching funds. It is estimated that there are 40,000 Medicaid eligible school children not being served. If EPSDT services could be provided by existing, public-funded school nurses, the program could generate \$652,080 in Medicaid funds.

Financial Impact: \$652,080 in enhanced services.

- 3. Direct the Department of Public Health and University of Iowa Child Health Specialties Clinics (CHSC) to work with DHS to apply for federal funding for public health consultants and CHSC nurse consultants.**

The Department of Public Health employs four persons that function as Public Health Consultants for local public health agencies. Approximately 15 percent of their work time is attributed to clarifying Medicaid issues for providers. Fifteen percent of the total wages for the four positions is approximately \$28,800.

Financial Impact: \$28,800 in general fund offset.