



## SFY 2013 Budget Cost Saving Strategy

**Strategy Name:** Local Yield Management Expansion

**Total Savings:** \$4,000,000

**General Fund:** \$1,608,800 (40.22%)

**Federal Fund:** \$2,391,200 (59.78%)

### **Summary:**

The IME Revenue Collections unit will add two (2) Iowa-based staff dedicated to local yield management activities. The yield management positions gather information to challenge claim denials made by other insurance that is identified as a primary payor to Medicaid and request additional information regarding the insurance claim denials to establish whether the denial was appropriate. One (1) FTE will be devoted primarily to challenging what appear to be inappropriate denials and requests for additional information for all carriers with the exception of Wellmark/Caremark. The other FTE will be devoted to the same activities with a focus on the state's largest insurers Wellmark and Caremark.

### **Detailed Description:**

The addition of two Yield Management positions will allow concentrated focus on working with carriers on specific activities. We expect that these two additional positions will be able to add \$2,000,000 in recoveries (per position).

### **Benefits:**

- This will ensure that Medicaid is not paying for services that other insurance should have covered.

### **Negative impacts:**

- None anticipated.



## SFY 2013 Budget Cost Saving Strategy

**Strategy Name:** "J" Code at AWP Less 12 Percent

**Total Savings:** \$218,024

**General Fund:** \$87,689 (40.22%)

**Federal Fund:** \$130,335 (59.78%)

### **Summary:**

Currently the reimbursement methodology for physician-administered drugs ("J" codes) is based on average wholesale price (AWP) minus 10%. The Department proposes to implement AWP minus 12% for all medical claims for "J" code payments. The total amount paid for "J" code claims for SFY11 was \$10,901,202. If Medicaid were to adopt the AWP minus 12%, there would be a savings of \$218,024.

### **Detailed Description:**

The proposed changes for the methodology for reimbursing physician-administered drugs would be consistent with how pharmacies are currently reimbursed for drugs. Drugs supplied by pharmacies are currently paid in this manner. This proposal brings in line a consistent process for paying for drugs that are administered in the physician offices. Eventually AWP publication will be discontinued. The change to implementing the current methodology of AWP minus 10% with AWP minus 12% will be an interim process until payment rates are based on another benchmark. Providers will continue to be paid for the administration of the drugs.

### **Benefits:**

- This proposal would create a consistent approach for drug payments across all IME processes.
- This method is transparent.
- This method would continue to ensure that Medicaid reimbursement covers the cost of the product.

### **Negative impacts:**

- This is a reduction in reimbursement to providers.



## SFY 2013 Budget Cost Saving Strategy

**Strategy Name:** Medicare Part B Disallowance

**Total Savings:** \$250,000

**General Fund:** \$100,550 (40.22%)

**Federal Fund:** \$149,450 (59.78%)

### **Summary:**

The disallowance project is the process of identifying Iowa Medicaid members with Medicare coverage and then reporting this information to providers that have submitted claims to the Iowa Medicaid Enterprise (IME) without first billing the Medicare. Providers will be given sixty (60) days to review the payment and either send the IME a refund, request that the IME recoup the claim payment, or refute the data. Currently, this process only applies to Medicare Part A claims (institutional). This proposal would add Medicare Part B to the current Medicare Part A disallowance cycles that run five times each year.

### **Detailed Description:**

Presently, Medicare Part A Inpatient claims are run through the disallowance cycle five times per year. This change will provide the IME with an effective way of recovering funds when Medicare Part B should pay as primary.

### **Benefits:**

- Allows Medicaid to ensure that Medicare is being billed and paying for all services for which they are the primary payor, therefore avoiding inappropriate billing and payment to Medicaid.
- Providers are able to rebill Medicare for these services which may pay at a higher rate than Medicaid for the services.

### **Negative impacts:**

- The identification of claims that weren't billed to Medicare first will result in additional administrative activity for both the provider and the IME.



## SFY 2013 Budget Cost Saving Strategy

**Strategy Name:** Medicaid Reimbursement of Medicare Part B (professional claims)

**Total Savings:** \$9,500,000

**General Fund:** \$3,820,900 (40.22%)

**Federal Fund:** \$5,679,100 (59.78%)

### **Summary:**

This proposal incorporates new edits in the Medicaid claims processing system to limit payment for Medicare crossover claims to the Medicaid fee schedule.

Currently for dual eligible's, Iowa Medicaid pays the entire amount of the deductible, coinsurance, and/or copayment remaining after the Medicare crossover claim has been processed. For all other claims for which a third party insurance payment has been applied, no additional payment is made by Medicaid if the amount paid by the carrier equals or exceeds the Medicaid fee schedule. If the amount paid by the third party insurer does not exceed the Medicaid fee schedule, Medicaid pays the difference up to the fee schedule amount. This change would make payment policy for claims for dual eligible members the same as for any other Medicaid member with other third party insurance coverage.

Medicaid currently enrolls 73,429 dual eligibles for which Medicaid pays coinsurance, deductibles, and copayments through crossover claims.

***NOTE: This is a high level estimate based on FY 2011 claims data. The actual savings amount will vary. Effective 1/1/2013, Iowa Medicaid will be increasing its reimbursement rates, for certain primary care services, as mandated by the Patient Protection and Affordable Care Act (PPACA). This payment increase will bring the Medicaid rate in alignment with the Medicare rate for these primary care services. As such, the estimate above assumes \$0 savings for these primary care services. Under current federal law, Medicare physician fees would otherwise decrease by a substantial amount effective 3/1/12. We assumed this decrease would not take place for the purpose of this analysis.***

### **Detailed Description:**

#### Definitions:

- **Dual Eligibles:** Persons who are eligible for Medicare Part A (hospital), Medicare Advantage Plans and/or Part B (professional services) and are eligible for some form of Medicaid benefit. There are several categories of dual eligibles; the largest category is a Qualified Medicare Beneficiary. A **Qualified Medicare Beneficiary (QMB)** is a low income person who is eligible for Medicare, and who also qualifies for Medicaid to pay their



Medicare premium, deductible, coinsurance, and copayment amounts. Any costs for Medicare Part D (prescription drugs) are not included.

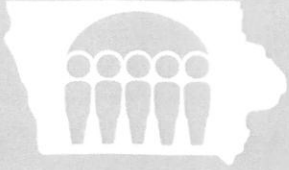
- Part B: The Medicare program that covers professional services (i.e. physician and other professional providers).
- Crossover Claim: A claim filed by a health care provider that was originally filed with Medicare, and subsequently submitted to Medicaid for payment of the remaining balance on the claim (for coinsurance, deductible, copayments, or services Medicare does not cover).

#### Benefits to the policy change:

- Payment accuracy -- Current payment rules do not prevent payment for crossover claims to Medicaid coverage limits. There are no means to ensure payments are accurate.
- Efficiency – Current payment processes provide inconsistent information and there are limited means to prevent overpayments. This would allow providers to bill Medicaid for crossover claims using the same claims form and processes as used for all other claims.
- Consistency. Payment policy is different for Medicare beneficiaries (dual eligibles) than for other members with other third party coverage.
- Many other states have implemented these limits. This change is permitted under federal law. Section 1902(n) of the Social Security Act states “a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for Medicare cost-sharing to the extent that payment under Title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this Title for such service if provided to an eligible recipient other than a Medicare beneficiary.”

#### Negative impacts:

- Providers (physicians and other professional providers in the case of Part B crossovers) would receive a reduction of approximately \$9.5 million in their Medicaid payments.
- The summary payment totals for Part A and Part B for the 50 providers with the highest crossover claims payments is attached.



## SFY 2013 Budget Cost Saving Strategy

**Strategy Name:** Hospital Readmission within 7 days of Discharge

**Total Savings:** \$650,000

**General Fund:** \$261,430 (40.22%)

**Federal Fund:** \$388,570 (59.78%)

### **Summary:**

When a patient is readmitted to the hospital, for the same or similar diagnosis, within 7 days of discharge, this change would combine all claims and allow only one DRG payment.

### **Detailed Description:**

When a provider discharges a patient too early and then subsequently readmitted, the provider receives two full DRG payments. If the patient was kept longer there will be less likelihood of readmission and additional cost. Facilities will be fairly compensated for these longer stays if they meet either the cost or long stay outliers. Even with longer stays, the State should realize savings.

Unnecessary hospital readmissions are a recognized cost and quality issue in the health care system, and are often caused by uncoordinated care. Readmission rates are a key quality indicator. More payors are instituting this type of incentive for hospitals to ensure appropriate discharge planning and coordination with other providers to ensure individuals receive appropriate follow up care.

Every year Iowa Medicaid receives 150 -175 readmission claims that meet the criteria above. Under this proposal the original and readmission claim will be combined together resulting in one DRG payment. In many cases the savings will equal the entire amount of the second hospital claim. In some instances, the combining of both claims will result in a day or cost outlier payment. Cost savings estimates were reduced by 20% to account for these outlier payments.

### **Benefits:**

- Incentives greater care coordination at discharge to prevent readmissions for the same condition.
- Improved outcomes for members.

### **Negative Impacts:**

- Medicaid revenue loss to hospitals.



## SFY 2013 Budget Cost Saving Strategy

**Strategy Name:** Estate Recovery Agreement with Iowa Public Employees Retirement System (IPERS)

**Total Savings:** \$2,000,000

**General Fund:** \$780,000 (40.22%)

**Federal Fund:** \$1,220,000 (59.78%)

### **Summary:**

This change would require the Iowa Public Employees Retirement System (IPERS), to notify the Iowa Medicaid Enterprise's Revenue Collection Unit (Estate Recovery) prior to releasing funds to heirs and benefactors of deceased Medicaid Members in order to recover Medicaid funds spent on behalf of the person.

### **Detailed Description:**

After the death of a person who has received Title XIX funded medical assistance, the law requires that the individual's assets be used to provide repayment to the Iowa Department of Human Services (IDHS). Title XIX funded medical assistance includes Medicaid and various waiver programs, including the Medically Needy Program and the Elderly Waiver Program.

Currently, IPERS funds are simply disbursed to the heirs and benefactors of deceased Medicaid members without regard to any claims of the Department. Prior to disbursement to the heirs and benefactors, state and federal taxes are deducted from the IPERS funds. When the Estate Recovery program attempts to get the payout back from the heirs or benefactors directly, often times the result is either no repayment or only a partial repayment.

### **Benefits:**

- This proposal will result in increased recoveries for the Medicaid program and result in decreased state and federal expenditures.

### **Negative impacts:**

- The amount received by the heirs and beneficiary of deceased Medicaid members may be decreased.
- There will be some minor, additional administrative cost placed on IPERS.



## SFY 2013 Budget Cost Saving Strategy

**Strategy Name:** Savings from Health Home Initiative

**General Fund:** \$4,900,000

### **Summary:**

Medicaid intends to implement a Health Home program beginning July 1, 2012. The program will make payments per member per month to providers who meet the certification standards to provide care coordination, health coaching, and quality activities to improve the coordination of care for persons with chronic disease. The IME actuarial firm estimates a General Fund savings of \$4.9M in FY 2013 from the initiative.

### **Detailed Description:**

The Iowa Medicaid Enterprise (IME) proposes a health home program under section 2703 of the Patient Protection and Affordable Care Act (PPACA). With an approved State Plan Amendment, a 90% federal match rate applies toward specific health home services for eight quarters.

**Goals:** Through proper implementation of a statewide health home program, the Iowa Department of Human Services can accomplish five key outcomes:

1. Improve the health of the Iowa Medicaid population using outcome-driven quality measures to track improvements.
2. Provide payment for providers for the infrastructure needed to track member health and enable patient coaching and engagement.
3. Achieve savings due to reductions in usage of health care services.
4. Develop a collaborative model with providers to develop a population health management approach that improves quality, reduces cost, and provides the learning and infrastructure needed for future payment reform efforts, such as Accountable Care Organizations.
5. Evaluate the fiscal impact and quality outcomes.

### **Projected Savings**

Milliman, Inc. analyzed detailed components of the IME Proposed Health Home program and has projected savings between \$7 million and \$15 million in state dollars over a 3-year-period. When administrative expenses and evaluation costs are factored into the





projection, the IME can still conservatively expect the program to achieve budget neutrality beyond the enhanced FMAP period. The estimated savings for FY 2013 is \$4.9 million

## Provider Participation

Health Homes may include, but are not limited to, Medicaid entities such as physician clinics, Community Mental Health Centers, Federally Qualified Health Centers, and Rural Health Clinics. Providers must:

- Meet certification/recognition requirements within 12 months of enrolling.
- Agree to provide health home services to qualifying Medicaid members and operate under health home provider standards established by IME.

## Payment Methodology

In addition to the standard fee-for-service rates, health home payments subject to the enhanced federal match include:

1. Patient management per-member-per-month (PMPM):
  - Targeted only for those with specific chronic disease.
  - Tiered into 4 levels - depending on member's acuity or risk.
2. Performance payment tied to achievement of quality performance
  - Tracked through Iowa's Health Information Network (HIN), starting annually in the 2<sup>nd</sup> state fiscal year (SFY).

## Members Opt-in to the Program

Members opt-in from the Health Home Provider's office. **Payment is tied to members with qualifying chronic conditions.** Members qualify if they have two of the listed chronic conditions; or one chronic condition and are at risk of developing a second condition:

- Categories of qualifying chronic conditions:
  - ✓ Mental Health Condition
  - ✓ Substance Use Disorder
  - ✓ Asthma
  - ✓ Diabetes
  - ✓ Heart Disease
  - ✓ Obesity (BMI of 25, or 85 percentile)
  - ✓ Hypertension



## SFY 2013 Budget Cost Saving Strategy

**Strategy Name:** Pharmacy Reimbursement Conversion

**Total Savings:** \$4,900,000

**General Fund:** \$1,970,780 (40.22%)

**Federal Fund:** \$2,929,220 (59.78%)

### **Summary:**

The current methodology Medicaid uses to reimburse pharmacies for drugs is being phased out due to a national class action lawsuit that found fraud in the methodology. This would convert reimbursement to Average Acquisition Cost (AAC) plus a reasonable dispensing fee of \$10 per prescription.

### **Detailed Description:**

The current method for reimbursing pharmacies for drugs is 'Average Wholesale Price' (AWP) minus 12%. AWP is a national benchmark standard used by many payors and Medicaid programs. The benchmark was used to approximate the average cost of acquiring or purchasing the drug. A class action lawsuit was initiated by states alleging that the benchmark was fraudulently inflated, causing states to overpay for drugs. The court found that the benchmark was fraudulently inflated and as part of that decision, AWP is being phased out.

HF 649 from the 2011 session required IME to evaluate other reimbursement methods in consultation with provider groups and other stakeholders. In the report, IME recommended that the state convert to an 'Average Acquisition Cost' (AAC) method, whereby actual pharmacy invoices for the amounts paid for drugs are collected and used to calculate the reimbursement rates. This method is very similar to the method used by Medicaid for reimbursement of generic drugs (called State Maximum Allowable Cost or SMAC).

Federal regulations require reimbursement to also include a reasonable dispensing fee. The report found that other surveys had shown the cost of dispensing to range from \$10 to \$11 per prescription.

This proposal would convert pharmacy reimbursement to an AAC method and pay a \$10 dispensing fee. This would result in a general fund savings of \$1.9 million.



## Benefits:

- This proposal would ensure an accurate payment for prescription drugs based on the actual cost of the drug product and cost of dispensing.
- This method is transparent.
- This method would ensure that Medicaid reimbursement covers the cost of the product and service for pharmacies.

## Negative impacts:

- This is a reduction in reimbursement to pharmacies.
- The estimated dispensing fee would be \$11.10 if it was set at a budget neutral rate.
- CMS would require completion of a cost of dispensing survey to approve a change in reimbursement methodology. It is not clear whether that would show a \$10 dispensing fee. It may be higher or lower.

## Additional costs:

- A cost of dispensing study would cost approximately \$125,000 total funds.
- The change in reimbursement to AAC would require a contract amendment with Provider Audit and Rate Setting for approximately \$131,500 total funds annually, depending on the final policy decisions



## SFY 2013 Budget Cost Saving Strategy

**Strategy Name:** Medicaid Reimbursement of Medicare Part A (institutional claims)

**Total Savings:** \$13,500,000

**General Fund:** \$5,429,700 (40.22%)

**Federal Fund:** \$8,070,300 (59.78%)

### **Summary:**

This change in reimbursement would bring the payment policy for Medicare Part A (institutional) claims in line with the current Medicaid policy for all other claims. Today, in cases where Medicaid members have other, third party insurance, Medicaid pays for coinsurance, deductibles, or non-covered items, the Medicaid payment is limited to what Medicaid otherwise would have paid for the claim. In the case of Medicaid members enrolled in Medicare, Medicaid currently pays any amount billed. This change would make Medicare claims consistent with policy for all other third party payors and avoid overpayments, or payments for costs that are not covered by the Medicaid program. If the Medicare payment amount exceeds or equals the Medicaid-allowed amount for a claim, the Medicaid reimbursement for the crossover claim would be zero.

***NOTE: This is a high level estimate developed using hospital cost to charge ratio data. We will need to develop programming that will allow us to model Medicaid payments in the system to develop a more refined estimate. The IME is performing more detailed, claim level analysis of the savings; however, there are elements that IME cannot model, such as paper claims where all necessary information is not currently submitted to IME.***

### **Detailed Description:**

#### Definitions:

- Dual Eligibles: Individuals who are entitled to Medicare Part A and/or Part B and are eligible for some form of Medicaid benefit are often referred to as “**dually eligible**.” There are several categories of dual eligibles, the largest category is a Qualified Medicare Beneficiary. A **Qualified Medicare Beneficiary (QMB)** is a low income person who is eligible for Medicare, and who also qualifies for Medicaid payment of their Medicare premium, deductible, coinsurance, and copayment amounts. Any costs for Medicare Part D is not included.
- Part A: The Medicare program that covers institutional or hospital costs.
- Crossover Claim: A claim filed by a health care provider that was originally filed with Medicare, and subsequently submitted to Medicaid for payment of the remaining balance on the claim (for coinsurance, deductible, copayments, or services Medicare does not cover).



This proposal would incorporate new edits in the Medicaid claims processing system that would process crossover claims so that the payment amount for crossover claims will be limited to the Medicaid payment limits (the amount Medicaid otherwise would have paid for the claim).

Currently for dual eligible's, Iowa Medicaid pays the entire amount of the deductible, coinsurance, and/or copayment remaining after the Medicare claim has been processed. For all other third party liability payments, Iowa Medicaid limits payments to the Medicaid-allowed amount minus all third party liability payments. This change would make payment policy for crossover claims the same as payment for any other third party coverage for Medicaid members.

Medicaid currently enrolls 73,429 dual eligibles for whom Medicaid pays coinsurance, deductibles, and copayments through crossover claims. In FY 2010, Medicaid paid \$60 million (state and federal funds combined) for crossover claims, for Medicare Part A. A high level analysis using the payment to charge ratio estimates that correcting the reimbursement process will save approximately 22.5% of the payment amounts made for Medicare Part A.

#### Benefits:

- Payment accuracy -- Current payment rules do not prevent payment for crossover claims to Medicaid coverage limits. There is no means to ensure payments are accurate.
- Efficiency – Current payment processes provide inconsistent information and there is limited means to prevent overpayments. This would allow providers to bill Medicaid for crossover claims using the same claims form and processes as used for all other claims.
- Consistency. Payment policy is different for Medicare beneficiaries (dual eligibles) than for other members with other third party coverage.
- Many other states have implemented these limits. This change is permitted under federal law. Section 1902(n) of the Social Security Act states “a State is not required to provide any payment for any expenses incurred relating to payment for deductibles, coinsurance, or copayments for Medicare cost-sharing to the extent that payment under Title XVIII for the service would exceed the payment amount that otherwise would be made under the State plan under this Title for such service if provided to an eligible recipient other than a Medicare beneficiary.”

#### Negative impacts:

- Providers (hospitals in the case of Part A crossovers) would receive a reduction of approximately \$13.5 million in their Medicaid payments.
- The summary payment totals for Part A and Part B for the 50 providers with the highest crossover claims payments is attached.