# IOWA MEDICAID ENTERPRISE (IME)

# PERFORMANCE REPORT

**JANUARY 26, 2006**

**DRAFT**

# IME PERFORMANCE REPORT
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# CLAIMS PROCESSING

## Medicaid Management Information System (MMIS) Narrative

The MMIS used in the IME is a federally certified claims processing and reporting system that has been in continuous operation since July 1997.

- Twice per month the MMIS produces payments to Iowa Medicaid Providers.
- The MMIS adjudicates all claims for payment except Pharmacy claims. Pharmacy claims are adjudicated by the IME POS and fed to the MMIS for payment.
- The MMIS produces the capitation payments for Medicaid Members enrolled in the Iowa Plan and the Medicaid HMO.
- The MMIS produces all state and federal MARS (Management and Administrative Reporting Subsystem) reports monthly, quarterly, and annually.
- The MMIS has on line real time update capability.
- The MMIS produces the quarterly expenditure reports to CMS.

The MMIS has been enhanced to process claims related to:

- IowaCare Implementation — July 1, 2005
- Children's Mental Health Waiver — October 1, 2005
- Family Planning Waiver — February 1, 2006

# Iowa Medicaid Enterprise – Core Claims Unit

The Medicaid Management Information System (MMIS) claims processing system accepts claims from providers electronically or paper. These claims are entered into the MMIS for processing. Each adjudication cycle, the system will process these claims based on logic or edits built into the system. This will cause claims to pay, deny or suspend. The MMIS adjudicates claims each night, Monday through Friday.

## Claims Adjudication

- Claims suspend for manual review from each adjudication cycle
- Both EMC and Paper claims may be received
- Staff use processing guidelines to either pay or deny the claim
- Types of edits include:
    - Eligibility
    - Pricing
    - Correct Coding
    - TPL
    - Suspected Duplicate
    - Frequency or Utilization of Services

## Adjustment Examination

The claims unit is also responsible for processing adjustment/credit requests. These requests could be initiated by the provider or internally within the IME. Once a request is made to the Core claims unit, it is reviewed and the proper transaction is conducted in the MMIS system.

- Requests for an adjustment are received electronically within the IME Work Flow Management System.
- Staff will screen the request for complete information.
- If the request is complete, the appropriate transaction is conducted in the MMIS system.

**IME Core**

**Monthly Claims Summary**

| Month End Reporting - All Claims | Dec 2005 | Nov 2005 | Oct 2005 | Sept 2005 | Aug 2005 | July 2005 |
|---|---|---|---|---|---|---|
| Beginning of the Month Carryover* | 101,425 | 215,409 | 92,975 | 293,271 | 47,957 | 0 |
| + Paper Claims Received* | 230,133 | 233,127 | 268,750 | 257,817 | 237,779 | 308,553 |
| + EMC Claims Received* | 394,424 | 432,976 | 301,362 | 242,246 | 255,480 | 40,396 |
| + Computer Generated Claims** | 416,177 | 415,719 | 417,190 | 416,806 | 413,067 | 414,700 |
| + POS Claims | 702,724 | 746,778 | 639,383 | 731,637 | 578,152 | 572,237 |
| = Claims Processed | 1,844,883 | 2,044,009 | 1,719,660 | 1,941,777 | 1,532,435 | 1,353,368 |
| # Claims Paid | 1,683,201 | 1,794,640 | 1,528,778 | 1,683,521 | 1,366,932 | 1,180,137 |
| # Claims Denied | 126,009 | 218,127 | 151,811 | 233,425 | 131,990 | 161,010 |
| # Claims Suspended (remaining) | 35,673 | 31,242 | 39,071 | 24,821 | 33,513 | 12,221 |
| Other Remaining | 69,040 | 70,183 | 176,338 | 68,154 | 259,758 | 35,736 |
| Avg. Days From Receipt to Payment | 11.2 | 14.8 | 13 | 11.9 | 10.4 | 10.1 |

* Excludes POS Claims

** Computer Generated Claims include Iowa Plan Capitation, HMO Capitation, MediPASS Patient Management Fees, and Nursing Facility Paper Turnaroud Documents

## IME Core

## Monthly Claims Summary

| Month End Reporting - EMC Claims | Dec 2005 | Nov 2005 | | 2. Sept 2005 | 3. Aug 2005 | 4. July 2005 |
|---|---|---|---|---|---|---|
| Total EMC Claims Processed | 394,424 | 432,976 | 301,362 | 242,246 | 255,480 | 40,396 |
| # of Claims Paid | 327,394 | 349,419 | 254,588 | 163,230 | 211,520 | 33,448 |
| # of Claims Denied | 52,857 | 71,603 | 38,164 | 69,349 | 35,506 | 5,615 |
| # of Claims in Suspense | 14,173 | 11,954 | 8,610 | 9,667 | 8,454 | 1,632 |
| Avg. Days From Receipt to Payment | 8.9 | 10.6 | 9.2 | 6.9 | 6.1 | 5.9 |

| Month End Reporting - POS Claims | Dec 2005 | Nov 2005 | Oct 2005 | Sept 2005 | Aug 2005 | July 2005 |
|---|---|---|---|---|---|---|
| Total POS Claims Processed | 702,724 | 746,778 | 639,383 | 731,637 | 578,152 | 572,237 |
| # of Claims Paid | 694,153 | 735,576 | 625,956 | 719,931 | 567,745 | 515,013 |
| # of Claims Denied | 8,571 | 11,202 | 13,427 | 11,706 | 10,407 | 57,224 |
| Avg. Days From Receipt to Payment | 11.3 | 14.7 | 10.2 | 8.5 | 6.6 | 8.5 |

## IME Electronic Data Interchange (EDI) Narrative

EDI enables providers to submit claims, eligibility verification, and prior authorization requests electronically. EDI also allows the IME to send payment remittances electronically to providers.

The IME accepts all HIPAA required claims transactions. Providers can submit electronic claims through their own software, a clearinghouse, or the IME's free PC Ace Pro 32 electronic claims software.

The IME receives HIPAA compliant claims (HIPAA 837) transactions from the following:

- 6,741 Providers Submit Claims Using HIPAA Complaint Electronic Transactions
- 1,234 Providers Submit Using the IME's Free Software PC-ACE Pro 32

The IME produces HIPAA compliant electronic claims payment (HIPAA 835) remittances to the following providers

- 2.205 Providers Receive HIPAA Compliant Electronic Remittance Advices

As new standard HIPAA transactions are mandated by CMS, e.g., electronic claims attachment, the IME will implement those HIPAA transactions as well.

## IME Web Portal Narrative

The IME's Web Portal allows providers with an Internet connection to access Medicaid information 24 hours per day, seven days per week. Through a simple enrollment process with the IME's Electronic Data Interchange office, providers can access the following information via the Internet:

- Medicaid Member Eligibility
- Claim Status
- Provider Payment Summary

The IME has received feedback from the provider community about the functionality of the Web Portal. As a result of provider feedback, the following Enhancements to the Web Portal currently in development:

- Medicaid Member Optometric and Dental Service Limitation Information
- Detailed Claim Denial Information

These enhancements will truly make the IME Web Portal a full service product for the IME Provider Community.

# IOWA MEDICAID ENTERPRISE WEB PORTAL TRANSACTIONS

| | PROVIDER PAYMENT AMOUNT | ELIGIBILITY VERIFICATION | CLAIM STATUS INQUIRY |
|---|---|---|---|
| DECEMBER 2005 | 321 | 125,892 | 9,879 |
| NOVEMBER 2005 | 329 | 93,524 | 11,338 |
| OCTOBER 2005 | 207 | 114,949 | 7,781 |
| SEPTEMBER 2005 | 83 | 79,666 | 2,685 |
| AUGUST 2005 | 32 | 137,686 | 1,432 |
| JULY 2005 | 2 | 145,444 | 97 |

- Provider Payment Summary – Allows the Provider to access their most current Medicaid Remittance Check Amount
- Eligibility Verification – Allows the Provider to verify Member Medicaid eligibility including any third party resources
- Claim Status Inquiry – Allows the Provider to determine the status (Paid, Denied, or Suspended) of claims submitted to the IME

C.

## IOWA MEDICAID ENTERPRISE ELVS TRANSACTIONS

| | PROVIDER PAYMENT AMOUNT | ELIGIBILITY VERIFICATION |
|---|---|---|
| DECEMBER 2005 | 3,431 | 179,621 |
| NOVEMBER 2005 | 4,567 | 191,234 |
| OCTOBER 2005 | 4,624 | 199,209 |
| SEPTEMBER 2005 | 4,326 | 194,721 |
| AUGUST 2005 | 4,621 | 209,601 |
| JULY 2005 | 3,534 | 170,274 |

- Provider Payment Summary – Allows the Provider to access their most current Medicaid Remittance Check Amount
- Eligibility Verification – Allows the Provider to verify Member Medicaid eligibility including any third party resources

# PHARMACY

## Pharmacy Programs and Cost Containment

**SFY 2005 PDL/PA Savings (state and federal) Estimate:**

- The projected SFY 2005 PDL savings was $17.8 million of which state share was $6.5 million. These savings represent only six months of program operation.

**SFY 2006 PDL Savings (state and federal) Estimate:**

- The projected SFY 2006 PDL savings, taking into account the loss of the dual eligibles for the last six month of the SFY and supplemental rebates from participation in the SSDC pool, is $22.6 million.

**Preferred Drug List (PDL) :**

- The States of Iowa, Maine, and Vermont have joined together forming the ***Sovereign States Drug Consortium (SSDC)***. GHS handles the negotiations for the multi-state supplemental rebate pool. This effort differs substantially from the existing multi-state pools because it is state, not vendor administered. This is a truly State-directed and entirely state controlled effort. Each state has an equal vote and can act independently as deemed necessary. The participating states pool their purchasing power for their Medicaid Programs using the combined leverage of Medicaid-members to obtain better drug pricing. The Medicare Part D drug benefit, which began operations in January 2006, resulted in the loss of Iowa's dually eligible members, reducing the state's bargaining power by nearly $200 million. By joining the pool Iowa can expect to recoup some of the lost dual supplemental rebates in the amount of $1.2-1.3m (state and federal combined) in SFY 06 and $2.4-2.6m in SFY 07.

**State Maximum Allowable Cost (SMAC):**

-SMAC is a methodology for setting Medicaid reimbursement rates for generic drugs. Brand name drugs are reimbursed under a different methodology.

-SMAC rates are based upon the average cost of drugs purchased by Iowa pharmacies. Both brand and generic drug costs are included in the average cost of a drug.

-Drug cost information is collected from a sample of Iowa pharmacies, representing different sizes and locations of operation. Therefore, these are the costs that the pharmacies pay their wholesalers or distributors. This is done annually and as needed. The most recent invoice collection was done in November 2005 and rates are being finalized from this collection.

-A mark-up of 40% is added to the average drug cost to allow for variations between provider purchasing power and allow for profit for cost efficient pharmacies.

-Drugs with a State MAC rate are reimbursed at the lower of the following reimbursement methodologies: Estimated Acquisition Cost (EAC - which is Average Wholesale Price minus 10%), Federal Upper Limit (FUL), State MAC rate (SMAC), or Usual & Customary charges (U&C-the amount submitted by the pharmacy).

-***State MAC savings for SFY 2005:*** there was an estimated savings of $11,887,163 (State and Federal $).

- The **Federal Budget Resolution Bill** that is awaiting Congressional approval has been reviewed by the Department and the savings attributed to these changes are being evaluated with the initial evaluation showing minimal savings. The two main changes are:

  1). Federal Upper Limit (FUL) Calculation which would change from using 150 percent of the least costly published price to using 250 per cent of the Average Manufacturer Price (AMP) and requiring only one generic be available as opposed to two or more. Because the SMAC tends to be lowest reimbursed rate and Medicaid pays the lowest of EAC, FUL, SMAC, and U&C, this will most likely not impact savings for Iowa. We also cannot guarantee what the real AMPs will be prospectively.

  2). Physician Administered Drugs and the Collection of Rebates could produce some minimal savings; however there would also be associated programming changes involved, including the collection of NDCs for drugs reimbursed through medical claims. The collection of rebates on Physician Administered Drugs will become a requirement for Medicaid programs to get federal reimbursement for these drugs.

The projected estimate of state savings for SFY 07 for the proposed initiatives would be approximately $1.2 million.

## Drug Prior Authorization Activity

Background: Prior authorization (PA) is a means of implementing prescribing or practice guidelines. A drug prior authorization (PA) program requires the prescriber and/or the pharmacist to obtain approval in advance from the Medicaid agency or contractor before Medicaid payment will be made for certain drugs. The program is designed to assure that the most economical drug therapy appropriate for given medical conditions is used and to assure that drug therapy is only continued for as long as it is medically necessary.

### Prior Authorizations (PA) Statistics for Q4 2005 from 10/1/2005 through 12/31/2005

- Prior Authorization requests received : 17,904
- Prior Authorizations approved: 10,394
- Prior Authorizations denied: 4,601
- Prior Authorizations incomplete: 2,132
  NOTE: The incomplete and not required requests have decreased by 30% compared to the prior quarter.
- Prior Authorizations not required: 777
- Average Determination Time: 1.68 hours
  NOTE: The average determination time has decreased from 4-8 hours at implementations on 1-15-05 to 1.68 hours currently.
- % of total claims requiring a PA: 0.95%
- % of total claims requiring a PA where the PA was denied: 0.25%
- Number of Appeals from 10/1/2005 through 12/31/2005: 8
  NOTE: Out of the 8 appeals, 2 were approved through the PA process with more information provided, 1 was a billing error, 3 were for off label indications not approved by the FDA, and 2 were non-preferred medications on the PDL.

**Pharmacy PA/PDL Call-Center: Statistics for Q4 2005 from 10/1/2005 through 12/31/2005**

- Calls answered: 4,308
- Average Queue Time: 8 seconds
- Average Length of call: 2 minutes and 49 seconds

**Total Savings SFY 05**

- PDL: $17.8 million
- SMAC: $11.9 million
- Operational Costs = $1.0 million (PDL) + $0.30 million (SMAC)
- Net to State: $28.4 million

**Point of Sale (POS) Call-Center: Statistics for Q4 from 10/1/2005 through 12/31/2005**

- Calls answered: 11,764
- Average Queue Time: 8 seconds
- Average Length of call: 3 minutes and 31 seconds
- % of claims generating a call: 0.86%

Point of Sale (POS) Claims Processing: Pre-Rebate Statistics for Q4 from 10/1/2005 through 12/31/2005

- Total Claims Paid: 1,867,266
- Total Cost for Claims Paid: $114,510,732
- Average Cost Per Claim: $61.33

| | Amount Paid | Number of Claims Paid | |
|---|---|---|---|
| October, 2005 | $35,006,410 | 574,475 | |
| November, 2005 | $39,601,222 | 651,494 | |
| December, 2005 | $39,903,100 | 641,297 | |
| Total for Quarter | $114,510,732 | 1,867,266 | Note: 57.9% of claims were for generics |
| January 1st-23rd, 2006 | $26,123,077 | 423,736 | |

## Iowa Pharmaceutical and Therapeutics Committee

- House File 619 (Iowa Code 249A.20a) authorized the establishment of the Iowa Pharmaceutical and Therapeutics (P&T) Committee.
  -The Governor appointed committee is comprised of 9 members: 1 dentist, 3 pharmacists, and 5 physicians.
  -The main focus is the PDL (Preferred Drug List) and Recommended Drug List (RDL) design and maximizing the initial utilization of the most cost-effective, clinical choices available.
  -By first considering the therapeutics and then the cost, the P&T Committee ultimately decides which drugs to recommend to the State of Iowa as preferred and recommended.

- The P&T Committee meets on a quarterly basis and as needed. The following topics are discussed at the meetings:
  -Discuss any new drugs or new generics on the Market.
  -Discuss any areas for potential savings on the PDL or RDL.
  -Discuss any changes to be made to the PDL or RDL based on any local or national issues.
  -Receive and discuss feedback from the public through a Public Comment session of each meeting as well as a dedicated website for comments.
  -Complete a yearly review of the entire PDL and RDL.

- The final quarterly meeting is the Annual PDL/RDL Review. This meeting occurred on December 8th and 9th, 2005. The process is to:
  -Review key supplemental rebate negotiations that could potentially change the preferred/recommended or non-preferred/non-recommended status of a drug.
  -Vote on the entire PDL and RDL.

- The P&T Committee developed a report in response to a request from the 2005 Iowa Legislative session asking them to "develop options for increasing the savings relative to psychotropic drugs, while maintaining patient care quality" for individuals receiving medications through Iowa Medicaid. Attached is the Executive Summary:

  *The report summarizes key background information on patterns of utilization and cost of psychotropic medications within Iowa's Medicaid system (section II), and describes the process through which recommendations were developed (section III). Much of the work was done by a mental health subcommittee that was formed specifically to carry out this task. That subcommittee came up with a range of options for the full P&T committee to review. Each of those options is presented in this report (section IV). Finally, the recommendations that the P&T committee approved and chose to forward to the legislature are described (section V), and delineated below:*

  1) *Eliminate the current exemption to the Preferred Drug List (PDL) process for the class of drugs known as "second generation antipsychotics" (SGA's).*
  2) *Develop and implement prior authorization protocols for prolonged concomitant use of multiple mental health drugs within the same class.*
  3) *Develop and implement prior authorization protocols for use of specific second generation antipsychotic medications outside of evidence-based dose ranges.*
  4) *Implement a program to more aggressively target outliers, i.e., prescribers whose patterns of prescribing are consistently out of line with their peers, and with the existing evidence base.*

## Drug Utilization Review (DUR) Committee

- **Commission meetings are held eight times a year; 4 meetings have been held in SFY06, the 5th meeting is scheduled for 2/1/06. The Commission is comprised of four physicians and four pharmacists serving staggered 4-year terms. The IME Medical Director has assumed a coordinating role with the DUR Commission.**
- **Professional staff for the Commission includes three registered pharmacists and two administrative staff.**

**SFY05 Results:**

- Total annualized cost savings estimates were increased by approximately 40% when comparing SFY05 savings of $1,966,769.27 to SFY04 savings of $1,406,445.02: Return on investment increased with $4.02 savings per dollar spent on the program. Savings can also be stated as $16.08 per state dollar spent due to the federal match at a ratio of 3:1.

**SFY06 Activities To Date:**

- Patient-focused reviews are completed via the review of at-risk patient profiles (1500 profiles reviewed to date).
- Problem-focused reviews target specific issues for an in-depth educational effort. About 750 profiles have been reviewed to date.
- The Commission conducted focused intervention to physicians prescribed combination antipsychotic polypharmacy.
- The Commission recommended to DHS that drugs used to treat sexual dysfunction be considered not medically necessary.
- The Commission also identifies situations to recover funds from inappropriate billing with $14,000 in the last 6 months.
- The Commission recommends new or updated guidelines for use in the drug prior authorization program.
    - Recommendations for seven categories have been forwarded to the Department thus far in SFY06 and two recommendations based on changes to the PDL.
    - Two drug categories were recently reviewed with no recommended changes to the criteria.
    - There are four PA categories to be reviewed in February and March. This will complete the annual review process for clinical PA criteria, a charge to the Commission. Review of lipase inhibitor drugs was deferred pending a weight management disease management program.
- The Commission generates an educational newsletter, the *DUR Digest*, features therapeutic information along with updates regarding policy issues. Two newsletters have been produced in SFY06, published, and posted to the IME website.
- The Commission maintains a website as an additional communication tool including meeting agendas and minutes.
- Commission staff participates in quarterly advisory groups with the Magellan managed health program.

## Drug Expenditures

10-1-05 to 12-31-05 Prescription Drug Expenditures In Iowa By Drug Category

| State Match Rate | | 36.36% | 63.64% | Percent of Total |
|---|---|---|---|---|
| Category | State Expenditures | Federal Expenditures | Total Expenditures | Dollars |
| **Physical Health Drugs** | | | | |
| Cardiac | $2,198,252 | $3,847,545 | $6,045,797 | 5.5% |
| Gastrointestinal | $2,455,782 | $4,298,294 | $6,754,076 | 6.2% |
| Antibiotics | $2,777,990 | $4,862,247 | $7,640,237 | 7.0% |
| Respiratory | $3,028,504 | $5,300,715 | $8,329,219 | 7.3% |
| Analgesics | $3,136,925 | $5,490,482 | $8,627,407 | 7.9% |
| Anticholesterol | $1,729,751 | $3,027,541 | $4,757,292 | 3.7% |
| Antihemophilic | $438,440 | $767,390 | $1,205,829 | 1.1% |
| Antihistamines | $179,935 | $314,936 | $494,871 | 0.6% |
| Other | $9,163,219 | $16,038,154 | $25,201,373 | 25.6% |
| | | | | Subtotal: 64.9% |
| **Behavioral Health Drugs** | | | | |
| Antipsychotics | $7,441,592 | $13,024,832 | $20,466,424 | 17.1% |
| Antidepressants | $3,451,994 | $6,041,939 | $9,493,933 | 8.7% |
| Anticonvulsants | $3,100,727 | $5,427,125 | $8,527,852 | 7.5% |
| Psychostimulants | $1,848,537 | $3,235,449 | $5,083,986 | 0.6% |
| Sedative/Hypnotics | $412,823 | $722,554 | $1,135,377 | 0.6% |
| Anti-anxiety | $271,293 | $474,837 | $746,130 | 0.6% |
| | | | | Subtotal: 35.1% |
| TOTAL | $41,635,764 | $72,874,038 | $114,509,803 | 100.0% |
| Generic Drugs | | | $17,700,000 | 15.5% |

NOTE: Prescription drug expenditure figures do not include offsets for rebates drug product cost rebates, which the average savings for drug rebates is 25%.

## Methods to Assist Pharmacy Providers

- The www.iowamedicaidpdl.com website is available for providers to find information about the PDL and PA programs 24 hours a day/7 days a week. There is also a special e-mail address to send in questions with a return response in 24 hours during the normal workweek.

- A variety of special Preferred Drug Lists have been developed to assist the provider including:
  - The alpha list, which lists all of the drugs on the PDL in alphabetical order.
  - The OTC rebatable drug list that lists all the OTC manufacturers signed to the drug rebate program.
  - The Brands preferred over Generics List.

- The Department set up a fax list, collecting all the fax numbers of Iowa pharmacies, to send fax-blasts when information regarding the PDL or any other pharmacy issues needs to reach the pharmacies quickly.

- DHS is in the process of getting a contract with ePocrates regarding the Preferred Drug List. Health care providers can instantly access the Select Drug Program formulary on their handheld or desktop computers by using one of the ePocrates drug reference applications. These products combine up-to-date formulary information with robust clinical information found in the ePocrates drug reference guide. By accessing formulary information on ePocrates, providers benefit from safer, more cost-effective prescribing and less time spent on both pharmacy callbacks and pharmacy benefit paperwork.

## Medicare Part D Prescription Drug Program

- Effective January 1, 2006, Medicaid members who also qualify for Medicare, referred to as dual eligibles, began to have their prescription drugs paid through Medicare Part D. State Medicaid programs were allowed by CMS to cover the excluded Part D drugs for full benefit dual eligibles and Iowa elected to do so.

- **Number of Iowa Dual Eligibles and Success of Auto-Enrollment:** Using data from the December 05 MMA response file (we have not received the January 06 response file from CMS yet)
  -Full Duals - 54,826
  -Full Duals indicated as enrolled in a part-d plan - 52,883 - (96.5%)
  -406 of the full duals that were not indicated as being enrolled in a part-d plan, are instead indicated as enrolled in a Medicare Advantage.

- **Iowa Medicaid covered drugs for Part D eligibles:**
  1. Barbiturates
  2. Benzodiazepines
  3. Over-the-Counter Drugs (see the OTC Drug List posted at www.iowamedicaidpdl.com)
     - Analgesics- Acetaminophen, Aspirin, Ibuprofen
     - Antifungals- Clotrimazole, Miconazole, Tolnaftate
     - Antihistamines- Chlorpheniramine, Diphenhydramine, Loratadine, Meclizine
     - Cough/Cold- Guaifenesin w/dextromethorphan, Pseudoephedrine
     - Gastrointestinal- Loperamide, Omeprazole, Pediatric electrolyte solution, Senna, Sennosides-docusate sodium
     - Ophthalmics- Artificial tears, Sodium chloride hypertonic ophthalmic
     - Supplements- Calcium, Iron, Niacin, Magnesium Oxide, Sodium Bicarbonate
     - Topicals- Bacitracin ointment, Benzoyl peroxide, Lactic acid lotion, Neomycin-bacitracin-polymyxin ointment, Permethrin, Pyrethrins-piperonyl butoxide, Salicylic acid liquid
  4. Prescription Vitamin and Minerals, except prenatal vitamins and fluoride preparations
  5. Weight Loss Products (i.e. Xenical®-orlistat)

- **Medicare Part D Impact on Pharmacies and IME Pharmacy Help Desks**
  The IME Pharmacy Help Desk staff estimate that approximately 60% to 80% of the calls received pertain to Medicare Part D questions. Some of the most frequently asked pharmacy questions are:
  *-What drugs does Medicare Part D cover?*
  *-What Plan is the member in and what is the Plan ID number?*
  *-Will Medicaid cover what Medicare denies?*
  *-Issues regarding high co-payments being charged to the dual eligible members by the Prescription Drug Plans (PDPs).*
  -Complaints of long hold times when calling the PDP

- The implementation of Medicare Part D should cause a decline in the total call volume. However, the total call volume for the IME Pharmacy Help Desks has stayed about the same as before Medicare Part D. Providers are waiting less than one minute for the help desk staff to answer their calls during our busiest times.

- **Why doesn't Iowa have the serious Medicare Part D problems other states have?**

1. Many Pharmacies worked with their corporate offices to make sure the transition to Medicare Part D went smoothly
2. The pharmacists in Iowa have been more willing to assist customers with problems.
3. The eligibility file that Iowa sent to CMS was very complete and more accurately reflected the dual eligibles.
4. Other states have the complicating factor of wrapping around for State Pharmacy Assistance Programs (SPAP) that complicates the coverage process for the dual eligibles. Iowa does not have an SPAP.

- **Part D impact on Preferred Drug List (PDL) savings**

The impact of Part D on Preferred Drug List (PDL) savings for SFY 06 will be almost $3.0 million state in lost revenue due to the reduction in prior authorization and supplemental rebate savings for those dually eligible now covered under Part D.

The 2006 State per-capita phase-down (clawback) payment:

- January – September, 2006: $98.07
- October – December, 2006: $102.46 *

* This reflects FY 2007 Federal Medical Assistance Percentage (FMAP).

# MEDICAL SERVICES

Prior Authorization (Except Pharmacy)

Medical Prior Authorization requests must be made in writing and are received by mail or fax. All requests must be supported by appropriate documentation certifying medical necessity. When medical necessity is questioned, a physician or licensed specialty consultant is utilized to make the final determination. The medical necessity requirements are described in Provider Manuals and the Iowa Administrative Code for most prior authorizations. Updates are planned to include medical criteria for prior authorizations that are not currently included in Provider Manuals.

Requests for Targeted Case Management are received from case managers by email and are for persons with mental retardation, developmental disabilities or persons with chronic mental illness who are over age 64 or who have medically needy with spend down eligibility. Requests are also reviewed for children receiving services under the Children's Mental Health Waiver.

Qualifications of Reviewers:

**Medical Prior Authorization - Registered Nurses with specialty field experience**
**EPSDT - Registered Nurses with pediatric experience**
**Targeted Case Management - Bachelor Degrees in Social Work with experience in Case Management and with designated population**

| Prior Authorization Type 7/1/05-12/31/05 | Carry Over | # PA received | # in process* | total # adj | # adj timely | % timely | total # approved | total # denied | % denied |
|---|---|---|---|---|---|---|---|---|---|
| Audiology | 22 | 224 | 16 | 230 | 210 | 91% | 212 | 18 | 8% |
| Home Health (EPSDT) | 18 | 178 | 2 | 194 | 188 | 97% | 182 | 12 | 6% |
| Vision | 35 | 1,626 | 20 | 1,641 | 1,619 | 99% | 1,593 | 48 | 3% |
| Dental (Adult and EPSDT Ortho) | 108 | 2,359 | 81 | 2,386 | 2,231 | 94% | 2,069 | 317 | 13% |
| Durable Medical Equipment | 108 | 1,257 | 38 | 1,327 | 1,039 | 78% | 1,050 | 277 | 21% |
| Surgeries and Office Procedures | 7 | 333 | 5 | 335 | 332 | 99% | 209 | 126 | 38% |
| Bone Marrow Transplants | 1 | 12 | 0 | 13 | n/a | n/a | 13 | 0 | 0% |
| Gastric Bypass | 8 | 103 | 0 | 111 | n/a | n/a | 57 | 54 | 49% |
| Heart Transplant | 1 | 2 | 1 | 2 | n/a | n/a | 2 | 0 | 0% |
| Liver Transplant | 1 | 6 | 0 | 7 | n/a | n/a | 7 | 0 | 0% |
| Lung Transplant | 1 | 2 | 0 | 3 | n/a | n/a | 3 | 0 | 0% |
| Pancreas Transplant | 0 | 1 | 1 | 0 | n/a | n/a | 0 | 0 | 0% |
| Targeted Case Management | 0 | 5,337 | 9 | 5,328 | 5,328 | 100% | 5,311 | 17 | >1% |
| **TOTAL** | **310** | **11,440** | **173** | **11,577** | **10,947** | **96%** | **10,708** | **869** | **8%** |

*** Prior Authorizations in process are waiting for additional information from the provider**

## Psychiatric Medical Institutions for Children (PMIC) (Pre-Admission and Post Admission Review)

Psychiatric Medical Institutions for Children are facilities serving children and adolescents under the age of 21 with a diagnosis of mental illness or substance abuse. These facilities provide 24-hour continuous care for individuals whose needs have not been met at a lower level of care. Medical Services reviews PMIC level of care for children with a primary mental health diagnosis. There are twelve (12) in state and nine (9) out-of-state PMIC facilities providing mental health care.

As outlined in IAC 441-85 Preamble, Medicaid covers inpatient psychiatric services for persons under age 21 in psychiatric medical institutions for children. PMIC authorization requests are received from facility liaisons telephonically or by fax upon admission and at least every 90 days, if not sooner, depending on member status. Iowa Administrative Code 441-85.22-25(249A) provides the reference for PMIC utilization review. When medical necessity for level of care is questioned, a child psychiatrist consultant is utilized to make the final determination.

The Iowa Plan (Magellan) reviews for children who are hospitalized in an acute setting for psychiatric care and for children in PMIC whose primary diagnosis is substance abuse related.

Qualifications of Reviewers: **Registered Nurses with child psychiatric experience**

Enhancements: **Telephonic review decision provided immediately**
**Fax reviews available to facility liaisons with one business day response**

| PMIC Census 7/1/05 | Admission Reviews 7/1/05 - 12/31/05 | Denied | CSRs 7/1/05 - 12/31/05 | Denied | Reviews 7/1/2005 - 12/1/05 | Average Length of Stay | Average Daily Census | PMIC Census 12/31/05 | Children Served 7/1/05-12/31/05 |
|---|---|---|---|---|---|---|---|---|---|
| 654 | 387 | 0 | 1,267 | 4 | 1,654 | 250 days | 650 | 647 | 805 |

Long Term Care (LTC) Overview

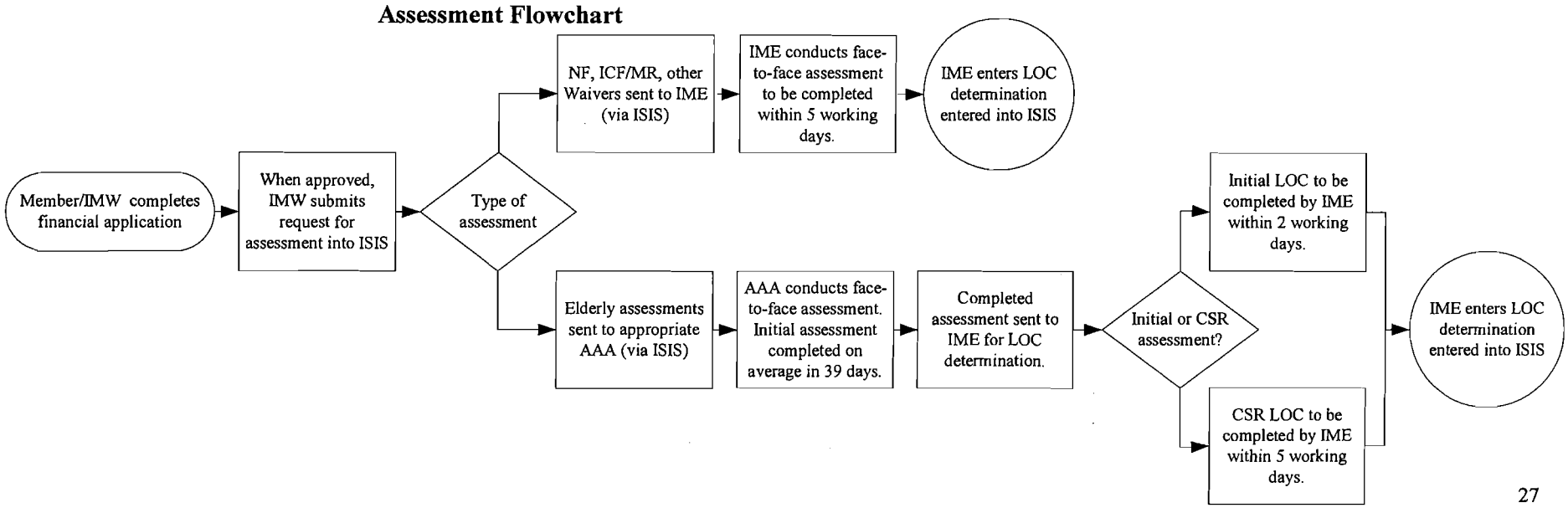
LTC Review Process

Assessments are conducted statewide on a face-to-face basis with Medicaid-eligible members or applicants, often with family members or other concerned parties present. The purpose of the assessment process is to establish medical necessity and to determine level of care for Medicaid. Education regarding the LTC alternatives is provided as part of the onsite assessment.

The IME Medical Services Unit completes LTC reviews for institutional programs (nursing facility and intermediate care facility for the mentally retarded) and community-based waiver programs (AIDS/HIV, brain injury, children's mental health, elderly, ill & handicapped, mental retardation and physical disability). In all cases except elderly waiver, the assessment tool is completed by an IME Medical Services Unit RN or LPN who meets in person with the individual and their family. The IME nurse reviewer completes the assessment tool, and then applies criteria to determine level of care for Medicaid. In the case of the elderly waiver, the assessment is completed by Area Agency on Aging (AAA) or their subcontractor and reviewed by an RN from IME. The IME nurse reviewer then applies the criteria and determines level of care for Medicaid.

An individual contacts a DHS income maintenance worker (IMW) to request funding for institutional or community-based services. The IMW assists the individual in completing a financial application and then notifies the medical services unit or the AAA in the case of elderly waiver, that an assessment is needed. Assessments conducted by IME Medical Services are to be completed: a) within five (5) working days for an initial review b) within 90 days for a reassessment for nursing facility (NF) or ICF/MR c) annually for the waiver programs or d) within 5 days of a reported significant change in condition for all members.

**Assessment Flowchart**



**Elderly Waiver**

IME's role in the Elderly Waiver program is to determine level of care for the Medicaid members applying for the Elderly Waiver services. This process is started by the Income Maintenance worker who notifies the Area Agency on Aging (AAA) to perform a face-to-face assessment. Once the assessment is completed the AAA's electronically submit the completed tools through the Seamless system developed by the Department of Elder Affairs. The IME nurse reviewer then reviews the assessment, applies the criteria, and determines level of care for Medicaid.

**Qualifications**: Registered Nurses, Licensed Practical Nurses, and Medicaid Medical Director and/or peer consultant with the exception of the review staff for Children's Mental Health Waiver, which are Licensed Practitioners of the Healing Arts and peer consultants.

**Program Tool and Criteria**

Assessments conducted by IME medical services are completed using DHS approved instruments and criteria. The tool and criteria that is used for admission to a program is also used for any reassessments or annual reviews. If there is a significant change in condition, the medical services unit would be notified by the facility or by the CM involved with the waiver program to complete an assessment.

| Program | Initial Review | 90-day post admission review | Annual Review | Criteria |
|---|---|---|---|---|
| Nursing Facility | Med Services Tool | Med Services Tool | n/a | ASE |
| ICF/MR | Med Services Tool | Med Services Tool | n/a | Long Term Care FA/PP |
| Aids Waiver | HCBS assessment or reassessment | n/a | HCBS assessment or reassessment | ASE |
| Brain Injury Wavier | Brain Injury Functional Assessment | n/a | Brain Injury Functional Assessment | ASE or Pediatric Skilled or Long Term FA/PP |
| Ill & Handicapped Waiver | HCBS assessment or reassessment | n/a | HCBS assessment or reassessment | ASE or Pediatric Skilled or Long Term Care FA/PP |
| Mental Retardation Waiver | Mental Retardation Functional Assessment Tool | n/a | Mental Retardation Functional Assessment Tool | Long Term Care FA/PP |
| Physical Disability Waiver | HCBS assessment or reassessment | n/a | HCBS assessment or reassessment | ASE |
| Children's Mental Health Waiver | Children's Mental Health Waiver Assessment | n/a | Children's Mental Health Waiver Assessment | Children's Mental Health Waiver Criteria |

**Long Term Care Review Types**

| | Face-to-Face Assessment | Initial LOC Determination | 90-day post admission | Annual Review | Significant Change | Review Qualifications |
|---|---|---|---|---|---|---|
| Nursing Facility (NF) | X | X | X | | X | RN, LPN |
| PASRR for Medicaid | X | X | | | | RN |
| PASRR Non Medicaid | | X | | | | RN |
| ICF/MR | X | X | X | | X | RN, LPN |
| Ill & Handicapped Waiver | X | X | | X | X | RN, LPN |
| Brain Injury Waiver | X | X | | X | X | RN, LPN |
| AIDs Waiver | X | X | | X | X | RN, LPN |
| Mental Retardation Waiver | X | X | | X | X | RN, LPN |
| Physical Disability Waiver | X | X | | X | X | RN, LPN |
| Elderly | | X | | X | | RN |

| | | | | | | |
|---|---|---|---|---|---|---|
| Waiver* | | | | | | |
| CMH Waiver** | × | × | | × | | LPHA |

* AAAs do initial and annual assessments & send to IME to complete level of care
**First 300 Assessments to be done telephonically to expedite program start-up

Long Term Care (LTC) Overview

**Analysis of Attendance and Completion Time per Assessment**

| Program | Average time to Complete assessment and LOC determination | Average # attendees at assessment | Average time to complete LOC determination |
|---|---|---|---|
| Nursing Facility (NF) | 39 minutes | 2 | n/a |
| ICF/MR | 65 minutes | 3 | n/a |
| Ill & Handicapped Waiver | 65 minutes | 3 | n/a |
| Brain Injury Waiver | 59 minutes | 3 | n/a |
| AIDs Waiver | 63 minutes | 2 | n/a |
| Mental Retardation Waiver | 54 minutes | 3 | n/a |
| Physical Disability Waiver | 63 minutes | 3 | n/a |
| Elderly Waiver* | n/a | n/a | 20 minutes |

Long Term Care (LTC) Overview

**Current Review Status (as of 1/21/06)**

| LTC | Reviews due next 5 days | | Reviews Past Due | | |
|---|---|---|---|---|---|
| | | | Initial | 90-day | Total |
| **As of 1/21/06** | 785 | 6 - 30 days | 90 | 357 | 772 |
| | | > 30 days | 43 | 282 | |

| Initial assessments > 6 days late (as of 1/21/06) | Residing in NF (changing to Medicaid coverage) | In hospital (awaiting discharge prior to waiver assessment) | At home (awaiting initial assessment for waiver, other than elderly waiver) |
|---|---|---|---|
| 133 | 26 | 3 | 104 |

**Long Term Care Reviews**

| (completed 7/1/05 - 12/31/05) | NF | ICF/MR | MR Waiver | I & H Waiver | PD Waiver | BI Waiver | AIDs Waiver | Elderly Waiver | CMH Waiver |
|---|---|---|---|---|---|---|---|---|---|
| Initial Face-to-Face Assessments | 2,928 | 78 | 765 | 464 | 183 | 205 | 4 | n/a | 240 |
| **90-day Face-to-Face Assessments** | 819 | 24 | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| **Annual Face-to-Face Assessments** | n/a | n/a | 2,431 | 633 | 157 | 157 | 16 | n/a | 0 |
| **Initial Level of Care Determinations** | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 1,804 | n/a |
| **Annual Level of Care Determinations** | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 2,726 | n/a |
| **Initial Telephonic Reviews** | n/a | n/a | n/a | n/a | n/a | n/a | n/a | n/a | 302* |

* Implemented October 1, 2005

Long Term Care (LTC) Overview

**Performance Standards**

| Description | | 1st Quarter | 2nd Quarter |
|---|---|---|---|
| Initial face-to-face admission review shall be completed for ninety five percent (95%) of the members within five (5) working days. | Within 5 days | 66% | 68% |
| | Within 7 days | 74% | 75% |
| | Within 10 days | 80% | 81% |

| Description | 1st Quarter | 2nd Quarter |
|---|---|---|
| CMH Waiver telephonic admission review shall be completed for ninety five percent (95%) of the members within five (5) working days. | n/a* | 100% |

* Implemented October 1, 2005

| Description (IFMC shall:) | | 1st Quarter | 2nd Quarter |
|---|---|---|---|
| Complete 90% of admission reviews for the Elderly Waiver within 2 working days of receipt of information. | Completed | 834 | 970 |
| | Timely | 623 | 346 |
| | Overall % | 75% | 36%* |
| Complete 95% of CSRs for the Elderly Waiver within 5 working days of receipt of information. | Completed | 1,314 | 1,412 |
| | Timely | 1,016 | 753 |
| | Overall % | 77% | 60%* |

* This number reflects the start of the Seamless project. There were duplication of assessments between Seamless, OnBase, and US mail.
Seamless went live October 15, 2005.

**Long Term Care Denials**

| | NF | ICF/MR | MR Waiver | I & H Waiver | PD Waiver | BI Waiver | AIDs Waiver | Elderly Waiver | CMH Waiver |
|---|---|---|---|---|---|---|---|---|---|
| Initial Review Denials | 10 | 0 | 5 | 54 | 23 | 11 | 3 | 49 | 62 |
| **90-day Review Denials** | 1 | 0 | n/a | n/a | n/a | n/a | n/a | n/a | n/a |
| Annual Review Denials | n/a | n/a | 0 | 19 | 5 | 6 | 2 | 40 | n/a |

Children's Mental Health Waiver

IFMC determines level of care review for the Children's Mental Health Waiver Program (CMH). This new Home and Community Based Service (HCBS) waiver program began October 1, 2005. The program provides supports to children with serious emotional disturbance. The following services are available: environmental modifications, adaptive devices and therapeutic resources; family and community support services; in home family therapy and respite. The child must choose HCBS services as an alternative to institutional services. Three hundred children will be served within this program.

Review coordinators will conduct face-to-face assessments with the child and family members that determine medical necessity and appropriateness of services. Referrals are received from DHS social workers and families. The first 300 referrals for assessment will be completed telephonically to facilitate program implementation. Review coordinators authorize a preliminary care plan and provide education regarding care alternatives. Assessments are completed within five (5) working days of receipt of the referral. Notice of decision is given to the member at the time of the review.

The criteria for assessments were developed in collaboration with DHS and reviewed by two peer consultants.

Review coordinators are Licensed Practitioners of the Healing Arts (LPHA) with experience in children's mental health services.

**MDS and OASIS Validation**

An onsite validation review utilizing all pertinent information (including the MDS/OASIS, the medical record, interviews, and observation of the member) is conducted annually on 25 percent of all Medicaid members in NFs, and 10-11 members receiving elderly waiver services from each of the 13 AAAs. An exit conference is conducted with NF staff or with AAA staff. During the exit conference, identified inconsistencies are identified as well as suggested areas for staff education and training.

| | MDS Validation | OASIS Validation* |
|---|---|---|
| **1st Quarter** | 80 | 0 |
| **2nd Quarter** | 65 | 0 |

* 13 AAAs to be completed - scheduled in the 3rd and 4th quarters.

Long Term Care (LTC) Overview (PASRR)

**PASRR** for Medicaid-eligibles is completed at the time of the initial face-to-face assessment to determine if a member has a diagnosis of mental illness (MI), mental retardation (MR), or related conditions (RC). The outcome of the PASRR is provided to the admitting NF in a written document. Members with these conditions may require special services, which the nursing facility (NF) is required to provide. Members identified through the initial screening, as having MI, MR, or RC must have a further evaluation arranged by the NF prior to admission.

PASRR for Non Medicaid eligibles is completed telephonically to determine if a member has a diagnosis of mental illness (MI), mental retardation (MR), or related conditions (RC). The review process is initiated by the nursing facility (NF) at the time an individual applies for admission. Information received is evaluated and the outcome is provided in writing.

| PASRR | Reviews Completed |
|---|---|
| July 2005 | n/a |
| August 2005 | 1,580 |
| September 2005 | 1,681 |
| October 2005 | 1,613 |
| November 2005 | 1,624 |
| December 2005 | 1,686 |
| **TOTAL** | **8,184** |

**Ongoing Monitoring of Services**

There are several processes in place to review the ongoing need for long term care services. For nursing facilities, the MDS validation is completed to:

- Confirm medical necessity
- Determine appropriateness of services provided, and to
- Identify quality improvement projects.

For the HCBS waiver programs, a DHS service worker, Medicaid case manager or AAA case manager is responsible for:

- Participating in the development and approval of the service plan (plan of care) in coordination with the interdisciplinary team.
- Monitoring service utilization to determine that services were provided in accordance with the service plan and appropriately billed.
- Making a face-to-face visit to the member at least annually.
- Confirming ongoing service eligibility and reviewing/updating the service plan

The Bureau of Long Term Care has a quality assurance/quality improvement (QA/QI) system for the HCBS Waiver programs, conducted by Iowa State University. During scheduled QA/QI reviews, the review would include:

- Health and safety issue of members receiving HCBS service
- Abuse/neglect/exploitation of members
- Plan of Care discrepancies
- Availability of services to meet needs
- Complaints of service delivery

In addition for the elderly waiver, onsite reviews are conducted by IME Medical Services to validate the information submitted on the assessments that are used to determine level of care for Medicaid. During these OASIS validation reviews, inconsistencies in consumer care needs are identified as well as identification of areas to suggest for staff education and training.

For both institutional and community based programs, the level of care review is completed by IME Medical Services to ensure continued level of care need and medical necessity of services.

**Observations and Improvements to the Process**

1. Completion 100 percent of the time within five (5) working days-
   - Hire additional staff
   - Evaluate case loads frequently
   - Deploy more effectively to areas where this is not being met

2. Evaluate the quality of the assessment tools:
   - Use the most up to date tool
   - Approval rate upon review of elderly waiver is lower than other waiver programs
   - Another tool may be appropriate for the elderly waiver program

3. Evaluate data on the status of individuals in institutions to determine how and to what extent we could build support systems to implement money follows the person (MFP).

4. Evaluate process for validation of data and make system changes as warranted.

5. Evaluate the level of care determination process assessing to be sure the Seamless assessment is completed within established performance standards.

## Program Operations (Disease Management)

**Disease Management** is an organized, proactive approach to healthcare delivery that engages the patient in self-management of their disease. The components of disease management are 1) identifying the population with the disease most likely to benefit, 2) utilizing practice guidelines as standards for care, and 3) providing support and education to the individual to manage their disease effectively.

Status

The Disease Management Program focuses on Asthma for adults and pediatrics. Review is done telephonically by a registered nurse and under the direction of the Medical Director. Current status includes:

- 270 members enrolled
- 22 members have disenrolled due to non-compliance, ineligibility, have moved and are unable to contact, voluntarily left the program
- 61 counties have at least one member enrolled

Evaluation

The initial call to enroll the member includes a health status assessment. This assessment must be completed within 30 days of enrollment. One hundred (100) percent of members have an assessment within this timeframe. This process includes collecting data on their asthma as it relates to:

- hospital admissions
- physician visits
- ER visits
- symptom changes
- flu vaccinations
- medications

Education

Once the member has enrolled, educational material is provided to the member and his/her PCP. To date:

- 544 introductory letters were disseminated. One to each member and his/her PCP
- 272 asthma overview brochures were included with each letter to the member
- 100 PCPs received five (5) laminated asthma guidelines to post in their offices

Follow-up

After enrollment, a monthly telephonic follow-up review is conducted. Findings during these reviews show:

- visits to physician to change medication for better control
- receiving flu vaccination
- placed on nebulizer at home to avoid ER visits
- taught how to clean home nebulizer equipment resulting in improved effectiveness of the medication
- understanding the importance of taking their medication, side effects, and not missing any doses

## Program Operations

**Enhanced Primary Care Case Management** (EPCCM) is a new and unique way to systematically approach healthcare for Medicaid members with complex medical needs. These members often experience either high service utilization or high costs, and are a challenge to their healthcare providers.

Initially, Medical Services received referrals from hospitals through their faxed admissions. Currently faxes are no longer used as hospital discharge planners and case managers call Medical Services Care Coordinator directly with referrals. To date:

- 99 referrals have been received
- 39 members were not enrolled due lack of need for service, unable to contact, service(s) currently in the home are sufficient
- 46 members enrolled in the program
- 67 days is the average length of time a member is enrolled

After Medical Services receives a referral, the member is contacted. This contact must be made within five (5) working days of the referral. To date:

- 98 percent of first contacts are made within five working days
- 141 introductory and follow-up letters have been sent to members, PCPs, and hospitals

Members are referred to EPCCM for a variety reasons and diagnoses. Those are:

- terminal cancer
- new moms needing help with bonding
- kidney failure with dialysis
- chronic ulcers requiring dressing changes and IV antibiotics
- multiple morbidities
- need for lifeline due to poor support at home and terminal illness
- multiple services needed in the home

This program requires a registered nurse whose role is to be a care coordinator. She has frequent telephonic contact with each member, assists with service providers in the home and follows up with the PCP and needed. She also attends staffings and care conferences as needed.

## Program Operations

Adult Rehabilitation Options **provides administrative case planning services for adults with chronic mental illness with a need for rehabilitative services as prescribed by a Licensed Professional of the Healing Arts. These members are not eligible for Targeted Case Management under the state plan, but are eligible for ARO services. Case planning services are necessary for a member to access ARO.**

Coordinators who have a minimum of a BS/BA degree with experience in working with adults with chronic mental illness complete face assessments. The coordinators assemble an interdisciplinary team and develop a comprehensive plan for service. Coordinators monitor services to ensure continued necessity and appropriateness. Monthly contacts are completed with the consumer, provider, or collateral contact. Quarterly face-to-face reviews assess the consumer's progress. An annual assessment of the consumer's level of functioning and continuing need is completed.

| | Current Enrollment | # Referrals | Letter in 5 days | Assessment - 30 days | Team Meeting - 60 days |
|---|---|---|---|---|---|
| **1st Quarter** | 233 | 37 | 37 | 37 | 37 |
| **2nd Quarter** | 301 | 62 | 62 | 61 | 62 |

Claims Processing **is a process to identify certain claims requiring prepayment review for determination of medical necessity, meeting Medicaid guidelines, appropriate billing, and/or manual pricing. Of the total number of claims submitted, three (3) percent suspend to Medical Services for review. Ninety (90) percent of these claims are processed within 30 days and twenty (20) percent require additional documentation before a determination can be made. These claims are not approved or denied until they suspend Medical Services for review and a determination has been made.**

**Claims Processing Data (10/01/2005 – 12/31/2005)**

| # Claims in Suspense as of 10/01/05 | # Claims Suspended 10/01/05 - 12/31/05 | # Claims Worked | #Pending as of 12/31/05 | Average Claims Suspended Weekly | Average Claims Suspended Daily | Average Claims Processed Weekly | Average Claims Processed Daily |
|---|---|---|---|---|---|---|---|
| 6,378 | 63,058 | 50,310 | 12,748 | 4,360 | 872 | 3,870 | 774 |

**Percentage of Claims Processed by Type**

| Types of Claims that Suspend to Medical Services | Percentage of Claims that Suspend |
|---|---|
| Dental/Inpatient LTC Concurrent care | 19% |
| Hospital inpatient DRG/outpatient APG/Concurrent care | 15% |
| Multiple Surgery | 5% |
| Manual Pricing | 22% |

| | |
|---|---|
| Sterilization/Hysterectomies | 3% |
| Prior Authorizations | 9% |
| Ambulance/Ultrasounds/Home Health/Labs/Botox/DME | 27% |

Administrative Adjunct Responsibilities

**Provider Inquiries** is a process by which providers can informally request review of a claim that has been completely or partially denied. The provider submits a form to Provider Services who forwards the request on to Medical Services for review. If it is determined that the claim is not payable after this review, the provider can request formal appeal. A majority of claims as a result of an informal inquiry are approved. Both of these functions require a registered nurse and input from the Medical Director.

| Description | | 1st Quarter | 2nd Quarter |
|---|---|---|---|
| Screen claims appeals and review within two (2) business days of receipt. | Completed | 243 | 572 |
| | Timely | 0 | 345 |
| | Overall | 0% | 60% |
| Notify the provider within three (3) business days of receipt of inquiry. | Completed | 243 | 572 |
| | Timely | 136 | 341 |
| | Overall | 56% | 60% |
| Send the final determination letter on a claims appeal to the provider within ten (10) business days. | Completed | 243 | 572 |
| | Timely | 225 | 561 |
| | Overall | 93% | 98% |

Policy Support Activities

**Appeals**
Medical Services provides medical expertise to support administrative appeals by preparing case summaries and providing testimony regarding the review process.

| Appeals | Requested | Hearing Held | Withdrawn | Dismissed | Modified | Reversed | Upheld |
|---|---|---|---|---|---|---|---|
| Enteral | 5 | 0 | 2 | 3 | 0 | 0 | 0 |
| Dental | 8 | 5 | 2 | 1 | 0 | 1 | 4 |
| DME/Supplies | 24 | 15 | 6 | 3 | 0 | 8 | 7 |
| Drugs/Biologics | 1 | 1 | 0 | 0 | 0 | 0 | 1 |
| Home Health | 4 | 1 | 2 | 1 | 0 | 1 | 0 |
| Pre-procedure | 6 | 5 | 1 | 0 | 2 | 0 | 3 |
| Ambulance | 61* | 28 | 31 | 0 | 0 | 15 | 13 |
| Brain Injury Waiver | 6 | 4 | 2 | 0 | 0 | 0 | 4 |
| Ill & Handicapped Waiver | 13 | 6 | 0 | 7 | 0 | 3 | 3 |
| Physical Disability Waiver | 3 | 2 | 0 | 1 | 0 | 0 | 2 |
| Elderly Waiver | 11 | 3 | 1 | 7 | 0 | 1 | 2 |
| ICF/MR | 2 | 1 | 1 | 0 | 0 | 0 | 1 |
| NF | 7 | 2 | 3 | 2 | 0 | 1 | 1 |
| CMH Waiver | 1 | 0 | 1 | 0 | 0 | 0 | 1 |
| TCM | 9 | 3 | 6 | 0 | 0 | 1 | 1 |
| Lock-in | 2 | 2 | 0 | 0 | 0 | 1** | 1 |
| **TOTAL** | **163** | **78** | **58** | **26** | **2** | **32** | **44** |

* 2 were Magellan appeals
** currently under review by DHS

**Exception to Policy**

An exception to policy (ETP) is a request for an item or service not otherwise covered by the Department of Human Services. An ETP may be granted to the Department of Human Services rules, but they cannot be granted to rules that are based on federal policy or state law. There is no fee or charge for requesting an ETP. An ETP is a last resort request and should only be requested when all other options have been exhausted. The Director of the Department of Human Services (DHS) must approve or deny an ETP request.

When an ETP is requested for services covered by Medicaid, a review is completed to determine if the request is medically necessary. The IME Medical Services Unit completes ETP reviews for medical necessity and makes a recommendation to DHS Policy staff. DHS Policy staff considers the medical necessity determination made by IME Medical Services and makes a recommendation to the Director on approval or denial of the ETP. States are not required to describe methods used to determine medical necessity in its State plan. However, they must use a process to make medical necessity decisions for services that are otherwise covered under the State Medicaid plan and that the process is available to all similarly situated Medicaid-eligible individuals. Iowa's identified process meets these requirements, and therefore federal financial participation (FFP) is available for services determined by the State to be medically necessary in accordance with Federal Regulations at 42 CFR 440.230(d).

Qualifications of Reviewers: Registered Nurse and Medicaid Medical Director and/or peer consultant.

| Exception to Policy (ETP) | # ETP Requested/ Processed | Processed within 10 days | % Completed Timely |
|---|---|---|---|
| Vision | 13 | 13 | 100% |
| Enteral | 12 | 12 | 100% |
| Dental | 28 | 21 | 75% |
| DME/Supplies | 68 | 63 | 93% |
| Drugs/Biologics | 25 | 15 | 60% |
| Home Health | 10 | 9 | 90% |
| Surgical | 4 | 3 | 75% |
| Therapies | 6 | 6 | 100% |
| Psychiatric | 4 | 4 | 100% |
| **TOTAL** | **170** | **146** | **86%** |

## Utilization Review

**Post Pay Admission Review** is a process to identify and eliminate unreasonable, unnecessary, and inappropriate care provided to Medicaid members. Claims are extracted for a variety of reasons to monitor quality, premature discharges, medically unnecessary admissions, and DRG validation.

| | 1st Quarter | 2nd Quarter |
|---|---|---|
| Reviews Requested | 498 | 178* |
| Reviews Completed | 383 | 178 |
| Reviews Approved | 362 | 157 |
| Reviews Denied | 21 | 21 |
| Reviews Pending | 115 | 0 |

*Number includes 115 reviews pending from the previous quarter

**Qualifications for program operation**: Registered Nurse and Medical Director

Member Health Education Program (MHEP) and Lock-in (LI)

**IFMC has coordinated the MHEP and LI Programs for 15 years. The program was created in response to IAC 441-76.9 and 42 CFR Chapter IV 431.54(e) to promote quality health care for Medicaid members by preventing harmful practices including:**

- **Duplication of scheduled and non-scheduled medications**
- **Unintended medication interactions**
- **Duplication of medical services and treatment**
- **Medication abuse**

| | |
|---|---|
| Qualifications of Reviewers: | **Registered Nurses and Medicaid Medical Director** |
| Enhancements: | **Family data indicating excessive use of medications and medical services** |
| Outreach: | **Review Coordinators meet with pharmacists and physicians across the state** |

Members are selected for review through applying statistical methods to claims data utilizing algorithms to identify utilization patterns most likely to be of concern. Some members selected have high utilization due to severe illness and are not further reviewed. Overuse of services is defined in IAC 441-76.9(7) as receipt of treatments, drugs, medical supplies or other Medicaid benefits from one or multiple providers of services in an amount, duration or scope in excess of that which would reasonably be expected to result in a medical or health benefit to the patient. Members who have overused services but are not engaged in harmful practices receive an educational intervention of a letter describing appropriate ways to utilize healthcare services. Members who have overused services with duplication of medications or services receive a similar letter and are flagged for follow up review in 6 months. All members who receive the educational intervention are provided a toll-free number to discuss with a nurse review coordinator any questions or concerns that they may have about their healthcare services.

Claims detail reports for members flagged for follow up are monitored 6 months following the educational intervention. Before a Medicaid member is restricted to specific providers, a physician reviewer must determine that the member is overusing or misusing Medicaid medical services and that the member would benefit from the Lock-in Program. When a determination has been made that a member would benefit from restrictions, the member's Medicaid card is restricted as follows:

- One primary care physician
- One pharmacy
- One hospital
- One specialty physician, if needed

The member's Medicaid card is restricted for 24 months. The member has the right to appeal the Lock-in decision. Claims detail reports are reviewed again prior to removal from restrictions and 6 months following removal from Lock-in.

Member Health Education Program (MHEP) and Lock-in (LI)

| Lock-in Statistics | |
|---|---|
| **Enrolled in MHEP on July 1, 2005** | **229** |
| **Enrolled in Lock-in on July 1, 2005** | **465** |
| Selected for potential review | 4,000 |
| Reviewed from selection process | 3,142 |
| Referrals – pharmacists, physicians (100% reviewed) | 153 |
| MHEP enrolled members reviewed (6 month review) | 333 |
| Lock-in enrolled members reviewed (24 month review) | 37 |
| Post Lock-in reviews (discharged 6 months previously) | 37 |
| **E. Total number of reviews** | **3,702** |
| Closed without intervention | 1024 |
| Received MHEP intervention without planned follow-up | 2,533 |
| Received MHEP intervention with planned follow-up | 100 |
| New members enrolled in Lock-in | 45 |
| Discharged from Lock-in due to compliance | 65 |
| Discharged from Lock-in due to Medicare Part D | 156 |
| **Enrolled in MHEP on December 31, 2005** | **2,633** |
| **Enrolled in Lock-in on December 31, 2005** | **284** |
| **Estimated Cost Savings in State dollars** | **$847,000** |

| | Requested | Hearing Held | Withdrawn | Modified | Reversed | Upheld |
|---|---|---|---|---|---|---|
| **Appeals** | 2` | 2 | 0 | 0 | 1* | 1 |

*Currently under review by DHS

## Managed Care Oversight

The Quality of Care (QOC) functions are designed to monitor the care provided to Iowa Medicaid members in MediPASS (a primary care case management system), the Medicaid managed care network (Coventry), and the Iowa Plan (MBCI).

MediPASS

- Requests for Special Authorizations received from treating providers (usually specialists, after hours care, etc.) who have treated MediPASS members and cannot obtain referral authorization from the designated Patient Manager (PM) utilizing normal procedures are completed. Medical Services assists the treating provider and the Patient Manager to approve requests for special authorizations.

| | 1st Quarter | 2nd Quarter |
|---|---|---|
| **Special Authorizations** | 14 requested and approved | 40 requested/ 35 approved* |

* Requests for Special Authorizations cannot be given if the member has not initiated a change in their designated PM (per DHS Policy Staff).

- Verification of compliance by MediPASS providers with contractual requirements for 24-hour coverage for assigned Medicaid members is conducted by placing telephone calls (before or after normal business hours) to 20 random providers each month. A total of 120 telephone calls were completed between July 1, 2005 and December 31, 2005. There was only one provider without 24-hour coverage. An educational letter was mailed to the provider.
- A quarterly Utilization Report will be sent to MediPASS Patient Managers showing the Patient Managers utilization compared to statewide average utilization. This process will be initiated in the third quarter.
- A quarterly referral authorization audit will be conducted on 1.25% of MediPASS provider paid claims to ensure treating providers have obtained referral authorizations appropriately.

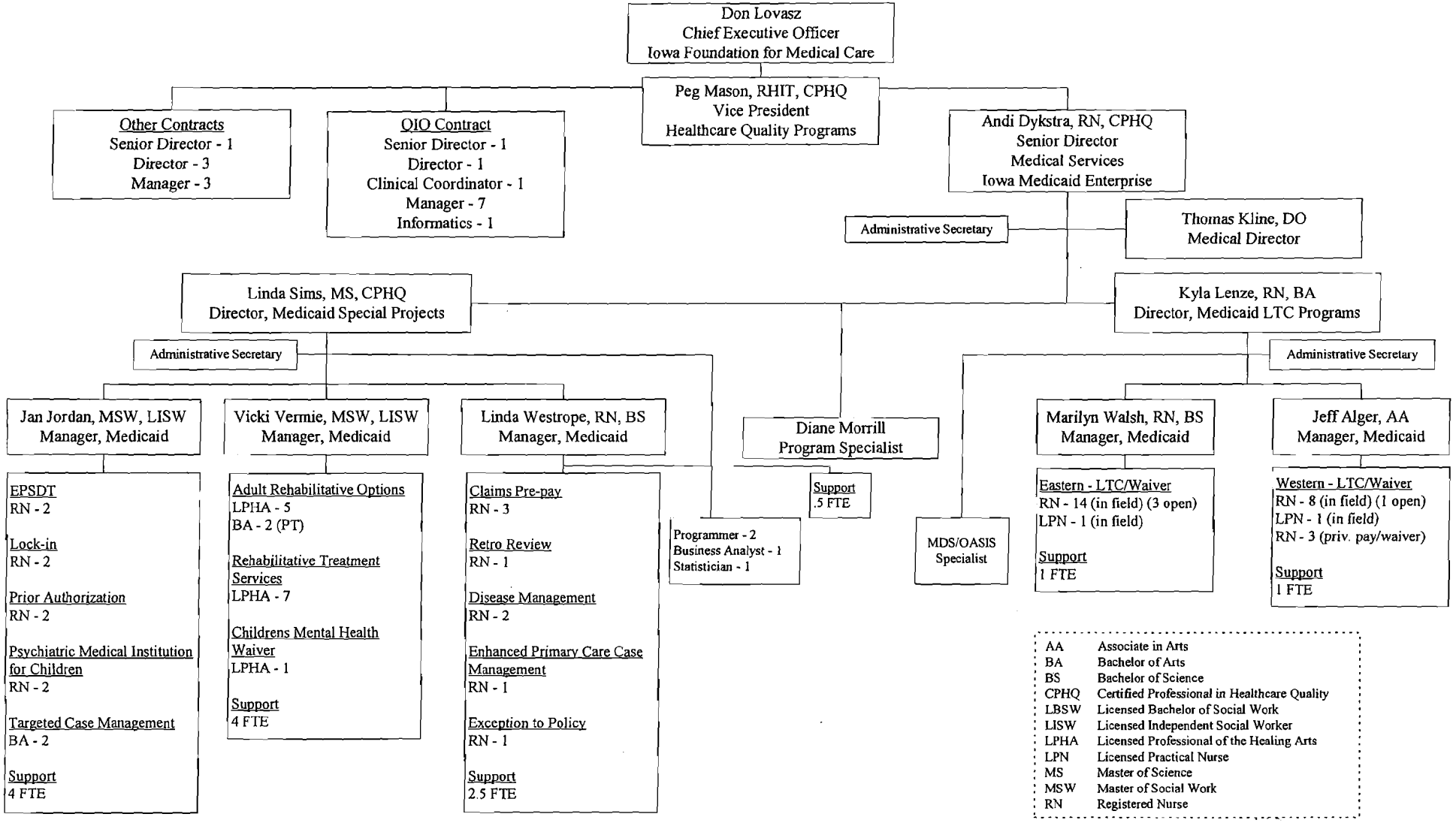
**Medicaid Managed Care** (Coventry and Iowa Plan)

- Annually the External Quality Review is conducted utilizing the Centers for Medicare & Medicaid protocols. The areas reviewed include:
  - Compliance with the Balanced Budget Act requirements
  - Validation of performance measures
  - Validation of performance improvement projects

## Approval of Outpatient Hospital Certifications

Oversight certification is completed to certify Diabetes Education and Cardiac Rehabilitation programs in requesting facilities. There are 95 Iowa hospitals with cardiac rehabilitation programs and 58 Iowa hospitals with diabetic education programs. During the first two quarters of fiscal year 2005 - 2006, a total of five facilities have had their diabetes education programs certified by Medical Services.

Iowa Medicaid Enterprise - Medical Services Unit
Iowa Foundation for Medical Care - Table of Organization



# PROVIDER SERVICES

## Iowa Medicaid Provider Resources

Provider Relations Team
- Provider Enrollment
- Call Center Management
- Provider Education and Outreach

Pharmacy Provider Relations Team
- Administration of Prior Authorization (PA) requests for the pharmacy program
- Questions regarding pharmacy claims

Medical Staff
- Review Prior Authorization (PA) requests
- Review suspended claims
- Assist Provider Services when providers question payment or denial of Medical Services reviewed claims

DHS Policy Staff
- Policy Development
- Policy Clarifications and Review

IME Provider Website
- Enrollment Documents
- Publications
- Medicaid Provider Manuals
- Provider Informational Letters
- Fall Provider Services Training Materials
- Link to Provider Web Portal Services
- Provider Forms
- Frequently Asked Questions
- IME Contact Information

ELVS
- Voice response for Medicaid Member Eligibility

Web Portal
- Medicaid Member Eligibility
- Claims Status
- Claims Submission through batch transmission

## Provider Relations Functions

Provider Enrollment

- Call center assistance
- Mail Medicaid provider applications as requested
- Process provider applications
- Process provider requested changes

Provider Inquiry/Provider Services Call Center

- Call center assistance
- Respond to written questions from providers
- Respond to E-mail from providers (www.imeproviderservices@dhs.state.ia.us)

Education and Outreach

- Provider Training
  IME Transition Training (May and June 2005)
  Annual Fall Training (September, October, and November 2005)
  Individual or group provider training as requested
  Assistance with outstanding claims issues
  Electronic claims submission questions
  Managed Care
- Provider Publications
  Provider Informational Releases
  Web Site Information
  Medicaid Provider Manuals
  Remittance Advice Messages
- Managed Care
  Enroll primary care Medicaid providers into the MediPASS program
  Assist with questions regarding managed care

## Provider Relations Team

Unit Manager: Mary Tavegia

Account Manager: Julie Lovelady

Call Center Supervisor: Linda Huber
Call Center Quality Assurance Coordinator: Desiree Smith
Call Center Trainer: Heidi Bevins
Call Center Unit Leads: Patricia Jo and Heidi Bevins
20 Customer Service Representatives
1 Provider Check and EFT Research Specialist

Provider Enrollment Supervisor: Robert Schlueter
4 Enrollment Specialists

Education and Outreach Supervisor: Jeremy Morgan
4 Education and Outreach Coordinators

Report Manager: Kelly Peiper

## Provider Services Statistics
## 10/01/05 through 12/31/05

### Provider Enrollment

| | |
|---|---|
| Enrolled Providers as of 10/1/2005 | 49,990 |
| Enrolled Providers as of 12/31/2005 | 51,007 |
| **Net Increase of Providers** | 1,017 |

| | |
|---|---|
| Applications Pending as of 10/1/2005 | 1,578 |
| Applications Received during quarter | Approximately 1500 |
| **Total Actionable Applications** | 3,078 |

| | |
|---|---|
| Applications Approved as of 12/31/2005 | 1,017 |
| Applications Denied as of 12/31/2005 | 372 |
| Applications Pending Additional Information from Provider | 1428 |
| Applications to be Processed | 261 |
| **Total** | 3,078 |

Conclusions:

- 1,010 new providers enrolled
- Reduced applications to be processed by 83%
- 12% of applications denied
- 249 providers terminated Medicaid

## Provider Services Statistics
## Provider Services Call Center

**10/01/05 through 12/31/05:**

- Total number of calls received – 79,974
- Total number of calls answered – 62,520

12/11/05 through 1/11/05:

**Calls Answered**

- Percentage of calls answered in 30 seconds or less –54%
- Percentage of calls answered in greater than 30 seconds – 46%

**Calls Abandoned**

- Percentage of calls abandoned in 30 seconds or less – 31%
- Percentage of calls abandoned in greater than 30 seconds – 69%

## Provider Services Statistics
## Provider Services Call Center

**10/01/05 through 12/31/05:**

- Total number of calls received – 79,974
- Total number of calls answered – 62,520

12/11/05 through 1/11/05:

**Calls Answered**

- Percentage of calls answered in 30 seconds or less –54%
- Percentage of calls answered in greater than 30 seconds – 46%

**Calls Abandoned**

- Percentage of calls abandoned in 30 seconds or less – 31%
- Percentage of calls abandoned in greater than 30 seconds – 69%

## Provider Services Statistics
## 5/01/05 through 12/31/05

**Education and Outreach**

**IME Transition Training:**

| | |
|---|---|
| Number of Sessions | 36 |
| Number of Attendees | 2,783 |

Training sessions were conducted in Council Bluffs, Sioux City, Fort Dodge, Des Moines, Waterloo, Cedar Rapids, Dubuque, and Bettendorf

**Annual Fall Training:**

| | |
|---|---|
| Number of Sessions | 64 |
| Number of Attendees | 1,895 |

- Training sessions were conducted in Council Bluffs, Sioux City, Fort Dodge, Des Moines, Waterloo, Cedar Rapids, Dubuque, and Bettendorf
- Training materials available on IME Provider Services website at http://www.ime.state.ia.us/Providers/TrainingSchedule.html :
    - General Information Packet
    - General PowerPoint Presentation
    - Billing of Medical Services
    - Dental Services
    - Durable Medical Equipment
    - Hospital – Inpatient and Outpatient
    - Nursing Facility
    - Practitioner Handout
    - Vision
    - Home Health and Hospice
    - Waiver and Targeted Case Management
    - Using the Iowa Medicaid Web Portal

**Individual Provider Training:**

| | |
|---|---|
| Number of Sessions (10/1/2005 – 12/31/2005) | 134 |

## Summary of Calls Received for Quarter Ending 12/31/05

Callers are given the option to select a category relating to their call. Below is a summary of the calls received and answered for each category:

| Call Type | Received | Answered |
|---|---|---|
| Eligibility | 7,954 | 6,873 |
| Status | 38,704 | 29,487 |
| Inquiry | 30,130 | 23,881 |
| MediPASS | 3,186 | 2,279 |

The **eligibility** subject matter consists of inquiries from providers requesting information regarding a Medicaid member's eligibility for certain dates of service, eligibility for vision exam and eyeglasses, and dental eligibility.

The subject matter for **status** consists of questions from providers inquiring about the status of a claim. Typically, providers want to know if the IME has received the claim, when the claim will be paid or denied, and if the claim denied, why it denied.

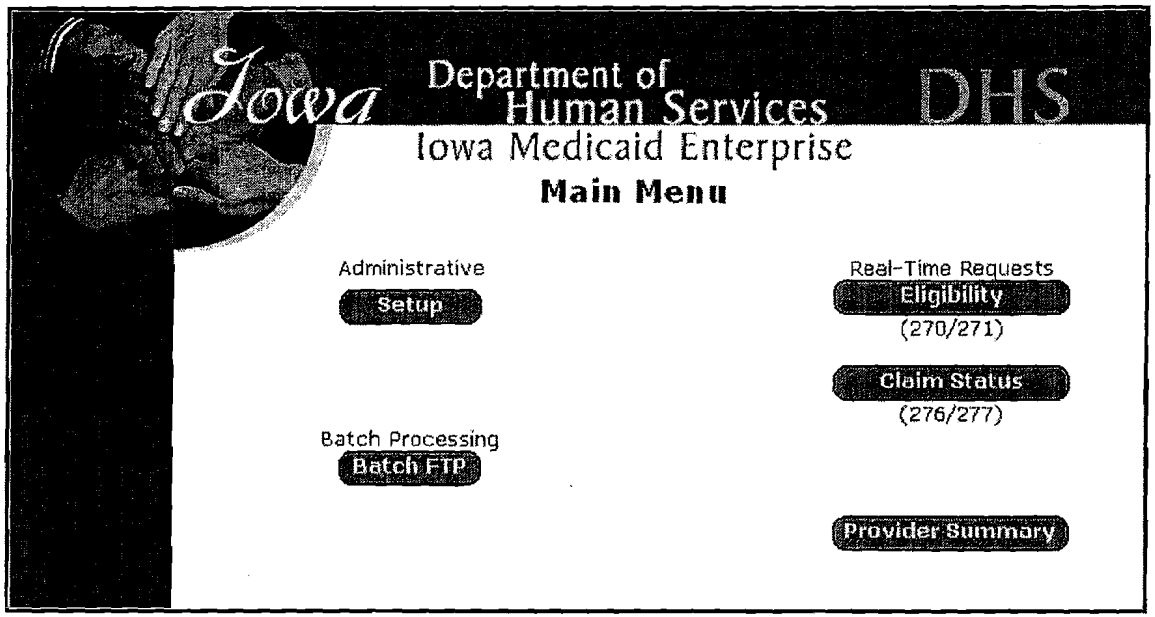
The subject matter of the **inquiry** call type includes providers requesting copies of remittance advices, forms, waiver claims, check that have not been received, questions regarding procedure codes, claim questions, status of claims, and if a prior authorization is needed.

The subject matter relating to the **MediPASS** call type are inquires from providers verifying MediPASS patient manager status for a member, calling with enrollment approvals for members, MediPASS enrollment questions, and any other questions relating to managed care.

**Methods to Decrease Provider Hold Times when Calling Provider Services**

*Medicaid member eligibility and MediPASS provider information can be obtained from ELVS (voice eligibility response system) at 1-800-338-7752 or locally at 515-323-9639, twenty-four hours per day, seven days a week.

*Medicaid member eligibility , MediPASS provider information, and claims status can be obtained from or the Web Portal, twenty-four hours per day, seven days a week.




*IME staff is researching methods to enhance Web Portal to include a member's last date of an eye exam, glasses, dental exam, or hearing aid eligibility, as well as claim denials.

*Provider Services is in the process of recruiting, hiring, and training additional staff.
*In addition, provider services staff is making changes in the way they approach training and staffing needs.

## Provider Services Contractual Performance Measurements Include:

### Provider Enrollment

- 95% of provider enrollment applications must be approved, assigned a provider number, denied, or returned to the provider for additional information within five days of receipt of the application.
- Send enrollment packets to prospective Medicaid providers who request them within one business day following the receipt of the request from the provider.
- Perform online updates to provider data within one business day of receipt of the update

Current Assessment: Approximately 230 applications waiting to be processed
Solution: High number due to requests for additional information and 1099 project; staff working overtime

### Provider Relations/Provider Inquires

- Maintain a service level of eighty percent for incoming calls, which includes answering calls within thirty seconds.
- Respond to 90% of written, faxed, or E-mailed inquiries within five business days of receipt. If a complete response cannot be made within the five days, an interim response must be provided within the five business days.

Current Assessment: 44.5% service level since January 1, 2006; Oldest piece of mail to be worked from January 10; approximately 800 pieces of mail outstanding.
Solution: Due to number of holidays, mail amassed. We were within the five-day requirement until the 18th. Our solution consists of staff working overtime, reorganization within the unit, new training and additional training.

### Provider Education and Outreach

- Maintain informational letters, bulletins, training materials, and manual updates on the provider website
- Provide annual training to Medicaid providers
- Increase MediPASS provider participation

Current Assessment: Website is current regarding informational letters and training materials; all manuals on website, some require updating. Annual training was successfully completed Fall, 2005.
Solution: Work with DHS to implement manual changes. Process report on newly enrolled providers to gain MediPass participation.

# MEMBER SERVICES

## I. Medicaid Member Population

The state of Iowa currently has 320,095 enrolled Medicaid members. The following categories illustrate the breakdown of the Medicaid population.

| | |
|---|---|
| ▪ Children | 159,708 |
| ▪ Parents | 40,694 |
| ▪ Pregnant Women | 6,511 |
| ▪ Disabled | 62,726 |
| ▪ Elderly | 34,102 |
| ▪ Nursing Facility | 15,894 |
| ▪ ICF/MR | 2,184 |

**The Medicaid program is intended to offer the following types of health care:**

- Preventive health care for children with physical and mental treatment needs.
- Acute care for the ill and handicapped population.
- Chronic care for the elderly needing access to Long Term Care Facilities.
- Rehabilitative services for the physically and mentally disabled.
- Nursing Home and Health and Community Based Services for the physical and behavioral medical conditions that require temporary or permanent medical problems interfering with daily living activities.

## III. Medicaid Benefits

The Iowa Medicaid program provides health care to members in the same manner other Iowans receive health care including access to the following types of providers:

- Doctors
- Dentists
- Pharmacies
- Hospitals
- Nursing Homes

The use of intermediaries serving the Medicaid population is few. We have a limited Managed Care Organization, the Iowa Plan for behavioral health, Primary Care Case Management and Medicare as a supplemental health insurance program.

- MediPASS – 140,470
- Coventry – 5,249
- Iowa Plan –275,357 (170,721 Age 17 and under)
- Medicare – 54,826

## IV. Access of Care

The number of members accessing at least one service in December 2005 was 301,777.

It is the goal of the Iowa Medicaid Program to assist members in utilizing health care services effectively. The Iowa Medicaid Enterprise Member Services Unit provides educational information through many venues including a call center. The information provided to members include:

- Information of benefits available by providing publications and brochures.
- A list of available providers and encouraging members to actively participate with the provider giving care
- A medical home – Primary Care Case Management program.
- Assisting with Transportation services.
- Health care education that enables the member to make informed choices relating to staying healthy and becoming healthy.
- Assistance with the completion of paperwork, i.e. a bill from a provider, application completion, premium payments etc.

## V. Iowa Medicaid Enterprise Member Services Overview

### Mission

Increasing the ability of Iowa Medicaid members to access and utilize their benefits and the health care system readily and wisely, make good choices, and become informed medical consumers.

### Who We Are

Account Manager: Tom Mologianes
Call Center Operations Manager: Shawn Gebhart
Communications and Compliance Coordinator: Betty Binkard
Quality Assurance and Report Analyst: Vicki Shearer
Administrative Assistant: Tara Ross
Bill Call Assistant: Tish Hopkins
11 Call Center Customer Service Representatives (CSR) positions

### What We Do

Serve as the Enrollment Broker for Managed Health Care
Member Inquiry and Member Relations
Member Publications and Education
Member Quality Assurance
Upon request of the Director, report on trends and issues facing members.

The Member Inquiry/Member Relations function involves staffing an expanded Call Center staffed with 11 CSR positions from 8 to 5 Monday through Friday.

Members have a place to call for information about any Medicaid related issue in addition to inquiring about bills from providers. To date Member Services has answered 52,674 calls from members or their representatives.

The following is a breakdown by topic and the number of calls that CSRs in the IME Member Services Call Center handled from June 30, 2005 to December 31, 2005. The following represent inquiries that would not have been responded to in the past by any designated or centralized resource.

Enrollment (26,286)
Dental, Vision, and Medical Benefits (8,162)
Iowa Care (5,905)
Eligibility Issues (2,723)
Claim Status (2,286)
Medicare Part D (1,297)
Prescriptions (1,236)
Publication Requests (877)
Prior and Special Authorizations (330)

As Medicaid members increase their utilization of IME Member Services, the following enhancements are in process:

Adding CSRs to decrease call hold time.
Adding voice mail for MediPASS provider enrollment.
Exploring the option of expanding the Member Services Call Center operation to evenings and weekends.

## V. Iowa Medicaid Enterprise Member Services Overview (continued)

The Member Services Call Center continues to respond to calls from members about medical bills received from Medicaid providers. As of December 31, 2005, we have responded to 1,571 calls about bills from providers.

Member Services realigned staffing for this function to respond in writing to members within 30 days. The number of calls has almost consistently increased each month:

| | | |
|---|---|---|
| July | 201 | |
| August | 196 | |
| September | 235 | |
| October | | 266 |
| November | | 344 |
| December | 329 | |

- Utilizing calls about bills from providers as opportunities for member education. For instance, a call from an IowaCare member who has gone to a non-IowaCare provider can be an opportunity to educate about use of the network; a call from a member who has gone to an emergency room for a non-emergent reason provides an opportunity to discuss seeking care (and a referral) through their Primary Care Provider for routine care.
- A series of educational inserts is currently in the planning stage. These "info nuggets" will be sent with the member Medical Assistance ID cards each month and focus on issues dealing with proper access to the health care system and

effective benefit use.

- Member Services currently coordinates all aspects of the mailing of around 15,000 *Healthy Start* booklets to new parents each month. This project, which is part of a federally funded grant, sends monthly booklets to parents about child development and preventive health concerns. One booklet is sent for each month of the baby's life from birth through age one year.

Two topics stand out from others as far as the numbers of calls received.

- The number of calls about IowaCare is second only to those about general benefits. Enrollees typically voice concerns about the limited provided network, problems with access and transportation related to geographical distances, uncertainties about what is covered, and premium payments.

A baseline survey was mailed to 1,028 Medicaid members who were asked to reflect on their experience over a past period of up to 12 months. Hence their responses would be heavily influenced by their experience with Medicaid prior to the IME becoming operational on June 30, 2005.

Excluding the 67 undeliverable surveys, 367 surveys were returned for a return rate of 36%; however, 9 of these reported that they were not Medicaid recipients and 27 did not answer any questions other than possibly the first. As a result, we received 331 completed or partially completed surveys from Medicaid recipients for a response rate of 32%.

**Findings:**

- 77% of the respondents said they had chosen their primary health care provider.
- 76% indicated that it was not a problem to get a primary care provider with whom they are happy.
- For those with a primary health care provider, 46% rated their provider as the "best primary provider possible."
- 81% of the respondents made an appointment for routine care in the last six months.
- For routine appointments 80% got their care only from their primary care provider. Of those who received care somewhere else, 70% indicated their primary care provider recommended another place to get care.
- Almost half (48%) of the respondents have had at least one preventive visit in the last six months while 71% have had a preventive visit in the last year.
- 41% of respondents indicated they have a good understanding of the Iowa Medicaid program, rating their understanding at 8 or higher on a scale of 1 to 10.
- Over 80% (82%) of the respondents rated their satisfaction with the Iowa Medicaid program as high (between seven and ten).
- Fifteen percent (15%) of the respondents who called the Medicaid Hotline (limited access member service prior to 6/30/05) in the past six months were never helped nor was their call answered quickly.
- Over 65% of the respondents stated that their overall health right now was good, very good or excellent. Eight percent of the respondents stated that their health was poor.

## VII. Member Quality Assurance

Dental care is a major concern of respondents as the following comments show:

- *Better dental coverage. I am tired of being turned down. I need a dentist bad!*
- *Impossible to get dental care.*
- *Need more and better dentist options!*
- *Need some help with cost of my infusions every three months at Dr. Rodney's.*
- *I have difficulty getting adequate dental care. I need sedation/general anesthesia for appointments.*
- *(Medicaid) needs to pay for 2 pair partials or fix them, and needs to pay for crowns and root canals because people like me can't afford to up nine hundred cash to have these things done. You should at least reconsider some of the things the state doesn't pay that people like in an emergency situation at times need a little more help in getting the problem taken care of. "*
- *Good medical but I don't understand why some things are not covered, like certain teeth or orthopedics.*

Other areas of concern raised in comments are:

- Lack of vision coverage
- Having to choose from a limited set of providers and needing a referral
- Perception of discriminatory treatment by providers and staff due to being on Medicaid
- Customer service difficulties with referrals, billing, pre-authorizations
- Prescription coverage

## VII. Member Quality Assurance (Continued)

A second quality assurance survey is in the design and approval-seeking process. This more comprehensive survey will enable us to demonstrate differences in levels of member satisfaction. Member Services will also study differences in satisfaction among sub-groups in order to learn more about the factors that increase satisfaction, which can be assumed to link to more effective use of health care services and improved member health. For instance, Member Services would compare satisfaction among those who seek preventive care as opposed to those who do not, those enrolled in Managed Health care as opposed to those in fee-for-service arrangements, and so on.

# PROVIDER COST AUDITS

**SFY 2006 State Savings**

In SFY 2006 Iowa shall realize State Savings through collection of overpayments or avoidance of overpayments by the Provider Audit and Rate Setting Contractor of not less than $500,000 over a SFY 2005 base.

| | |
|---|---|
| Targeted Annual State Savings for SFY 2006 | $ 5,593,998 |
| Estimated Actual State Savings for July 1, 2005 - December 31, 2005 | $ 2,293,830 |

**Perform Cost Settlements: Cost Reports Received July '05 - December '05**

The following providers are reimbursed based on reasonable cost: Home Health Agency, Federally Qualified Health Center, Rural Health Clinic, Adult Rehabilitation Option Provider, Targeted Case Management, Critical Access Hospital, Mental Health Institute and Psychiatric Medical Institution for Children. Provider Cost Audit and Rate Setting Unit is required to complete a cost settlement based on actual allowable cost submitted by the provider within specific timeframes.

| | |
|---|---|
| Number of Cost Reports Received | 584 |
| Number of Cost Report Still in Process | 353 |
| Number of Cost Reports Completed | 231 |
| | |
| Number of Cost Reports Completed Timely | 231 |
| Number of Cost Reports Not Completed Timely | 0 |
| Percent of Cost Reports Completed Timely | 100% |

Provider Cost Audit and Rate Setting Unit
Performance Report Card
Report For the Quarter Ending December 31, 2005

Performance Standard:

Settle cost reports for all institutional providers within three (3) months after receipt of the final Title XVIII Medicare cost report or, if no Title XVIII Medicare cost report is submitted, within twelve (12) months after receipt of the submitted Medicaid report.

| | | | C/R Completed | | |
|---|---|---|---|---|---|
| **Provider Type** | **Month Received** | **Number Cost Reports Received** | **Standard Met** | **Standard Not Met** | **Still in Process at Time of Report** |
| Targeted Case Management | Jul-05 | 49 | 49 | | 0 |
| Targeted Case Management | Aug-05 | 5 | 5 | | 0 |
| Targeted Case Management | Sep-05 | 46 | 25 | | 21 |
| Targeted Case Management | Oct-05 | 9 | 4 | | 5 |
| Targeted Case Management | Nov-05 | 2 | 0 | | 2 |
| Targeted Case Management | Dec-05 | 2 | 2 | | 0 |
| Adult Rehabilitation Option | Jul-05 | 8 | 8 | | 0 |
| Adult Rehabilitation Option | Aug-05 | 0 | 0 | | 0 |
| Adult Rehabilitation Option | Sep-05 | 125 | 45 | | 80 |
| Adult Rehabilitation Option | Oct-05 | 44 | 1 | | 43 |
| Adult Rehabilitation Option | Nov-05 | 19 | 6 | | 13 |

Provider Cost Audit and Rate Setting Unit
Performance Report Card
Report For the Quarter Ending December 31, 2005

| | | | | |
|---|---|---|---|---|
| Adult Rehabilitation Option | Dec-05 | 15 | 2 | 13 |
| Rural Health Clinic | Jul-05 | 24 | 23 | 1 |
| Rural Health Clinic | Aug-05 | 1 | 1 | 0 |
| Rural Health Clinic | Sep-05 | 2 | 2 | 0 |
| Rural Health Clinic | Oct-05 | 1 | 1 | 0 |
| Rural Health Clinic | Nov-05 | 28 | 11 | 17 |
| Rural Health Clinic | Dec-05 | 30 | 0 | 30 |
| Federally Qualified Health Center | Jul-05 | 7 | 7 | 0 |
| Federally Qualified Health Center | Aug-05 | 0 | 0 | 0 |
| Federally Qualified Health Center | Sep-05 | 6 | 3 | 3 |
| Federally Qualified Health Center | Oct-05 | 3 | 0 | 3 |
| Federally Qualified Health Center | Nov-05 | 2 | 0 | 2 |
| Federally Qualified Health Center | Dec-05 | 7 | 0 | 7 |
| Home Health Agency | Jul-05 | 32 | 32 | 0 |
| Home Health Agency | Aug-05 | 0 | 0 | 0 |
| Home Health Agency | Sep-05 | 4 | 2 | 2 |
| Home Health Agency | Oct-05 | 3 | 0 | 3 |
| Home Health Agency | Nov-05 | 61 | 0 | 61 |
| Home Health Agency | Dec-05 | 20 | 0 | 20 |
| Psychiatric Medical Institution for Children | Jul-05 | 0 | | 0 |
| Psychiatric Medical Institution for Children | Aug-05 | 1 | | 1 |
| Psychiatric Medical Institution for Children | Sep-05 | 3 | | 3 |
| Psychiatric Medical Institution for Children | Oct-05 | 0 | | 0 |
| Psychiatric Medical Institution for Children | Nov-05 | 1 | | 1 |
| Psychiatric Medical Institution for Children | Dec-05 | 0 | | 0 |

Provider Cost Audit and Rate Setting Unit
Performance Report Card
Report For the Quarter Ending December 31, 2005

| | | | | | |
|---|---|---|---|---|---|
| Critical Access Hospital | Jul-05 | 2 | 2 | | 0 |
| Critical Access Hospital | Aug-05 | 0 | 0 | | 0 |
| Critical Access Hospital | Sep-05 | 0 | 0 | | 0 |
| Critical Access Hospital | Oct-05 | 0 | 0 | | 0 |
| Critical Access Hospital | Nov-05 | 18 | 0 | | 18 |
| Critical Access Hospital | Dec-05 | 1 | 0 | | 1 |
| Mental Health Institution | Jul-05 | 1 | | | 1 |
| Mental Health Institution | Aug-05 | 0 | | | 0 |
| Mental Health Institution | Sep-05 | 0 | | | 0 |
| Mental Health Institution | Oct-05 | 0 | | | 0 |
| Mental Health Institution | Nov-05 | 1 | | | 1 |
| Mental Health Institution | Dec-05 | 1 | | | 1 |
| **Total** | | **584** | **231** | **0** | **353** |

Percent Standard Met 100%

**Perform Desk Reviews and Notify Provider of New Payment Rate: Cost Reports Received July '05 - December '05**

The following providers are reimbursed based on a prospective basis: Nursing Facilities, Intermediate Care Facility for Persons with Mental Retardation, Residient Care Facilities and Home and Community Based Waiver providers. PCA is required to complete a desk review to determine allowable costs and calculate a prospective rate within a specified timeframe. For NFs, PCA is also required to calculate quarterly rates.

| | |
|---|---|
| Number of Cost Reports Received | 633 |
| Number of Cost Report Still in Process | 77 |
| Number of Cost Reports Completed | 556 |
| | |
| Number of Cost Reports Completed Timely | 518 |
| Number of Cost Reports Not Completed Timely | 38 |
| Percent of Cost Reports Completed Timely | 93% |

Provider Cost Audit and Rate Setting Unit
Performance Report Card
Report For the Quarter Ending December 31, 2005

Performance Standard:

For NF, ICFs/MR, RCF and HCBS providers, notify the provider and the Department of the new payment rate by sending a "rate sheet" within two (2) months of the end of the month after receipt of the financial and statistical report.

| | | | | C/R Completed | | |
|---|---|---|---|---|---|---|
| **Provider Type** | **Month Received** | **Number Cost Reports Received** | **Due Date** | **Standard Met** | **Standard Not Met** | **Still in Process at Time of Report** |
| Nursing Facilities | Jul-05 | 2 | 9/30/2005 | | 2 | |
| Nursing Facilities | Aug-05 | 10 | 10/31/2005 | 10 | | |
| Nursing Facilities | Sep-05 | 49 | 11/30/2005 | 48 | 1 | |
| Nursing Facilities | Oct-05 | 17 | 12/31/2005 | 13 | | 4 |
| Nursing Facilities | Nov-05 | 7 | 1/31/2006 | | | 7 |
| Nursing Facilities | Dec-05 | 24 | 2/28/2006 | | | 24 |
| Intermediate Care Facilities for Mental Retardation | Jul-05 | 22 | 9/30/2005 | 11 | 11 | |
| Intermediate Care Facilities for Mental Retardation | Aug-05 | 31 | 10/31/2005 | 29 | 2 | |
| Intermediate Care Facilities for Mental Retardation | Sep-05 | 44 | 11/30/2005 | 44 | | |
| Intermediate Care Facilities for Mental Retardation | Oct-05 | 0 | 12/31/2005 | | | |
| Intermediate Care Facilities for Mental Retardation | Nov-05 | 0 | 1/31/2006 | | | |
| Intermediate Care Facilities for Mental Retardation | Dec-05 | 0 | 2/28/2006 | | | |

Provider Cost Audit and Rate Setting Unit
Performance Report Card
Report For the Quarter Ending December 31, 2005

| | | | | | | |
|---|---|---|---|---|---|---|
| Residential Care Facilities | Jul-05 | 2 | 9/30/2005 | 2 | | |
| Residential Care Facilities | Aug-05 | 10 | 10/31/2005 | 10 | | |
| Residential Care Facilities | Sep-05 | 93 | 11/30/2005 | 90 | | 3 |
| Residential Care Facilities | Oct-05 | 13 | 12/31/2005 | 12 | | 1 |
| Residential Care Facilities | Nov-05 | 2 | 1/31/2006 | | | 2 |
| Residential Care Facilities | Dec-05 | 0 | 2/28/2006 | | | |
| Home and Community Based Waiver Services | Jul-05 | 27 | 9/30/2005 | 21 | 6 | |
| Home and Community Based Waiver Services | Aug-05 | 26 | 10/31/2005 | 26 | | |
| Home and Community Based Waiver Services | Sep-05 | 141 | 11/30/2005 | 103 | 16 | 22 |
| Home and Community Based Waiver Services | Oct-05 | 32 | 12/31/2005 | 28 | | 4 |
| Home and Community Based Waiver Services | Nov-05 | 55 | 1/31/2006 | 45 | | 10 |
| Home and Community Based Waiver Services | Dec-05 | 26 | 2/28/2006 | 26 | | |
| **Total** | | **633** | | **518** | **38** | **77** |

Percent Standard Met 93.17%

**General Inpatient and Outpatient Hospital**

Hospitals are reimbursed based on a DRG basis for inpatient services and APG basis for outpatient hospital services. PCA unit is responsible for rebasing and recalibrating the hospital base rates and weights to be effective October 1, 2005 and every three years thereafter. Work continues on finalizing the new base rates and weights. A meeting has been scheduled with the Rebase Task Force on February 2, 2006 to discuss the inpatient results. State Plan Amendment language changes were submitted Sept. '05. DHS is still waiting approval of the inpatient rebase.

**State Maximum Allowable Cost Program**

PCA is required to monitor State MAC rates and report to DHS at least every two months any necessary changes. PCA is also required to perform an annual acquisition cost study at least annually and update State MAC rates based on survey data.

Annual acquisition cost study was performed October - December 2005. Draft results were provided to DHS on January 13, 2006.

| INSTITUTIONAL | BASIS OF REIMBURSEMENT |
|---|---|
| **Inpatient** | |
| *Inpatient Hospital (General Hospital)* | Prospective reimbursement system for inpatient hospital services based on diagnosis-related groups (DRGs) |
| *Critical Access Hospital* | Cost-based w/ cost settlement (in-state and out-of-state) |
| *Psychiatric Medical Institution for Children (PMIC)* | Cost-based per diem rate to a maximum established by the Iowa Legislature |
| *State Mental Health Institution* | Cost-based w/ cost settlement |
| *Mental Hospital* | Cost-based w/ cost settlement |
| *Rehabilitation Hospital* | Per diem rate |
| *Psychiatric Hospital* | Cost-based w/ cost settlement (in-state); Percentage of charges interim rate (out-of-state) |
| **Outpatient** | |
| *Outpatient Hospital (General Hospital; Both in-state and out-of-state)* | APG-based |
| *Critical Access Hospital* | Cost-based w/ cost settlement (in-state and out-of-state) |
| *Laboratory Only* | Fee schedule |
| *Non-inpatient Programs (NIPS)* | Fee schedule |
| **Nursing Facilities** | |
| *Skilled Nursing Facility (SNF)* | Modified price-based case-mix adjusted per diem |
| *Specialty Skilled Nursing Facility (Specialty SNF)* | Cost-based per diem without case-mix factor; Without cap for State-owned |
| *Nursing Facility (NF)* | Modified price-based case-mix adjusted per diem |
| *Nursing Facility for the Mentally Ill (NF-MI)* | Modified price-based case-mix adjusted per diem; With cap for non-State owned, without cap for State-owned |
| *Specialty Nursing Facility for the* | Cost-based per diem without case-mix factor; |

| INSTITUTIONAL | BASIS OF REIMBURSEMENT |
|---|---|
| *Mentally Ill (Specialty NF-MI)* | Without cap for State-owned |
| *ICF/MR* | Per diem rate, capped at 80th percentile, except for State Resource Centers (Woodward and Glenwood) |
| **Other Institutional Reimbursements** | |
| *Home Health Agency* | Currently cost-based with cost settlement; Will be changed to Fee Schedule on 7/1/04 |
| *Family Planning Clinic* | Fee schedule |
| *Rural Health Clinic (RHC)* | Cost-based w/cost settlement |
| *Federally Qualified Health Center (FQHC)* | Cost-based w/cost settlement |
| *Partial Hospitalization* | APG or fee schedule |
| *Rehabilitation Agency* | Medicare fee schedule |
| *Acute Rehab Hospital* | Per Diem developed by submitted cost reports |

| NON-INSTITUTIONAL | BASIS OF REIMBURSEMENT |
|---|---|
| **Practitioners** | |
| *Physician (Doctor of Medicine or Osteopathy)* | Fee schedule (RBRVS) |
| *Dentist* | Fee schedule |
| *Chiropractor* | Fee schedule (RBRVS) |
| *Physical Therapist* | Fee schedule (RBRVS) |
| *Audiologist* | Fee schedule (RBRVS) for professional services, plus product acquisition cost and dispensing fee |
| *Psychiatrist* | Fee schedule (RBRVS, to the extent rendered/billed by psychiatrist or psychologist and then only for CPT coded services) |
| *Podiatrist* | Fee schedule (RBRVS) |
| *Psychologist* | Fee schedule (RBRVS) |

| NON-INSTITUTIONAL | BASIS OF REIMBURSEMENT |
|---|---|
| *CRNA* | Fee schedule (RBRVS) |
| *Nurse Practitioner* | Fee schedule (RBRVS) |
| *Certified Nurse-midwife* | Fee schedule (RBRVS) |
| *Patient Manager (Primary Care Physician)* | Capitated administrative fee |
| *Optician* | Fee schedule (RBRVS); Fixed fee for lenses. Frames and other optical materials at product acquisition cost. |
| *Optometrist* | Fee schedule (RBRVS); Fixed fee for lenses. Frames and other optical materials at product acquisition cost |
| *Clinical Social Worker* | Medicare deductibles / coinsurance |
| **Services / Supplies** | |
| *Hospice* | Medicare-based prospective rates, based on level of care provided |
| *Clinics* | Fee schedule |
| *Ambulance Service* | Fee schedule (Cost-based for critical access hospital-based ambulance) |
| *Independent Laboratory* | Fee schedule |
| *X-Ray* | Fee schedule (paid under either a Physician or Clinic billing) |
| *Pharmacy / Drugs* | Lower of: AWP minus 12%, usual and customary, or the MAC price (state or federal), plus dispensing fee |
| *Lead Investigations* | Fee schedule |
| *Hearing Aid Dealer* | Fee schedule for professional services, plus product acquisition cost and dispensing fee |
| *Orthopedic Shoe Dealer* | Fee schedule |
| *Medical Equipment and Prosthetic Devices Provider* | Fee schedule |
| *Supplies* | Fee schedule |
| **Other Agency / Organization Reimbursements** | |
| *Ambulatory Surgical Center* | Fee schedule |

| NON-INSTITUTIONAL | BASIS OF REIMBURSEMENT |
|---|---|
| *Birthing Center* | Fee schedule |
| *Community Mental Health Center* | Fee schedule |
| *EPSDT Screening Center* | Fee schedule |
| *Maternal Health Center* | Fee schedule |
| *Area Education Agency* | Fee schedule |
| *Local Education Agency* | Fee schedule |
| *Targeted Case Management* | Cost-based w/cost settlement |
| *Health Maintenance Organization* | Predetermined capitation rate |
| *Managed Mental Health and Substance Abuse* | Predetermined capitation rate |
| *HCBS Waiver Service Provider* | Negotiated rates |
| *Adult Rehabilitation Option* | Cost-based with cost settlement (100% of non-federal share paid by Counties, except for State cases for whom the State pays non-federal share |

# SURVEILLANCE AND UTILIZATION REVIEW SERVICES (SURS)

# EXPLANATION OF SURS INTEGRITY SYSTEM

## I. Initiation of Case

**A.** Federal Regulation requires states to perform statistical profiling of providers submitting claims for Medicaid covered services. In order to receive an enhanced federal financial participation (FFP) amount for the Medicaid Management Information System (MMIS), the state must conduct these profile reviews and identify inappropriate expenditures. All provider types must be reviewed at least annually. These requirements are in regulation at 42 CFR 455, 42 CFR 433.116(g) and Part 11 of the State Medicaid Manual produced by the Centers for Medicare and Medicaid Services (CMS)

**B. Federal Regulations (433.116(e)) also require states to send out notices to a sample of Medicaid recipients each month identifying what charges have been submitted to the program as services that were rendered to them. These are referred to as Explanation of Medicaid Benefits (EOMB). EOMB's returned from recipients which indicate the recipient has not received the services are investigated by the SURS unit. 400 EOMB are mailed monthly.**

**C.** Cases can be generated based on referrals from CMS, the Office of the Inspector General (OIG) or other state Program Integrity units. Iowa participates with other states in a network of program integrity units that share information on issues where overpayments have been identified.

**D.** Iowa receives and investigates referrals of possible inappropriate payments through maintenance of a reporting hotline. Calls to this hotline are fielded by the SURS staff and either investigated, or referred to the appropriate unit for follow-up.

## II. Case Review

**A.** SURS conducts a Preliminary Review to see if there are any unexplained items or items that require additional documentation review

**B.** If there is no indication of possible problems, or issues that warrant additional investigation, the review is closed. If there are questions related to the claims, appropriate records are requested.

**C.** SURS conducts a full review if records are requested.

## III. Resolution

**A.** If no problems are identified, the case is closed and the provider is thanked for participation.

**B.** If problems are identified, overpayments are recovered. In addition, other actions may be appropriate such as; sending an educational letter, referring suspected fraud cases to MFCU, and working with policy to modify or correct policy that is misleading or confusing.

**C.** Areas in which cost avoidance can be achieved are written up and referred to policy.

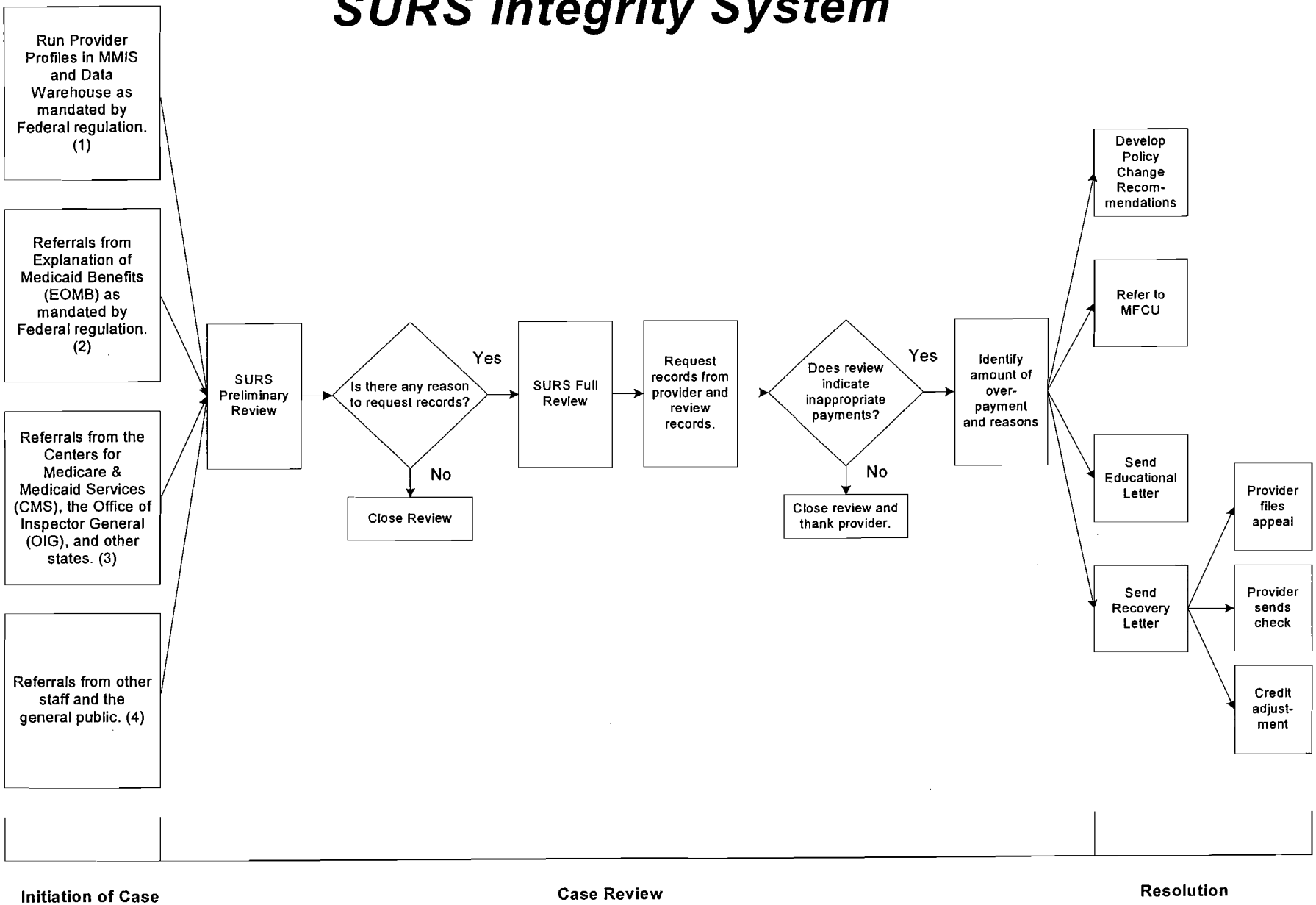
**D.** When a recovery letter is sent to a provider, the provider may

**1.** Contest the finding by filing a request for an administrative hearing,

**2.** Remit the amount due through a check,

**3.** Have the amount due recovered through recovery from future claims.

# SURS Integrity System



## RESOURCES UTILIZED BY THE IME SURS UNIT

### I. Human Resources:

A. **Account (Contract) Manager:** Ensures that the SURS unit is managed effectively in coordination with the State, the provider community, Medicaid member community and other IME units to provide excellent SURS services to the State of Iowa. All SURS staff members report directly to the Account Manager.

B. **Quality Assurance Specialist (Registered Nurse):** Ensures effective SURS activity at the operations level. Designs and implements systems for quality control and improvement of SURS processes; ensures accuracy and professionalism in SURS procedures, systems, and in all final products and documents. Identifies systems barriers and issues and implements operational resolutions to current and potential problem areas. Acts in direct support of Account Manager, and services as acting Account Manager in his/her absence.

C. **Review Coordinator (Registered Nurse):** Coordinates reviewers' caseloads and assignments; sorts and distributes scanned incoming documents; specializes in procedural and diagnostic coding systems. Expertise in MMIS claims research.

D. **Review Staff (Eight Total)**
   1. **Registered Nurse Reviewers (Six):** Provide expertise in broad spectrum of healthcare specialties and delivery systems to ensure efficient and effective surveillance and utilization review. SURS reviewers are attentive to detail and accuracy, with a dual perspective alert to subtle trends, potential problem areas, and broader, more complex systems issues.
   2. **Certified Coder/Reviewers (Two):** Trained for comprehensive knowledge of billing/payment codes: procedure codes, diagnosis codes and equipment and supply codes. Skilled in identifying areas of potential inappropriate utilization or over utilization of certain codes, or areas where services or documentation is not support of utilized codes.

E. **Financial Analyst (Certified Public Accountant):** Oversees all financial and billing areas, including Accounts Receivable, for the SURS Unit. Responsible for measurement of projected cost savings related to SURS findings; also projects long-range cost savings for the State related to SURS discoveries and recommended systems or policy modifications. Works closely with MMIS SURS subsystem reports (discussed in next section) to maximize utilization benefits for comprehensive and focused reviews. Works closely with the Database Management Administrator to use management information systems to accurately measure current and projected revenue figures.

F. **Database Management Administrator:** Coordinates utilization of all related database information; translates data requests and desired review foci into data queries, reports and spreadsheets to provide reviewers with accurate focused data to direct the review process. Works closely with the Financial Analyst to use management information systems to accurately measure current and projected revenue figures.

G. **Administrative Assistant:** Supports successful administration of SURS operations working closely with all SURS staff, other IME unit staff and the SURS parent company (Health Care Excel).

## II. Other Resources Utilized in the SURS Process

### A. Management Information Systems and Databases

1. **MMIS:** Comprehensive information system of all claims transactions, providers and members
   a. **MMIS SURS Subsystem:** Complex reporting system involving approximately thirty reports that are run quarterly, monthly or as needed
      i. Provides a federally mandated comprehensive profile of healthcare provider and recipients
      ii. Establishes "normal" or mean" parameters of medical practice, costs, and utilization
      iii. Identifies providers or practices that are aberrant or extreme
2. **Data Warehouse:** Updated, more "user-friendly Medicaid database; utilized for more focused queries and reports which complement and expand upon MMIS reports
3. **COLD (Computer Output to Laser Disk):** An advanced electronic report management (ERM) system that replaces "green bar" printed reports and Computer Output to Microfiche (COM) for storage and retrieval of computer-generated data.
4. **ISIS (Individualized Services Information System):** Processes and tracks Facility and Waiver programs, starting with entry from the ABC (Automated Benefits Calculation System) system through approval or denial.

- Other Iowa Medicaid Enterprise Units: **SURS interfaces and collaborates with all IME Units in all aspects of operation. Most frequently:**

  - **DHS Policy Unit:** Meet semi-weekly with representative leadership, along with representative of the Medicaid Fraud Control Unit (MFCU). Discuss impact of Policy on SURS review foci and findings, as well as possible impact of findings on Policy
2. **Core:** Work closely with Core Unit staff to modify parameters and statistical indicators of SURS Subsystem to maximum utilization and application. Also work with Core for to rectify identified "holes" in the claims processing system, discovered by trends in findings of SURS reviews. Work closely with mailroom and OnBase to track requested medical records and other key correspondence.
3. **Provider Services:** Collaborate on educating providers on areas of common error or confusion; offer training on upcoming changes, or areas of policy that are undergoing "clean up" or focus
4. **Medical Services:** Consult with and refer cases that are primarily questions of "medical necessity"; also consult regarding medically focused policy language or Iowa Administrative Codes and rules

## C. Infrastructure and Support from Contractor agent, "Health Care Excel" (HCE)

1. HCE is a healthcare Quality Improvement Organization (QIO), and certified by the highly regarded "International Standards Organization".
2. The HCE Division, "Center for State and Specialized Contracts" specializes in Medicare and Medicaid programs in multiple states. The HCE SURS program is highly regarded as a leader in SURS activity.

## D. Codes and Rules (largely through Internet access and reference manuals)

1. Iowa Code and Iowa Administrative Code and Rules
2. Provider Manuals
3. Diagnosis Codes (ICD-9)
4. Procedure Codes (CPT)
5. Healthcare Common Procedure Coding System (HCPCS)

## IME-SURS

## GENERAL REASONS FOR RECOUPMENT FROM MEDICAID PROVIDERS

Many of the issues reviewed and/or discovered in provider reviews are listed in the "Summary of Provider Reviews" table, which is included at the end of this document. The following list demonstrates common reasons for provider recoupment.

### Provider error

Coding Issues

- Upcoding (coding for services with higher reimbursement than for the services actually provided)
- Inappropriate coding
- Inappropriate use of coding modifiers
- Errors around global charges
- Inaccurate codes for disposition of patient at discharge from hospital

### b. Documentation Issues

- Insufficient documentation to support claim
- No documentation for services billed

**Other issues may be traced back to vague or outdated language in Iowa Code, Administrative Rules, or Policy Manuals.** Some examples include the following.

No rule requiring vendors of medical supplies to obtain refill requests before sending the member additional supplies

No rule disallowing nursing facilities to bill for durable medical equipment, even though those costs are included in their "global" payment

No rule to specifically require providers to submit requested medical records for SURS review within an identified time limit (proposal now for thirty day requirement)

Other issues may be traced back to issues with the MMIS Payment system.

No programming edit to deny claims from meal providers who charge for more meals than are authorized by policy

No programming edit to disallow a provider to use a modifier code that pays additional dollars for multiple procedures, when only submitting a claim for a single procedure

**A.** Other issues may point to larger or complex IME systems or multi-unit issues

**A.** Identification of need for a procedure to eliminate continued payment of claims to provider numbers of deceased providers, after the date of death

**B.** Consideration of the number of days IME pays for "bed holds" in nursing facilities while also paying for an acute care stay (higher limit in Iowa than in other states)

**C.** Consideration of a provision for an informal appeals process before a provider requests a formal appeal with the Department of Inspections and Appeals, which is a very costly process

**V.** **A final facet of the SURS process is the ability to identify provider fraud.** These cases are not handled by the IME, they are immediately referred to the Iowa Medicaid Fraud Control Unit (MFCU) as required by federal law. In some cases, there can be administrative findings (for recoupment of the actual overpayments to the provider) as well as criminal findings and punitive damages.

# REVENUE AND COLLECTIONS`

# Revenue Collections Overview

- Third Party Liability Identification & Recovery
- Other Insurance Verification
- Estate Recovery/Miller Trust Identification & Recovery
- Lien (Casualty) Identification & Recovery
- Iowa Care Premium Posting

# Third Party Liability Identification and Recovery

Results July-December, 2005

•Total Recoveries $11,405,949

Recovery Strategies

•Data feeds from Insurance Carriers
•Data match for paid Medicaid Claims vs. unreported TPL primary coverage
•Billing Process to Insurance Carriers, now 80% electronic submissions, includes pay & chase
•Posting recovery payments to MMIS, now automated datafeeds to adjust MMIS claim history
•Update MMIS with new coverage information for future cost avoidance

# Insurance Verification

Results July-December, 2005

•More than 5,000 referral forms have been processed
•Cost Avoidance due to TPL $55,908,189

Cost Avoidance Strategy to update other insurance coverage information

•Referrals from SIQs, leads letters, phone calls from Providers
•Capture information electronically in a database
•Transfer into calling tool for verification
•Load verified insurance information into the MMIS TPL Resource subsystem

# Estate/Miller Trust Identification and Recovery

Estates per Iowa code Section 249A.5 (2)
Miller Trusts per Iowa code Chapter 633C

Results July-December, 2005

•Total Recoveries $6,309,984

Recovery Strategy

•Identify deceased and potential assets for recovery
•Enter/track case in case management software
•Caseworkers work case
•Case is settled or disputed

# Lien (Casualty) Identification and Recovery

Results July-December, 2005

•Total Recoveries $1,056,693

Recovery Strategy

•Identify casualty/trauma cases
•Enter into case management software
•Caseworker works case
•Case is settled or disputed

# Iowa Care Premium Posting

Results July-December, 2005

- Average 6500 statements now processed per month
- Total premium payments posted $351,539

# Revenue Collections FY2006 Projections for State Dollar Savings

- Target for FY2006 State dollars $32,520,491 (15% increase over FY2004)
- Fiscal year-to-date State dollars as of 12/31/05 $26,762,164