Medicaid Cost Containment Initiatives –SFY2016-SFY2017

1. Strategy: IME Program Integrity Pre-Payment Editing

Total Savings: $1,100,000

General Fund: $500,000

Summary: The Iowa Medicaid Enterprise (IME) Program Integrity (PI) Unit will create and maintain a pre-payment edit process based on a series of analytics and predictive modeling. This will enhance the current editing in MMIS instead of the less efficient pay-and-chase processes currently in place.

This pre-payment editing process will reduce the incidents of pay-and chase claims where the provider is paid and then IME staff must follow the claim to recoup overpayments. By denying the claim up front based on these models, we anticipate better use of staff resources, and more stability in payments for providers. We also anticipate that providers will change their billing based on this new process, further reducing problem claims.

2. Strategy: Reduce Home and community based service costs

Total Savings: $13,340,000

General Fund: $6,000,000

Summary: The Department has initially proposed the following strategies to achieve the goal of saving $6M.

- For all HCBS Waiver transportation rates, establish $0.575 as the rate per mile (2015 IRS mileage rate) and $9.29 as the limit per one way trip (current statewide average). Savings estimated to be $1.1M. Waiver recipients will continue to have non-emergency medical transportation (NEMT) for medically necessary transportation to medical services.

- Cap the total costs of all services received by an ID Waiver recipient to the daily ICF/ID per diem rate of $346.39 per day based on the 80th percentile of all ICF/ID rates. Savings estimated to be $1M.

- Carefully review individual requests for exceptions to policy and align with capped cost of services noted above. Savings estimated to be $1M.

- Utilize the Supports Intensity Scale (SIS) to determine payment amounts for the services provided to adults served in the ID Waiver. As SIS is implemented, utilize the data in combination with an established tiered payment system to determine payments. The top tier amount would be limited to the ICF/ID Payment rate. This resource allocation process will include methods for addressing members' needs which require resources that go beyond the capped limit. Savings estimated to be $2.5-$3M.

3. Strategy: Implement Consumer Directed Attendant Care transition to Personal Care Attendant Services beginning July 1, 2015.

Total Savings: $2,200,000

General Fund: $1,000,000

Summary: Beginning July 1, 2015, the Department will require services through the Consumer Directed Attendant Care (CDAC) option to be provided through an agency or consumer choices option. After extensive review and negotiation during the 2014 legislative session, Iowa 2014 Acts, chapter 1068, sec 1(1a) allows the Department to implement this change effective July 1, 2016. This proposal recommends moving up the implementation by one year.

The Department will retain the consumer choices option for those individuals able, and desiring, to self-direct services. An individual providing services to a member under a Home and Community-Based Services (HCBS) waiver in effect on June 30, 2015, may continue to act as an individual provider under the agreement.

4. Strategy: Systems of Care funding reallocated to Integrated Health Home

Total Savings: $1,600,000

General Fund: $1,600,000 (100%)

Summary: Funding for community-based Systems of Care (SOC) services for non-Medicaid children and youth with a serious emotional disturbance will be reallocated to the Medicaid program to support Integrated Health Home (IHH) services for Medicaid-eligible children with a serious emotional disturbance.

- There are currently four programs that receive SOC funding through 100% state appropriations. The programs serve 14 counties. The University of Iowa Community Circle of Care (CCC) serves 10 counties in northeast Iowa, the

Central Iowa System of Care (Orchard Place) serves Polk and Warren Counties, the Four Oaks System of Care serves Linn and Cerro Gordo Counties, and Tanager Place serves Linn and surrounding counties.

- During SFY14, the combined programs served 1,181 children and youth.
- Each of the recipients of SOC funding is also a Pediatric Integrated Health Home (P-IHH) and provides IHH services to Medicaid members. The P-IHH programs operate using System of Care practices and principles.
- Prior to the introduction of the IHHs, the SOC funding supported both Medicaid and non-Medicaid eligible children as care coordination was not funded by Medicaid or private insurance.

5. Strategy: Complex Pharmaceutical Oversight Program (CPOP)

Total Savings: $2,000,000 - Includes Iowa Health and Wellness Plan (IHWP)

General Fund: $700,000

Summary: Effective January 1, 2015, CPOP will provide oversight of clinically complex and high-cost drugs. This effort is designed to reduce waste, enhance medication adherence and improve clinical outcomes. It is a quality assurance/program integrity process that provides a comprehensive assessment of drug utilization, prescribing and dispensing patterns. Members, pharmacies and prescribers may be contacted.

The Complex Pharmaceutical Oversight Program (CPOP) is intended to provide increased, targeted oversight of clinically complex and high-cost drugs and their members. Expenditures for these complex specialized drugs are expected to increase by 65% between mid-2013 and the end of 2015. By 2016, these drugs will account for seven of the top ten selling drugs in the U.S. The CPOP is a coordinated program aimed at ensuring that these costly drugs are used only in the most clinically appropriate manner ensuring best clinical practices and outcomes while also helping blunt the significant financial impact that these drugs can have on the IME's pharmacy spend. Calendar year 2015 will represent the pilot period for this new program.

The CPOP uses techniques that are not feasible for traditional PA programs, which are designed to cover a broader range of drugs and larger number of patients. The drugs and Iowa Medicaid lives targeted by the CPOP are so costly (with many over $300,000 per year for one drug and one patient) and pharmacologically complex that a more thorough clinical evaluation of each patient prior to, during and after treatment is warranted, both financially and clinically.

6. Strategy: National Average Drug Acquisition Cost (NADAC)

Total Savings: $1,100,000

General Fund: $400,000

Summary: Drug reimbursement is a state set Actual Average Acquisition Cost (IA AAC). NADAC is the Centers for Medicare and Medicaid Services (CMS) program that provides average drug acquisition costs based on invoice costs from national pharmacy surveys. Changes to NADAC may or may not need to remove the Federal Upper Limit (FUL) portion of reimbursement.

The current methodology of drug reimbursement is a state set Actual Average Acquisition Cost (IA AAC) and if an AAC does not exist for a drug reimbursement the claim reimburses at Wholesale Acquisition Cost (WAC) plus zero. When an IA IAAC and a WAC rate are not available, the rate setting contractor develops a rate based on published data and provider invoices.

The recommendation is to change to the National Average Drug Acquisition Cost (NADAC) and assess retaining the Federal Upper Limit (FUL) in the reimbursement. NADAC is the Centers for Medicare and Medicaid Services' (CMS) program that provides average drug acquisition costs based on invoice costs from national pharmacy surveys. This is similar to the Iowa (IA) AAC reimbursement but IA Medicaid can use the national data rather than doing state specific invoice collection and rate setting for the drugs on the NADAC. During the 2014 Legislative session, HF 2463 provided the Department with the authority to utilize a reimbursement based on NADAC if implemented by CMS.

If CMS implements the Average Manufacturer Price (AMP) based FULs in their current form, the recommendation is to remove the FUL from the reimbursement methodology. Pharmacy providers will be reimbursed at NADAC, not at an FUL rate below their acquisition. However the regulation by CMS will not be final until at least April 2015.

Rates still need to be set by the rate setting contractor for those drugs without a NADAC or WAC.

7. Strategy: Increase Nursing Facility (NF) Quality Assurance Assessment Fee (QAAF), to be 3% of Non-Medicare Revenue – SFY2016

Estimated savings:

	Total	Federal	State
Assessment Fee Revenue	($7,509,555)	$0	($7,509,555)
Assessment Fee Expenditures	$8,071,154	$4,440,749	$3,630,405
Net Impact	$561,599	$4,440,749	($3,879,150)

Summary: This strategy was implemented as a way of funding a portion of the nursing facility rebase included in the Governor's budget recommendation. The nursing facility

(NF) assessment fee is increased to 3% of non-medicare revenue. The NFs pay the assessment fee for each private pay and Medicaid bed day. The NFs are held harmless on fees paid for Medicaid bed days. These fees, and an additional premium, are passed back to the NFs for each Medicaid bed day. The state is able to draw federal match on the funds. This results in an estimated net increase in Medicaid revenue of $3,879,150. This revenue can then be used for other Medicaid expenditures.
This strategy does require CMS approval.

Note: The current federal assessment rate threshold is 6 percent, and lowering this threshold has been proposed as a way to reduce the federal deficit. Therefore, the savings may not be sustained if the federal government opts to lower the threshold in the future.

8. Strategy: Combine Hospital Readmission within 30 days of Discharge for Same Diagnosis Related Groups (DRG) – SFY2016-SFY2017

Total savings: $1,100,000

General Fund: $500,000

Summary: This initiative provides incentive for hospitals to ensure appropriate discharged planning and care coordination for patients.

When a provider discharges a patient too early and/or without proper support, and the patient is subsequently readmitted, the provider can currently receive two full DRG payments for claims that are more than 7 days apart. Under this strategy, the Department would remove the second full DRG payment by combining the two claims, where appropriate, to encourage better discharge planning to mitigate readmission. While this can result in longer hospital stays for a small number of patients, the state will realize savings as a result of preventing expensive readmissions.

Many payers including Medicare are instituting this type of incentive for hospitals for appropriate discharge planning and coordination to ensure appropriate follow up care. Iowa Medicaid implemented a 7 day readmission with the same DRG in SFY 2013 and realized about $850,000 in total savings in SFY 2014. Under this proposal the time frame is moved to 30 days, which is consistent with Medicare, from an original and readmission claim to be combined resulting in one DRG payment. In many cases, the savings will equal the entire amount of the second hospital claim.

9. Strategy: University of Iowa Hospitals and Clinics (UIHC) to fund a larger portion of the state share of their Enhanced Disproportionate Share Hospital (DSH) Payments

Estimated savings:

Funding	Total $$	Federal $$	State $$	Other $$
Current	$10,044,006	$5,531,234	$4,512,772	$0.00
Proposed	$10,044,006	$5,531,234	$0	$4,512,772
Net Difference	**$0**	**$0**	**($4,512,772)**	**$4,512,772**

Summary: UIHC receives a supplemental DSH payment in the amount of $26,633,430. The state share of $19,133,430 is funded by the Medical Assistance appropriation and the state share of the remaining $7,500,000 is funded by UIHC.

The legislature appropriates funds to pay for the state share of the $19,133,430 DSH payment. This cost will be $8,596,650 in SFY16.

This recommendation will increase UIHC's state share responsibility by $4,512,772, which will reduce the Medical Assistance state cost to $4,083,878. UIHC will need to either certify public expenditures or transfer the $4.5 million to the Medical Assistance program to operationalize this change. This will require funding to be changed in the appropriation bill.