

Idaho's Medicaid Program: The Department of Health and Welfare Has Many Opportunities for Cost Savings

November 2000

As Performed Under Contract by
The Lewin Group and
Sjoberg Evashenk Consulting, LLC



Office of Performance Evaluations
Idaho State Legislature
Report 00-05

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Idaho's Medicaid Program: The Department of Health and Welfare Has Many Opportunities for Cost Savings

November 2000

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Report 00-05

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At the direction of the Joint Legislative Oversight Committee, and upon the request of the Joint Finance-Appropriations Committee, we have overseen an evaluation of Idaho's Medicaid program. The evaluation, conducted by Sjoberg Evasheik Consulting, LLC, and The Lewin Group, addresses concerns about rising Medicaid costs as deliberated at length during last legislative session.

We are pleased to submit the completed evaluation for your review: *Idaho's Medicaid Program: The Department of Health and Welfare has Many Opportunities for Cost Savings*. As shown in the report, the consultants have identified opportunities for the state to benefit from \$4.7 and \$6.7 million in cost savings each year. The evaluation also responds to specific concerns related to Idaho's high Medicaid administrative costs and the Medicaid certification of veterans' homes.

Consistent with law and practice, the Department of Health and Welfare's response to the evaluation may be found at the end of the report. The department has concurred with each of the recommendations and provided a caution in the implementation of one of them.

We appreciate the professionalism and efforts of the consulting firms and wish to acknowledge the high standards of independence and documentation to which they adhered throughout the evaluation. We are additionally grateful for the full cooperation received from the Department of Health and Welfare, the Division of Veterans' Services, and others who contributed to this evaluation.

Sincerely,

A handwritten signature in cursive script that reads "Nancy Van Maren".

Nancy Van Maren



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November 15, 2000

Ms. Nancy Van Maren, Director
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Dear Ms. Van Maren:

The Lewin Group together with Sjoberg Evashenk Consulting is pleased to submit our final report entitled, "*Idaho's Medicaid Program: The Department of Health and Welfare has Many Opportunities For Cost Savings.*" As discussed in our report, we assessed Idaho's management, oversight, and administration of its Medicaid program in key areas including utilization management, fiscal and budgetary control, veterans' homes, and Medicaid automated systems.

This report concludes that Idaho has experienced cost increases in Medicaid services, such as mental health, developmental disability, nursing facilities, and pharmaceuticals, that outpace much of the rest of the country. However, our review of Idaho's Medicaid program revealed several opportunities to accrue between \$4.7 and \$6.7 million in state Medicaid savings. Specifically, we found that the Department of Health and Welfare could realize these savings by instituting a statewide expansion of its Healthy Connections program, obtaining Medicaid certifications for its veterans' homes, and capturing and billing administrative costs at higher federal participation levels. Other savings could accrue from reducing dispensing fees paid to participating pharmacists, increasing the discount on drug reimbursements, and requiring beneficiaries to pay a minimal co-payment for drugs.

Additionally, we believe that better utilization management techniques over mental health, developmental disability, nursing facilities, and inpatient services will result in more consistent and effective service. And while more effective protocols should accrue cost savings, we were unable to quantify the potential results of these efforts. Finally, the Department of Health and Welfare could improve its automated management information reporting and access to the automated system to enhance users' ability to manage and conduct Medicaid program activities.

We appreciate the opportunity to have been of service to the Office of Performance Evaluations and it has been our pleasure to work with you. We also appreciate the full cooperation we received from all those who assisted us throughout the course of our evaluation including the Idaho Department of Health and Welfare, the Idaho Division of Veterans' Services, and your staff.

Respectfully submitted,

Charles Milligan, Vice President
The Lewin Group

Kurt Sjoberg, Partner
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Executive Summary

Idaho's Medicaid Program: The Department of Health and Welfare Has Many Opportunities for Cost Savings

The provision of health care in America to the uninsured and underprivileged remains a critical issue to government leaders. Medicaid is the federal government's flagship program for ensuring the provision of medical care for the poor and disabled. Since its enactment in 1965, the costs of the program have continued to rise; in the last decade, due to a number of factors, costs have escalated at a much greater pace than in the past.

States deliver the Medicaid program to the beneficiaries and are required to provide state funding at prescribed participation levels. Idaho's Medicaid spending exceeded \$623 million for the fiscal year 2000. The Department of Health and Welfare (DHW), the department responsible for administering the program, estimates its program costs alone will increase more than 37 percent in the upcoming year, to an all-time high of \$786 million by 2002. While the federal government will bear the majority of these costs, Idaho taxpayers will fund nearly 30 percent of the total.

Idaho has experienced increases in mental health, developmental disability, nursing facilities services, and pharmaceuticals that outpace much of the rest of the country. With the trends in health care rising and limited resources available to fund the programs, the DHW and the Legislature must make difficult decisions to address Idaho's Medicaid challenges. Unless reforms are implemented and cost containment efforts are adopted and embraced at all levels of service delivery, the Medicaid budget will continue to grow.

Our review of Idaho's Medicaid program revealed several opportunities to reduce and avoid costs, increase federal reimbursements, and improve program delivery. Our report includes a variety of recommendations, some of which will generate savings of avoided costs as shown in Figure 1, while others will improve operations and services. However, these

Idaho's Medicaid spending exceeded \$623 million in fiscal year 2000, with estimates of program costs increasing 37 percent next year.

recommendations alone will not solve Idaho’s budget crisis. The following highlights the more significant issues we identify:

Expanding Healthy Connections can generate \$1.3 to \$3.1 million annually.

- Instituting a statewide mandatory expansion of its Healthy Connections program the state can achieve savings ranging from \$1.3 to 3.1 million annually, while providing quality care and a “medical home” to the participants.
- Obtaining Medicaid certifications for each of its three veterans homes will accrue a net savings, once fully implemented, of approximately \$1.6 million each year.
- Capturing targeted case management costs and information systems efforts separate from administrative costs will allow the state to bill them at a higher federal participation level—potentially recovering from the federal government an additional \$1.6 million annually.
- Reducing dispensing fees paid to participating pharmacies to reflect the regional average could generate annual state savings of \$153,000. Adopting an even more progressive approach, such as a sliding scale based on volume, could accrue additional savings.
- Increasing the discount one percent on drug reimbursements to pharmacists has the potential of annual savings ranging between \$125,000 and \$375,000.
- Requiring beneficiaries to pay a minimal fifty-cent to one dollar co-payment for drugs could reduce spending by at least \$200,000.
- Enhancing drug utilization management techniques such as pre-authorization for pharmaceuticals with generic equivalents will help control costs and minimize over utilization.
- Stronger utilization management protocols over developmental disability, mental health, case management, nursing facility and inpatient services will improve effectiveness and should reduce costs.
- Improved automated management information reporting and access will enhance users’ ability to manage and conduct program activities.

Reducing drug dispensing fees, adding to the discount on reimbursements, and requiring a modest co-payment could generate state savings of \$383 thousand annually.

While the state has many opportunities to improve its program while controlling the costs, stakeholders with varying interests and concerns accompany each initiative. The decisions are difficult but aggressive change is needed to help contain spending increases—therefore, each group, be it the state, providers, beneficiaries, or advocates, will be challenged to compromise for the good of the program overall.

Figure 1: Potential Cost Savings for the Idaho Medicaid Program

<u>Opportunity</u>	<u>Total Annual Cost Savings</u>	<u>State Medicaid Share Annual Cost Savings</u>
Statewide expansion of Healthy Connections	\$4.6 million to \$10.3 million	\$1.3 million to \$3.1 million
Conversion of Veterans' Homes to Medicaid	N/A	\$1.6 million
Administration:		
Capturing targeted case management separate from administration	N/A	\$1.3 million
Capturing information services separate from administration	N/A	\$218,000
Billing skilled medical professionals at appropriate federal rate	N/A	\$52,000
Pharmaceuticals:		
Reduce dispensing fees	\$511,000	\$153,000
Increase discount on drug reimbursements	\$125,000 to \$375,000	\$37,500 to \$112,500
Institute minimal co-payments	\$200,000 to \$393,400	\$60,000 to \$118,000
Total Annual Savings	\$5,436,000 to \$11,579,400	\$4,720,500 to \$6,653,500

Source: The Lewin Group analysis of data collected from the Department of Health and Welfare, federal Health Care Financing Administration, and other industry sources.

Introduction

Idaho's Medicaid Program

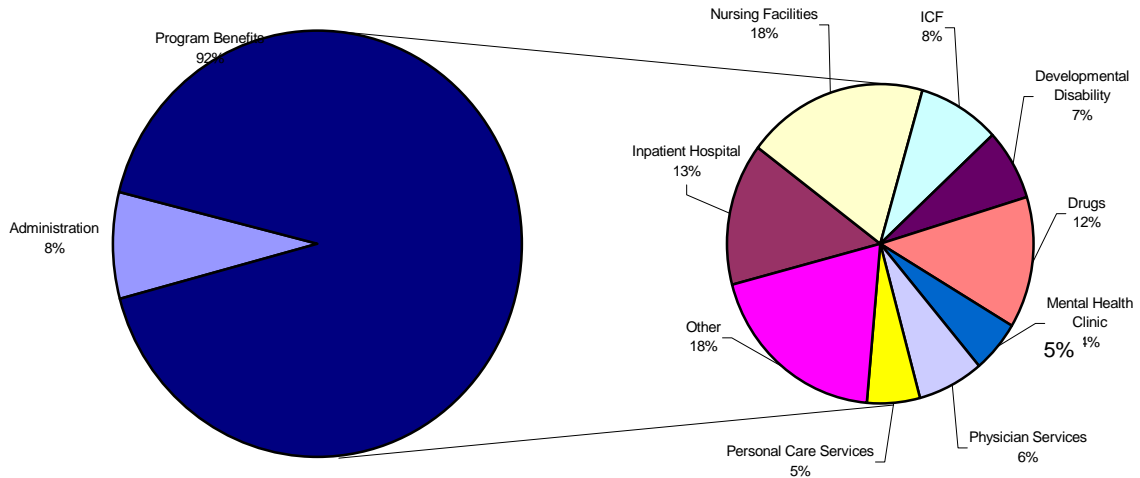
In 1965, Congress passed legislation establishing the Medicaid program as Title XIX of the Social Security Act in response to the widely perceived inadequacy of “welfare medical care” under public assistance. Under this program certain vulnerable and needy individuals and families meeting specified eligibility criteria related to low incomes and resources, such as pregnant women and children, are entitled to Medicaid assistance. States also have the option of providing Medicaid coverage to other eligible groups such as the elderly and people with disabilities.

To administer services under the Medicaid program, Idaho must formulate and describe its health care approach annually in the state plan submitted to the federal government for approval. Under this plan defining the nature and extent of health care services available to Medicaid recipients, Idaho must establish eligibility standards; determine the type, amount, and scope of services; and set the rate of payment for services that it proposes to offer as part of its Medicaid plan. Since its inception, Idaho's Medicaid program has grown to approximately 100,000 individuals receiving health services such as hospitalization, nursing home care, prescription drugs, and treatment of other medical conditions as defined in the state plan.

With seven regional service centers, the Department of Health and Welfare (DHW) administers Idaho's Medicaid program and is charged with ensuring effective use of the limited resources. Combining both state and federal funding sources, the total Medicaid spending in state fiscal year 2000 was over \$623 million while projections for program costs alone (exclusive of administration) are expected to increase by 37 percent to nearly \$786 million by fiscal year 2002. Figure 2 highlights some of Medicaid's larger spending categories, while Appendix A provides more detail on Medicaid spending.

**Since 1965,
the federal
Medicaid
program has
served the
medical
needs of
needy
individuals
and families.**

Figure 2: Medicaid Spending During Fiscal Year 2000



Source: MMIS Ad hoc report, Actual and Forecasted Medicaid Expenditures, Fiscal Years 2000–2002; Idaho Department of Health and Welfare, Bureau of Financial Services, spreadsheet: *Medicaid Costs by Category, 7/1/99–6/30/00*.

Cost-Sharing Arrangements and Waivers

In Idaho, the federal government provides 70.76 percent of every dollar spent on direct services and 50 percent for most administration.

Program expenditures of a state’s Medicaid program are reimbursed at different rates depending on that state’s formula. Each year, the federal government calculates a new federal participation rate for each state using a formula driven by a state’s population designed to reflect differences in each state’s program needs and capacity to finance them. In Idaho, the federal participation rate—also known as the federal match—for the current federal fiscal year 2001 is 70.76 percent for direct program services and 50 percent for most administrative costs. To receive the federal portion, states must contribute the remaining “match” to cover the full cost. Medicaid funds are not paid directly to clients, rather they reimburse each state, which Idaho in turn distributes to more than 14,000 providers including nursing homes, hospitals, physicians, pharmacies, and many others.

While the federal government requires state operated Medicaid programs to follow numerous regulations, mandates, and guidelines, it also allows for seeking certain waivers from complying with specified federal provisions. Waivers are intended to provide the flexibility needed to enable states to try new or different approaches for the efficient and cost-effective delivery of health care services, or to adapt their programs to the special needs of particular areas or groups of beneficiaries. These waivers allow states to implement innovative programs or activities on a time-limited basis subject to safeguards for the protection of beneficiaries. For instance, the federal Health Care Financing Authority (HCFA) granted Idaho a waiver to limit beneficiaries' choice of providers and link volunteer Medicaid beneficiaries with specific primary care providers as part of its Healthy Connections program. Additionally, Idaho has received an approved waiver to provide an array of home and community-based services—such as personal care, grooming, or special communication services—to beneficiaries who would otherwise need inpatient care furnished in a hospital, intermediate care facility, or skilled nursing facility, thus permitting individuals to avoid institutionalization.

Mandatory Versus Optional Benefits

To receive federal funding, states must agree to provide certain mandatory health benefits to eligible Medicaid beneficiaries such as inpatient and outpatient hospital services, prenatal care, doctor's office visits, laboratory and x-ray, and home health care as shown in Figure 3. In essence, the state does not have the discretion to eliminate these benefits. According to the department, in state fiscal year 1999, Idaho spent the majority of its Medicaid program budget—nearly 65 percent or \$324 million—on these *federally* mandated benefits. Additionally, Idaho provides *state* mandated services (required through state statutes) such as personal care services—including basic care and grooming, cooking, and grocery shopping—adult dental care, adult prescription drugs and intermediate care facilities. During 1999, Idaho spent over \$123 million, or nearly 25 percent of its Medicaid budget, on state mandated benefits. Given that 90 percent of Medicaid benefits are required by federal or state mandate, the DHW does not have the authority to eliminate more than 10 percent, or a total of \$52 million, of the Medicaid services currently offered. However, it does have the flexibility to limit the level of services provided, such as the number of dental visits

A majority of Idaho's Medicaid program budget—nearly 65 percent—is spent on federally mandated services.

allowed in a calendar year and provider reimbursement rates. Currently, the remaining 10 percent is spent on several optional services such as mental health, developmental disabilities, and nursing facility services for adults.

Eligibility

Federal law mandates Medicaid coverage for certain eligible groups such as children at federal poverty levels, adults meeting certain welfare tests, pregnant women with low-incomes, and

Figure 3: Benefits Offered Under Idaho’s Medicaid Program

<u>Benefits</u>	<u>Federal Mandated</u>		<u>State Mandated</u>		<u>State Optional</u>	
	<u>Adult</u>	<u>Children</u>	<u>Adult</u>	<u>Children</u>	<u>Adult</u>	<u>Children</u>
Inpatient hospital	✓	✓				
Outpatient hospital	✓	✓				
Doctor’s office visits	✓	✓				
Lab and x-ray	✓	✓				
Dental services		✓	✓			
Home health services	✓	✓				
Nurse-midwife	✓	✓				
Nurse practitioner	✓	✓				
Pregnancy-related	✓	✓				
Family planning	✓	✓				
Optometric		✓	✓			
Transportation	✓	✓				
Pharmacy		✓	✓			
Nursing home	✓	✓				
ICF/MR		✓	✓			
Therapies		✓			✓	
Personal care		✓	✓			
Mental health services		✓			✓	
Developmental disabilities services		✓			✓	

Source: 42 C.F.R. § 440.210 and 441 et. al. (2000); Idaho Department of Health and Welfare, *Facts/Figures/Trends 1999–2000*.

people who are aged, blind, or disabled meeting poverty guidelines. However, states have the option to extend coverage to other groups defined by federal law. Currently, Idaho has elected to serve children requiring intermediate or nursing home care and all individuals meeting eligibility criteria for needing home and community based waiver services not required by law. However, the relative effect of covering these optional groups is minimal, totaling less than 6 percent of the entire Medicaid budget.

Increasing numbers of beneficiaries may account for some of the recent growth in Idaho's Medicaid expenditures. This, combined with the department's intense outreach efforts to enroll children, may have contributed to growth in the population of Medicaid participants to nearly 100,000 as of June 2000. During the last fiscal year alone, the department added nearly 16,500 children to its Medicaid program for which services cost approximately \$25 million.

Previous Medicaid Reform Efforts

Fearing escalating costs within the Medicaid program in 1996, then Governor Batt established the Governor's Medicaid Reform Advisory Council to study the program and develop options for reform. Guided by ten overarching principles, the council designed specific reform initiatives as a framework to allow the Idaho Medicaid program to fulfill its mission and provide a blueprint for future decisions to follow. One principle called for the department to pursue private insurance or capitated options for Medicaid beneficiaries where cost-effective, while another principle encouraged the department to emphasize home and community-based services for the elderly and individuals with developmental disabilities, physical disabilities, and mental illness. Still other principles sought to tighten prescription drug reimbursement policies by ensuring the methods are the most cost-beneficial to the state and recipients, encouraging spending on direct services rather than on administrative functions, and strengthening fraud and abuse processes. However, the council cautioned that many of the recommended solutions could take several years to fully develop and implement. Based on the council's proposals, the Governor unveiled his package for Medicaid reform in May 1997 containing 34 consolidated proposals and including 84 recommendations from the council's report.

Medicaid reform efforts have been underway since 1996, with significant actions taken by the Legislature in

The Office of Performance Evaluations was charged with contracting with outside experts to conduct the evaluation.

In early 2000, the Idaho Legislature’s Joint Finance-Appropriations Committee established a task force to again review cost containment options for the Medicaid program. Working with representatives from the DHW, the committee was tasked with finding a solution to a significant budget shortfall in the Medicaid program. After several meetings and analyses, the committee identified some potential cost-saving options—many originally identified by the department. In April 2000, the Legislature adopted several of these options and created new budget intent language directing the DHW to take certain actions implementing Medicaid cost control measures. As shown in detail in Appendix B, the Legislature approved intent language designed to reduce the budget in several specific areas including generic drugs, targeted case management services, mental health services, developmental disability services, state veterans homes, client cost-sharing, and administration. In total, it was anticipated that approximately \$27 million, or 4.5 percent, of state and federal funds would be reduced from the proposed Medicaid budget for fiscal year 2001.

As discussed throughout this report, we examined several of these recent initiatives as they related to areas included as part of our review. In these instances, we assessed the DHW’s progress toward implementing the proposed cost savings and cost containment efforts identified in the intent language. However, we did not assess other initiatives outside the scope of our evaluation or those constituting a small portion of Medicaid spending, such as transportation-related initiatives comprising only 1.3 percent of spending.

Scope and Methodology

In April 2000, the Joint Finance-Appropriations Committee appropriated \$600,000 to the Office of Performance Evaluations to evaluate the state’s Medicaid program in light of growing budgetary concerns, with the understanding that this evaluation would be conducted largely by outside experts. To gather input on the scope of the Medicaid review, the Office of Performance Evaluations contracted with a private consultant to conduct a series of stakeholder interviews and focused group discussions with Medicaid beneficiaries, advocates, providers, and state staff. Subsequently, the Office of Performance Evaluations contracted with The Lewin Group, national health care specialists, and Sjoberg Evashenk Consulting, LLC, a government-consulting

firm, to conduct the evaluation. The purpose of our evaluation was to provide an independent examination of the state's management, oversight, and administration of Idaho's Medicaid Program. Our study's scope was developed to assess key program and administrative areas, including utilization management, administrative operations, fiscal and budgetary control, veterans homes, and Medicaid automated systems. However, due to resource constraints, we were unable to include program analysis in the area of provider reimbursement within specific Medicaid program areas. Refer to Appendix C for the evaluation scope approved by the Joint Legislative Oversight Committee in June 2000.

To gain an understanding of the Medicaid program and Idaho's administration of the program, we met with DHW representatives from executive management and their staff, the Medicaid Division, regional directors, and regional program managers. Additionally, we met with legislative leaders, Medicaid directors in other states, state vendors and contractors, and other national researchers to garner their perspective and knowledge. Finally, we ascertained the insight and opinions of other stakeholders such as representatives of the federal Health Care Financing Authority (HCFA), and Office of the Inspector General.

In addition to numerous interviews conducted, we reviewed federal and state laws, rules, and regulations related to all aspects of the Medicaid program including state legislative intent language introduced in 2000 as House Bill 797. Also, we reviewed other Medicaid studies, focus group reports, and previous cost containment efforts. We researched best practices and reviewed existing reports and studies conducted by the DHW, other states, and entities at the federal level on topics such as utilization management, prescription drug programs, automated Medicaid management systems, and fraud investigations. Additionally, we critiqued other program documents such as DHW policies and procedures, Idaho's state plan, and waivers for home and community-based services and internal fraud units. Moreover, we analyzed fiscal records, budgetary documents, random moment time studies, cost allocation plans, and raw claims data extracted from state systems.

We assessed the department's Healthy Connections program through interviews with stakeholders such as program managers, regional representatives, and federal HCFA representatives and

examined documents including primary care case management waiver, policy and procedure manual, enrollee and provider handbooks, national best practice guides, and customer satisfaction surveys. Additionally, to evaluate reported program cost savings, we analyzed the department's cost avoidance methodology and assumptions behind its projections. Moreover, we obtained a claims data extract and conducted an in-depth analysis of the actuarial equivalence between the populations enrolled in Healthy Connections and the rest of the Medicaid population enrolled in traditional Fee-for-Service programs.

To understand the full range of impacts associated with a shift to Medicaid funding of the Veterans' program, we interviewed executive management and staff from the Idaho Division of Veterans' Services, representatives from various advocacy groups, individual veterans, and external consultants assisting the department in their conversion efforts. Additionally, we reviewed budget documents, proposed legislation, eligibility requirements, and expenditure data. Using the department's forecasted cost and revenue projections, we assessed the reasonableness of estimates and the related assumptions.

Additionally, we compared the department's administrative costs to other states using the most recent federal expenditure and utilization reports published by HCFA. Further, to look for opportunities for administrative cost savings, we reviewed fiscal summaries, cost allocation plans, results from the most recent random moment time study, and job descriptions. We also sought best practices from other states to discern whether Idaho could benefit from some of their Medicaid administrative methods.

To evaluate the DHW's utilization management controls over the areas of developmental disabilities, mental health, prescription drugs, skilled nursing facilities, and acute care hospitals, we reviewed department policies and procedures, provider manuals, minutes from mental health committee meetings, preauthorization lists, departmental audits, drug utilization reviews, benefit packages, and user manuals for some of the department's automated systems. We reviewed literature such as the 1998 state data book on long-term care and market characteristics, industry report on Medicaid home and community based waiver programs, private consultant report on uniform assessment instrument development and results of field test, and medical research.

We used publications prepared by the National Pharmaceutical Council to compare statistics such as Idaho's total drug recipients, total drug payments, prescriptions per client, cost per prescription, and cost per client against the other regional states' data.

Additionally, using federal expenditure and utilization reports, we compared Idaho's performance in the skilled nursing care area with comparable regional states and against national averages for federal fiscal years 1994 through 1998. Specifically, we selected inpatient hospital spending data such as average cost per discharge and length of hospital stay. Further, we evaluated performance data in the skilled nursing area such as vendor payments, length of stay, and number of recipients. Finally, we used a federal Department of Health and Human Services' annual fraud report to compare Idaho's performance in recovering fraudulent payments to other states' performance in this area.

Specific to utilization controls over pharmaceuticals, we analyzed Idaho's annual drug utilization report, HCFA statistical information, federal Office of the Inspector General reports, Idaho's excluded drug list, other states' drug formularies, provider data and utilization trends, prospective and retrospective drug review practices and standards, and provider participation rates. To the extent that adequate data were available, we quantified the fiscal implications of current and recommended practices and identified potential cost savings. In evaluating the effectiveness of existing utilization controls, we compared Idaho to five states in the region: Montana, Wyoming, Colorado, Oregon, and Washington. Most of these states were comparable to Idaho in terms of geographical characteristics, urban and rural population concentrations, number of Medicaid recipients, and proximity to Idaho.

In assessing the DHW's automated systems and data availability, we reviewed and evaluated documentation from central databases, databases developed by regional staff, user and system manuals, resolution manuals, monthly data reports, and ad hoc reports. Additionally, we performed a limited review on system edits and audits, system overrides, claims adjudication authority, and system interfaces. Finally, we reviewed audit reports and data publications.

In evaluating the possible benefits or disadvantages of having an internal fraud unit, we met with key department representatives including the Medicaid director, fraud unit supervisor, and fraud

investigators, Deputy Attorney General, and officials at federal agencies including the Office of the Inspector General and HCFA. Additionally, we reviewed and evaluated the state's fraud waiver, fiscal records, policy and procedure manuals, federal and state task force reports, congressional hearing testimonies, and federal guidelines for addressing fraud and abuse. Moreover, we compared Idaho's performance statistics in terms of fraud recoveries and cases investigated to those from other comparable states. Finally, using the department's fiscal records, we calculated whether the department could realize potential savings from certifying its fraud unit and locating it external to the department.

Chapter 1

Expanding the Healthy Connections Program, Converting Veterans Homes to Medicaid, and Implementing Administrative Opportunities Are Likely to Generate Cost Savings

Chapter Summary

With spending projected to increase nearly 37 percent next year, Idaho's Medicaid budget for health care services will crest at over \$786 million by state fiscal year 2002. The Department of Health and Welfare (DHW) faces a significant challenge to contain these costs while delivering an effective health care program to eligible recipients. Thus, DHW must focus on critical areas affecting the budget including utilization controls and federal reimbursements.

To control Medicaid expenditures, the department has opportunities in three areas to accrue significant savings by expanding managed care techniques, converting the three veterans homes to Medicaid eligibility, and maximizing federal funding related to administrative activities.

For example, a statewide mandatory expansion and increased participation in the Healthy Connections program—Idaho's form of managed care—has potential to save between \$4.6 and \$10.3 million of total Medicaid funds, or between approximately \$1.3 and \$3.1 million in state funds, while providing a “medical home” and consistent care to beneficiaries. In addition, the department's certification of its veterans' homes as Medicaid eligible, while likely to derive savings lower than the Legislature expected during last session, should net \$1.6 million in state savings annually. And, finally, changes to the billing process combined with a state plan amendment to obtain a better federal match rate for case management services could boost federal reimbursements at least \$1.6 million annually.

Many of these options may prove controversial and cause stakeholder concern. These difficult decisions will challenge Idaho's leaders; however, unless aggressive actions are taken and opportunities such as those we present throughout this report are

Savings of between \$4.5 to \$6.3 million in state funds may be achieved by expanding managed care techniques, veterans' home eligibility and federal matching of certain administrative activities.

pursued, Idaho will continue to struggle in containing its costs and controlling its Medicaid budget.

A STATEWIDE EXPANSION OF THE HEALTHY CONNECTIONS PROGRAM WOULD REAP SIGNIFICANT BENEFITS

To contain Medicaid costs, in 1993, DHW developed and implemented an alternative health care delivery system utilizing a managed care concept—known as the Healthy Connections program. The program’s intent is to provide a “medical home” to beneficiaries, while also delivering significant savings in Medicaid expenditures. Currently, 30 percent of Idaho’s total Medicaid population participates in this program and these enrollees, with some minor exceptions, reflect proportionately the health status of the state’s overall beneficiary group.¹ For fiscal year 2000, the department reported that its Healthy Connections program saved more than \$16 million, which we adjusted to \$14 million, when compared to the more traditional Fee-For-Service Medicaid programs. If deployed statewide and made mandatory, participation in the program would increase. If enrollment increased to at least 50 percent of all Medicaid beneficiaries—up from the current 30 percent enrollment rate—savings of \$4.6 million could accrue, of which \$1.3 million is direct state savings. Further, if participation in the Healthy Connections program reached 75 percent of all beneficiaries, Idaho could accrue an additional \$10.3 million in Medicaid savings annually—which translates into \$3.1 million in state funds.

Healthy Connections has proven to minimize duplicative or unnecessary medical care.

Through Limited Exposure, the Healthy Connections Program has Likely Realized Over \$14 Million in Annual Savings Over Traditional Fee-For-Service

The basic concept of Healthy Connections is to operate under a managed care model by allowing enrolled Medicaid clients to select—or be assigned—a primary care provider (PCP) who acts as a “gatekeeper” to organize clients’ medical care and minimize duplicative or unnecessary care, resulting in better cost

¹ During our analysis, we found that slightly more inpatient deliveries of babies and low-birth weight babies were found in the Fee-For-Service program than in the Healthy Connections program. Refer to the results of our analysis in Appendix D.

containment. Perhaps more importantly, the department believes, and national research supports the view, that primary care case management programs improve access to physicians, provide a “medical home” for clients and builds stronger patient-physician relationships, thus leading to better preventive care and reductions in more costly emergency room visits.

Under the Healthy Connections program, Idaho pays participating physicians a monthly case management fee of \$3.50 for each individual assigned to that specific PCP to provide administrative services within the program and to refer patients for all necessary specialty services not delivered by the selected primary care physician. The physician is responsible for monitoring the health care and utilization of health care services for each of their enrolled participants. Like more traditional managed care programs, clients are restricted in the sense that they generally may receive services from their PCP or from specialty providers referred by their PCP. However, there are no referrals needed for some services such as emergency care, family planning, childhood immunizations, and dental care. Currently, Healthy Connections is mandatory in only two small counties, voluntary for Medicaid enrollees in most other counties, and unavailable in five counties within Idaho. As of June 2000, it had more than 32,000 reported enrollees—or roughly 30 percent of the total Medicaid population.

Even through its limited deployment, the Healthy Connections program realized over \$14 million in savings or “cost avoidance” over the traditional Fee-for-Service program during federal fiscal year 1998 when it reported enrollment levels of approximately 30,000. As shown in Table 1, the department originally calculated a \$16 million savings, but we adjusted the figure to \$14 million, based on actual costs from claims data obtained from the department’s automated claims payment system. Based on a department ad hoc report, total costs of the Healthy Connections program were \$78 million including costs of services provided, case management, and extra administrative expenses such as personnel and operating cost. Total costs for the traditional Fee-For-Service program providing services to the remaining Medicaid enrollees not in the Healthy Connections program were over \$155.6 million and included only the cost of services provided. Case management fees and extra administrative costs did not apply.

A 30 percent participation rate statewide has realized over \$14 million in savings or “cost avoidance.”

Table 1: Total Cost Avoidance Accrued in Healthy Connections Programs for Fiscal Year 1998, As Reported by the Department of Health and Welfare

	<u>Healthy Connections</u>	<u>Fee-For-Service</u>	
Total cost ^a	\$78,414,686	\$155,608,140	
Eligible beneficiaries^b (annualized into months)	347,923	572,410	
Cost per eligible month ^c	\$225.38	\$271.85	
Cost avoidance per eligible month ^d			\$46.47
Total Healthy Connections cost avoidance (per DHW) ^e			\$16,167,258

^a For Healthy Connections, cost includes case management fees, administration, and program benefit services. For Fee-for-Service, cost includes program benefit services only.

^b If individual enrolled for the full year, and individual would contribute 12 eligible months to the calculation. If an individual was enrolled for only eight months, an individual would contribute only eight months to the calculation, and so on.

^c Cost per eligible month = total cost/eligible beneficiaries

^d Cost avoidance per month calculated as follows: Fee-for-Service cost per eligible month (\$271.85) less Healthy Connections cost per eligible month (\$225.38) = \$46.47

^e Total avoidance calculated as follows: Cost savings per eligible month (\$46.47) x eligible beneficiaries (364,923) = \$16,167,258

Source: Healthy Connections 415(b) primary care case management waiver renewal, submitted to HCFA in May 1999; MMIS ad hoc report: *Reported Cost Avoidance for Healthy Connections Program in Fiscal Year 1998*.

The department's assertions and cost savings calculations are only sound if the composition of the Healthy Connections population is actuarially equivalent to those not enrolled in the program. Specifically, if individuals enroll in the Healthy Connections program who are typically "less sick" or require less intensive and costly care than individuals who remain outside the program, the department's cost reported cost savings would be skewed because these "healthy" individuals would naturally cost the state less. To ensure that the lower costs reflected in the program are not artificial, we evaluated the composition of the populations. We analyzed data extracted from the department's automated claims system for both Healthy Connections services and Fee-for-Service for the fiscal year 1999 (we excluded the two

populations not eligible for the Healthy Connections program—residents in long term care facilities and qualified *Medicare* beneficiaries). We determined diagnosis factors indicative of health status and cost patterns and, using a well-known statistical analysis software package, we computed health statistics for each population. Refer to Appendix D for various statistics calculated for each population.

Overall, the data suggests that the health diagnoses of Healthy Connections participants are representative of the entire Medicaid population with some minor exceptions. Our analysis revealed that on the basis of age, gender, and aid categories such as pregnant women, children, and the aged, blind, and disabled, the Healthy Connections and Fee-for-Service groups are largely equivalent but that more inpatient baby deliveries occurred in the regular Fee-for-Service Medicaid program than in the Healthy Connections program. Likewise, the Fee-for-Service program covered more low-birth weight babies as well. Based on these exceptions, we reduced the department's savings estimate by \$2 million to approximately \$14 million. We found the rest of the department's assumptions and calculations to be reasonable. Thus, reported cost savings are not the result of the healthier segment of the Medicaid population opting to participate in Healthy Connections, but rather may be the result of the program's emphasis on preventive care and the effectiveness of the PCP's "gatekeeping" functions.

These savings are not unique to Idaho; other studies have found that primary care case management programs reduce Medicaid costs between 5 and 15 percent when compared to Fee-for-Service programs. These studies have revealed that although costs typically increase for primary care services and prescription drugs, these increases are more than offset by decreased emergency room, inpatient hospital care, and physician specialist costs. As a result, one national study conducted by a health care group cited that several states without primary care case management programs are considering their development, while other states with these programs are striving to improve them.

In October 1998 and April 2000, the department surveyed the satisfaction levels of its Healthy Connections enrollees. Based on a 27 percent response rate for each survey, most enrollees seemed satisfied with the care received under the primary care case management program. Specifically, 93 percent of those

**Overall,
Healthy
Connections
participants
are
representative
of the entire
Medicaid
population in
terms of age,
gender, and
aid categories.**

responding claimed that their health is the same or better since joining the Healthy Connections program. Moreover, 92.5 percent of beneficiaries indicate that their ability to see physicians is the same or better since joining the program. On average, 87 percent of the responses indicated that most clients travel less than 20 miles to visit their PCP with only 5 percent of enrollees claiming that they travel more than 30 miles; but almost half of these enrollees choose to do so to visit a particular PCP. Other survey responses indicate that 93.5 percent of the enrollees scheduled an appointment for immediate, non-life threatening care within 48 hours and 86.5 percent could schedule routine medical check-ups within a two-week timeframe. Combined, these results seem to indicate that joining Healthy Connections has not impeded access to medical services.

Statewide Program Expansion Might Save An Additional \$10.3 Million

Given the success of the Healthy Connections program both in cost avoidance and client satisfaction, the department should seriously consider expanding to a mandatory program in more or all counties within the state. Based on an adjusted estimate of a \$40.24 monthly savings per participant, if the department could expand enrollment to include at least 50 percent of the beneficiaries, the state may save an additional \$4.6 million annually; if participation in Healthy Connections reached 75 percent of the beneficiaries, an additional \$10.3 million in annual savings might accrue. These participation rates would then result in actual state dollar savings between \$1.3 and \$3.1 million annually.

Currently, the program is only mandatory in two small counties and voluntary in most other counties in the state. The department reports it has considered expanding the mandatory nature of the Healthy Connections program, however it perceives one barrier to be securing adequate PCP participation or “medical homes” for Medicaid beneficiaries in the remaining Idaho counties. However, the Healthy Connections program has experienced relatively constant provider participation rates—nearly 70 percent annually since fiscal year 1995. In 1996, providers’ input on the Governor’s Medicaid reform efforts suggested that Healthy Connections be expanded throughout the state and made mandatory. Further, one independent study of exemplary practices in primary care case management cites that these types

With a \$40.24 monthly savings per participant, expanding the program to 50 or 75 percent of the population would result in \$1.3 to \$3.1 million in annual state savings.

of primary care programs actually improve access, especially for primary care.

Other states have incorporated several approaches to secure PCP participation for their mandatory primary care case management programs. Although all states emphasize the need for regular communication with physicians, certain states—such as Florida—conduct focus groups and surveys of participating physicians and non-participating physicians to uncover areas of concern and propose techniques to encourage program participation. Other states recruit physicians by visiting individual offices, distributing newsletters, and creating web-based communication with the physicians. Additionally, some rural states attribute higher participation rates to allowing participating physicians flexibility such as specifying the number of new Medicaid beneficiaries they will accept or serving primarily existing patients and accepting new ones on a temporary basis only. Others have relaxed requirements that previously limited the total number of enrollees to be treated by each primary care physician. These techniques encourage participation while allowing physicians some flexibility and management over their practices.

Another perceived barrier to PCP participation that is particularly difficult to overcome for some small or rural physician practices is the federal Medicaid prescribed 24-hour coverage requirement ensuring around-the-clock access for its PCP clients. To overcome this constraint, North Carolina contracts with an administrative organization to cover the 24-hour requirement with a toll-free telephone line staffed with registered nurses who make after-hour referrals and authorize services such as hospital care. Texas uses a “provider network field staff” to assist physicians with missed appointments and follow-up visits for Medicaid beneficiaries. North Carolina has similar representatives that follow-up with clients on missed appointments and ensure members obtain needed follow-up visits. In some enhanced primary care case management programs, states allow specialists, nurse practitioners, local health departments, rural health clinics, and other providers to participate as “primary care physicians” to expand the pool available to deliver services to Medicaid beneficiaries.

Several states have taken proactive measures to improve routine administrative processes such as developing efficient billing processes, ensuring adequate reimbursement rates, and making

Obstacles to expanded provider participation have been successfully addressed in other states.

timely claims payments. To make the program more attractive and overcome some barriers, some primary care case management programs provide additional reimbursement to group practices with significant numbers of enrollees or enhanced payments to physicians providing specified preventive services. Idaho too could enhance its Healthy Connections program with similar incentives to encourage participation in areas of low enrollment.

Case Management Fees Appear Reasonable

Under the Healthy Connections program, the department reimburses PCPs for direct services, such as office visits and laboratory tests, on a Fee-for-Service basis. Additionally, PCPs are paid a monthly fee of \$3.50 per member for case management services regardless of whether the patient visits the doctor in that month. To receive the monthly fee, PCPs must agree to provide comprehensive primary health care to beneficiaries who chose or are assigned to the PCP's practice. Additionally, they must offer access to an on-call professional 24-hours a day, seven days a week. As the "case manager," the PCPs must determine the medical need for and reference to other physician specialists, hospital care, and other services. In conducting these services, the PCP acts as the client's medical "gatekeeper," and is the first line of control for utilization management within the Healthy Connections program.

While case management duties are similar to those established in other states, several states pay a lower fee than Idaho. For instance, neighboring states of Montana and Colorado, pay PCPs a standard case management fee of \$3.00 per month for case management, 24-hour access, reviewing patient reports, assuming

Because providers are also asked to help with enrollment, the \$3.50 per month fee, although higher than other states, appears reasonable.

Figure 4: PCP Services Provided as Part of Case Management Fees

- Case Management
- Comprehensive Primary Health Care
- 24-hour Access
- Specialty Referrals
- Gatekeeper Services

Source: Healthy Connections Program Handbook, Revision V (December 1997)

responsibility for specialty referrals, providing medical management, and serving as a medical home. Although 20 percent may appear to be a significant differential and perhaps higher than necessary to secure provider participation in the program, it may not be out of line. The additional fifty cents premium Healthy Connections pays primary care physicians per month results in a total annual cost to Idaho for federal fiscal year 1998 of \$174,000, a fraction of the more than \$623 million of annual Medicaid spending. Furthermore, unlike other states, Healthy Connections' PCPs not only provide management services, they also perform much of the activity associated with enrollment. Given these additional duties and the necessity to attract and maintain PCPs, we believe the fifty-cents premium may be an important incentive to encourage PCPs to participate especially as the program grows.

INITIATIVES TO CERTIFY VETERANS' HOMES AND RESIDENTS AS MEDICAID ELIGIBLE WILL GENERATE SAVINGS, BUT MAY NEGATIVELY IMPACT SOME OF THE VETERANS

To maximize federal Medicaid funds, the Legislature and DHW set forth an initiative to certify state-run veterans homes and qualify their residents as Medicaid eligible. Currently, the Idaho Division of Veterans Services (IDVS) is leading the effort where current estimates indicate the conversion could eventually accrue an additional \$1.6 million in federal reimbursements annually by fiscal year 2003. However, the federal requirements to Medicaid certify the state veterans homes and qualify residents as Medicaid eligible may have far-reaching impacts on the veterans themselves. Those eligible for Medicaid—the majority of individuals currently residing in the veterans homes—should experience increased levels of care with more nurses available and receive additional health care benefits such as dental care, vision services, and audiology care; yet, for the estimated 40 percent of home residents that will not be eligible for Medicaid after the conversion, higher out-of-pocket costs to pay for their nursing home care are likely.

Conversion to Medicaid Eligibility Should Result in About \$1.6 Million Annually in Additional Revenue by 2003

The full benefit of Medicaid conversion will not be seen until fiscal year 2003.

Formerly part of the Department of Health and Welfare, the newly created IDVS has the responsibility of providing care and extended financial assistance to Idaho wartime veterans and their dependents. IDVS offers services to veterans ranging from managing and operating three veterans homes to obtaining federal benefits and emergency assistance. Only veterans meeting eligibility criteria—those who were honorably discharged after serving at least 90 days, of which at least one day must have been during a war or conflict, having eligibility for a federal VA pension, and meeting other eligibility requirements—can reside in and receive services in one of IDVS’ veterans home. Currently, 241 individuals reside in the three veterans homes.

As part of recent initiatives, the IDVS is tasked with certifying its homes and the resident veterans as Medicaid eligible to generate an influx of federal funds and thus reduce state spending on the program. While the initial estimate of state cost savings resulting from this effort was more than \$2.5 million annually, predicted savings from enhanced federal revenue have been adjusted to approximately \$1.6 million annually by fiscal year 2003.

It is expected that only 60 percent of its veterans will occupy Medicaid card eligible beds.

In order to recover the additional federal funds, the Department of Health and Welfare developed the initial plan premised upon first certifying all three veterans homes as Medicaid eligible by February 2001 and subsequently identifying those veterans residing in the homes that qualify for Medicaid benefits. Thus far, wings in two homes are Medicaid-certified, with certification for the third home expected by year-end and the process to qualify the residents in the two certified homes has begun. Until all three veterans homes are Medicaid certified and the portion of the population deemed eligible enroll in the program, the state will not realize the Medicaid revenue anticipated.

By obtaining Medicaid eligibility for the three facilities, it is possible that all beds could be “occupied” by Medicaid eligible veterans although at this time only 60 percent is expected. For each veteran added under the Medicaid program, the division could bill approximately \$157.55 per day, creating a state savings of \$43.42 per day. Because of the incremental nature to complete the home certification, establish eligibility of veterans, and the insights gained through continued research of Medicaid rules, the IDVS continues to modify its fiscal assumptions and cost savings projections. In particular, the division’s fiscal estimates assume a staggered implementation reflecting that only 20 percent of

veterans will be eligible in fiscal year 2001, up to 40 percent in the subsequent fiscal year, and, finally, 60 percent will be Medicaid eligible by fiscal year 2003. These estimates may change if the conversion process proceeds more slowly or rapidly than expected, or if the division learns about additional expenses or potential savings not currently included in its estimates.

To validate the division's projections, we independently estimated the flow of funds based on the gradual conversion to Medicaid and ensured the division's assumptions were reasonable and appropriate. While the conversion process is still ongoing, we found that IDVS' estimates were realistic, but somewhat higher than our estimates because they did not consider a modest annual inflation factor for future payments. Once adjusted for inflation, the division's projections that the conversion is likely to result in \$1.6 million in annual state costs savings when fully implemented by 2003 are reasonable.

When introduced in March 2000 as one initiative to help contain growing Medicaid costs, the Department of Health and Welfare estimated additional federal revenue of more than \$2.5 million annually. Subsequently, the IDVS adjusted the projections to include the additional costs incurred to achieve and maintain the Medicaid certification. For instance, as of September 30, 2000, initially overlooked implementation costs are more than \$400,000, including staff travel to meetings, staff training related to Medicaid, and consultant contracts to assist in the certification and conversion of the homes to Medicaid. Throughout the conversion process, the consultants cite, and we agree, that additional expenditures have been necessary to bring the homes into compliance with Medicaid standards. Additionally, there will likely be new software needs—estimated at \$100,000 by the division—to handle the new billing and trust accounting, stricter pharmacy requirements, and inventory tracking as required by Medicaid. On a recurring basis, the homes will need additional health care staff to meet the new requirements—such as higher nursing-to-resident ratios—and to fill requisite positions including administrative nurses and an eligibility service officer. Additional accounting and administrative positions will also be needed and will add to the cost of conversion.

Adjusting for these one-time and recurring costs of operating a Medicaid eligible home, the division estimates, and we find

Increased staffing, computer and other costs have reduced initial savings estimates by about \$900,000 per year.

reasonable, that the total annual costs of operating the three veterans homes are approximately \$14 million—or nearly \$158 per day per veteran, exclusive of ancillary services. Using the division’s estimates that 60 percent of the veterans—or 156 individuals—residing in the homes by 2003 will be Medicaid eligible, the total cost to provide care to these veterans will be almost \$9 million. Of this amount, the federal government pays approximately \$3 million through its VA per diem; while patient receipts—including private insurance—patient payments, and VA pension amounts, account for another \$3.7 million. The remaining nearly \$2.3 million is available to bill to the federal Medicaid program and be paid at a 70.76 percent match rate; thus, saving the state approximately \$1.6 million annually as shown in the Table 2. However, as of November 2000, these estimates are still in-flux and could be subject to additional costs or savings, thus reducing possible fiscal benefits, until all variables are known and approved.

To qualify a veteran for Medicaid, the IDVS will establish eligibility based upon personal income and assets and calculate the beneficiary’s “share of cost.” Using January 2000 patient financial status reports indicating income and asset levels of veterans, the division initially estimated that 68 percent—or more than 170 veterans—are likely to be eligible for Medicaid. However, some of these veterans may be financially eligible, but not meet medical eligibility requirements. To conservatively account for this situation, the division reduced its estimate to a 60 percent potential eligibility factor to project the potential cost savings. We reviewed the IDVS’ eligibility estimates and related assumptions as of September 2000 and find a 60 percent Medicaid veterans population to be reasonable. The estimate is somewhat conservative, but further supported when compared with Medicaid eligibility rates in Idaho’s private nursing homes at 61 percent and other nursing facilities nationwide at nearly 68 percent.

Veterans May Experience Both Additional Benefits and Face New Challenges

Once the veteran homes are Medicaid certified, all residents should experience several benefits resulting from the conversion such as increased levels of care and additional health services. In order to meet Medicaid standards, additional nursing and health care staff is required to provide care at the homes. According to

Table 2: Estimated Savings From Veterans Homes Medicaid Conversion, by Fiscal Year 2003

	Medicaid Eligible Veterans ^a	Non-Medicaid Private Pay Veterans ^b
Cost:		
Cost per day	\$157.55	\$157.55
Annual patient days ^c	<u>56,940</u>	<u>37,960</u>
Estimated annual cost ^d	<u>\$8,970,897</u>	<u>\$5,980,598</u>
Revenue:		
Patient receipts ^e	<\$3,717,926.00>	<\$2,478,617.33>
Federal VA per diem ^f	<\$2,976,762.36>	<\$1,984,508.24>
Estimated annual revenue	<\$6,694,688.36>	<\$4,463,125.57>
Unreimbursed cost/additional amount to be paid by veterans	\$2,276,208.64	\$1,517,472.43
Amount available to bill federal Medicaid program	\$2,276,208.64	\$0
Additional federal revenue generated ^g	\$1,610,645.24	\$0

^a According to DVS, 60 percent of veterans residing in the state homes will be eligible for Medicaid. This estimate appears reasonable.

^b According to DVS, 40 percent of veterans residing in the state homes will *not* be eligible for Medicaid. This estimate appears reasonable.

^c Based on 260 beds with 60 percent occupied with Medicaid-eligible veterans.

^d Estimated annual cost calculated as cost per day x 365 days x 156 patients.

^e Patient receipts are based on department records.

^f Federal VA per diem is based on federal rates adjusted for inflation.

^g As of October 2000, the federal participation rate is 70.76 percent.

Source: Sjoberg Evashenk Consulting, LLC analysis of data collected from the Idaho Division of Veterans Services.

the division, in order to be certified, direct care hours must be at least 3.5 per resident per day; while the national average is 3.7 staff hours per resident per day in Medicaid programs. Thus, the IDVS estimates it will need an additional 63 staff to provide the enhanced levels of skilled nursing care. With higher direct care staff hours, it is likely that all veterans will receive increased levels of care. Further, more staff and flexible staffing patterns offer the homes the ability to accept some high-acuity residents that it could not before the conversion. In addition to access to more skilled professional staff, veterans will also receive

Veterans will receive greater direct care service hours and gain access to some new services after conversion.

Figure 5: Comparison of Veterans' Benefits Before Conversion and After Conversion

<u>Benefit/Service</u>	<u>Before Conversion</u>	<u>After Conversion</u>
Monthly cost of room and board in Veterans home ^a	\$2,333	\$3,230
Monthly cost of ancillary services in Veterans home ^a	Included in monthly cost	Additional \$149 per month
Federal VA per diem ^b	\$51.38	\$51.38
Retention of VA Aid and Attendance Pension ^b	\$90	\$90
Spousal allowance ^b	\$1,073	Increased by \$334 per month to a minimum of \$1,407
Nursing care	Current staffing levels and level of care Cannot accept high-acuity residents	Increased staffing levels and possible better care Ability to accept high-acuity residents
Access to dental, vision, and audiology services	No	Yes

^a Amounts estimated by the DVS. Based on our review, we find these estimates reasonable and realistic.

^b Applies to Medicaid eligible veterans only.

Source: Sjoberg Evashenk Consulting, LLC analysis of data collected from the Idaho Division of Veterans Services.

enhanced access to services such as dental care, vision exams, and audiology services as shown in Figure 5.

Under the program, veterans will still qualify for several benefits and pensions available prior to the conversion. Specifically, they will continue to receive the long-term “per-diem” benefit available from the federal Department of Veterans Affairs’ Veterans Health Administration and paid to states furnishing nursing home care to eligible veterans in a state-operated nursing home. The current daily \$51.38 per diem rate—a monthly payment of more than \$1,500—is made directly to the home and is contributed towards a resident’s cost of care. On an annual basis, the federal government adjusts the per diem rate for inflation. And—like before the conversion—if veterans choose to stay in a private nursing home, they are *not* qualified to receive the per-diem benefit.

Veterans will also retain \$90 monthly of their federal Aid and Attendance pension. Rather than apply it toward the cost of the nursing home, veterans can use this pension for personal needs. Additionally for those veterans with spouses, the conversion to Medicaid will increase the spouse allowance from \$1,073 monthly to a minimum of \$1,407. Finally, nursing home admission requirements will be expanded under Medicaid to include peacetime veterans.

However, while the veterans will not lose benefits, many are likely to experience significant fiscal and social challenges. Federal rules demanding that non-Medicaid residents pay the full “customary charges,” which must be equal to or more than amounts the state charges to the Medicaid program, are likely to translate to significant increases to some veterans. Because the state can charge Medicaid no more than “customary charges” to the general public for the same services, the DVS must determine the actual cost of providing long-term care in each of its homes, and each resident, Medicaid beneficiary or not, must be charged the same amount. Prior to the conversion, the IDVS was not required to capture total costs to this degree. The IDVS’ current estimates project monthly charges will be more than \$3,200—or a 38 percent increase over the current (before conversion) charge of approximately \$2,300 which is an all-inclusive fee providing room, board, and ancillary services such as physical therapy and pharmaceuticals.

This new monthly charge includes the costs of room and board and non-Medicaid residents must pay additional out-of-pocket costs for ancillary services. Prior to the conversion, ancillary services were included in monthly rates and some of these services were offered by private providers or by staff in the veterans homes. However, under Medicaid rules, private providers must now supply all of these services. While there may be some benefits of access to a broader range of providers, the veterans may lose the existing ties between current care providers and this may have an emotional impact on the affected individuals.

Those who cannot or choose not to apply for Medicaid may be required to pay for the increased home service cost, in full, from other sources. The division estimates that approximately 40 percent—or 104 veterans—would be financially impacted negatively by the federal regulations. Two specific issues apply:

Non-Medicaid charges will grow from \$2300 to over \$3200 after conversion.

About 40 percent of veterans will be financially impacted negatively if they cannot or choose not to apply for Medicaid.

to be eligible for Medicaid, some veterans will need to “spend down” their personal assets; and others, not eligible or choosing not to participate in Medicaid, will be personally liable for the full cost of their care. It is possible that these higher out-of-pocket costs could cause an accelerated “spend-down” of the non-Medicaid eligible veteran’s assets and, at some future juncture, qualify the veteran for Medicaid—thus, a “natural” reduction in personal assets, resulting in eligibility. Alternatively, before Medicaid certification, some veterans could manage the private pay provisions without significant fiscal impact to their families. However, with the removal of state subsidies and the stringent Medicaid rules, many veterans currently residing in the state-run nursing homes would likely spend larger portions of their assets to cover the cost of nursing home care. At some point, some veterans may reduce their assets to the point where they will meet the income and asset qualifying requirements to have Medicaid pay for their care.

Five current residents would have liens placed on their homes to cover the costs of Medicaid services they receive.

One significant hardship facing the Medicaid eligible veterans is that Medicaid eligibility constraints may result in the possibility of liens being placed on their homes. Current federal regulations allow states to recover the cost of Medicaid benefits by filing a lien on real property if an individual is permanently in a nursing home; however, liens will not be placed on property as long as certain qualified individuals—such as spouses or children with disabilities—continue to live there. The division estimates that liens would affect two percent—or five of its current resident veterans. While there has been national legislation introduced to exclude veterans from being subject to this lien provision, as of November 2000, this matter is still unresolved.

At first glance, the elevated costs incurred by the veterans home residents may seem dramatic; however, these rates are comparable to private nursing home costs throughout the country and would be charged to veterans that opted to receive care from one of these private facilities. Moreover, because the federal Department of Veterans’ Affairs Veterans Health Administration daily allowance of \$51.38—or roughly \$1,500 monthly—can only be applied to the cost of care provided in state-run nursing homes, veterans will continue to benefit by residing in these state homes over private nursing homes because the personal liability for their cost of care will still be less.

The division is currently promulgating rules to exempt veterans that resided in the homes on or before June 30, 2000 from mandatory participation in the Medicaid program. Although no decision has been made, if implemented, this exemption would allow veterans to “choose” whether to participate in the Medicaid program. The division considered the effect of some veterans not joining the Medicaid program, which would otherwise be eligible, in their fiscal projections. While the IDVS assumed that 60 percent of all veterans are Medicaid eligible and included these estimates as part of its cost savings calculation, the process of determining eligibility is not yet complete.

Beyond the above exemption, the state is not proposing any other options or alternative solutions to lessen the impact of higher monthly charges for the non-Medicaid eligible veterans. While the state could choose to offset a portion of the cost with subsidies of General Fund money, this practice would also cause a reduction in federal reimbursements. Specifically, because the charge for private-pay residents and Medicaid recipients must be at least equal, if private payors were subsidized or charged less, the federal government’s reimbursement rates would be reduced accordingly. However, under current requirements, all incoming veterans after July 2000 must apply for and become eligible for Medicaid, or pay the full cost of home care services.

Clearly, Idaho’s initiative to move the Medicaid eligible veterans nursing homes is controversial and many veterans may not be receptive to the conversion. Some have negative views of aid programs and pride themselves on not being on welfare. According to one representative from an advocacy group, veterans feel that they are being forced into Medicaid. Other veterans’ advocacy organizations have joined the opposition to the conversion out of the fear that liens will be placed on their homes if they are forced into Medicaid.

Other Opportunities for Increased Medicaid Reimbursements May Exist

Certain Medicaid reimbursement rules, coupled with Medicare provisions, provide some states with flexibility and opportunities for recovering additional federal funds for veteran home care. Specifically, present regulations allow states the flexibility in determining payment rates for all their Medicaid providers based on “efficiency, economy, and quality of care.” These regulations

The department should closely follow the debate over the flexibility afforded state nursing homes to bill Medicaid at higher Medicare rates.

allow states to pay different rates to the same category of providers (such as hospitals or nursing homes) as long as the payments, in aggregate across the state, do not exceed the maximum amount of what *Medicare* would pay for the services rendered by these same providers. For instance, states can pay a provider, like the veterans nursing home, more than they would normally and have the home return the bulk of the extra money to the state. Because the veterans home payments are legitimate Medicaid costs reimbursable by the federal government, the practice generates additional federal funds. These additional funds can then be used by states to pay future state shares of Medicaid payments—or spent however the state determines.

In reviews conducted by the federal Department of Health and Human Services' Office of the Inspector General of three states exercising this reimbursement provision, findings indicate that enhanced reimbursements were not reflective of the actual cost of providing services or increasing the quality of care to the Medicaid residents of the health care facilities. Rather, the states charged the government the highest amounts allowable and effectively reduced their state share of Medicaid costs because the federal government reimbursed more than the cost of services. Moreover, no restrictions apply to the use of the excess funds, so states can redirect the money not only into other Medicaid services, but virtually into any other state activities unrelated to health care.

Not surprisingly, there is intense national controversy surrounding this issue. The political fight in Congress is escalating over how—and whether—to curtail this payment method. Some feel that the enhanced payments—although legal—divert funding from the intended purpose of improving the quality care of nursing homes and hospitals and removes the intended controls over these funds. Moreover, by supplanting *state* Medicaid dollars with *federal* Medicaid funds, some believe this practice violates the basic integrity of Medicaid as a joint federal/state program. On the other hand, many argue that the enhance payment provisions allow states extra health care revenue and terminating the practice would jeopardize hospitals and other facilities that rely on these excess funds.

Should the federal government continue to allow these enhanced payment provisions, Idaho should research these federal rules to see if the requirements and conditions can work within the

parameters of Idaho Medicaid policy and what changes would be required, thus tapping into another source of federal funding for the Medicaid program that could be directed to the veterans home program.

OPPORTUNITIES EXIST TO INCREASE REVENUE AND TO REDUCE ADMINISTRATIVE COSTS

At over eight percent of its Medicaid spending, Idaho's costs exceed the national average for administrative costs. Even though adjusted administrative costs are higher than average, we do not find them excessive because one-time costs and others directly related to program delivery may skew the overall percentage upward. Nevertheless, Idaho's current method of capturing and accounting for certain costs is not allowing for the maximum levels of federal reimbursement. DHW should make changes to its method of billing Medicaid for targeted case management and should consider isolating information technology expenditures that would allow additional recoveries—nearly \$1.6 million—from the federal government annually. Once adjusted for these direct program services included in its administrative costs, Idaho's level of spending is within regional averages, but remains at the high end of the spectrum.

Some of Idaho's high administrative costs can be explained or reduced.

Compared to National and Regional Averages, Idaho's Administrative Costs are High

The nationwide average for Medicaid Administrative costs hovers around 4 percent while, in fiscal year 2000, Idaho spent more than 8 percent on administrative activities. According to the most recent national data available for the federal fiscal year 1997, state administrative costs ranged from a low of around 1.6 percent in New Jersey to a high of 9.11 percent in Oklahoma. Idaho's percentage of its Medicaid budget allocated to these costs for that period was 9.05 percent and was exceeded in that year only by Oklahoma. Other states in its region reported administrative costs between 3.8 and 7.5 percent of their Medicaid budgets.

It is difficult to accurately compare administrative costs across states because of differences in state Medicaid programs and dissimilar and unknown elements included within the administration category. For instance, Idaho includes in this spending nearly \$2 million on a contract with a peer review

Although Idaho's administrative costs are high, direct comparisons with other states are not always meaningful.

organization to conduct utilization reviews required by federal mandate; on the other hand, states using risk-based managed care hire health maintenance organizations (HMOs) whose contract to deliver services also include utilization review activities. The result is that states paying HMOs claim all such payments as “direct service” expenditures, effectively moving utilization review costs out of administration and into program budgets. Another factor that could account for several differences in Idaho’s rate, especially in prior years, as compared to other states, is the inclusion of certain significant one-time costs. Specifically, over the past ten years, Idaho has spent more than \$21 million for a now-completed claims payment system, the Advanced Information Management (AIM) system. During the three fiscal years 1997 through 1999, costs particular to the AIM were a major component in administrative costs. The completion of the system can account for nearly half of the decrease in the administrative cost ratio between 1999 and 2000. Additionally, administrative costs have also included a \$2.2 million contract for third-party recovery services that the state has recently elected not to renew.

Amending the State Plan May Capture Additional Federal Funds

Given these and other reasons behind Idaho’s high administrative costs, with little additional effort and no additional services, the department could reduce its costs and maximize opportunities for increased federal financial participation. Specifically, the state could amend its state plan and leverage federal funds for current case management activities. Instead of billing approximately \$12.9 million of these services as part of its administrative budget at a 50 percent federal match rate, under federal guidelines the department could bill some portion of the \$12.9 million as direct services and realize a 70.76 percent federal match rate. The true proportion that can be classified as “targeted case management” must be determined; however, even billing half of these costs at the federal direct service rate would generate \$1.3 million in savings annually.

To operate its Medicaid program, Idaho must prepare and abide by a state plan, approved by HCFA, that details eligibility, benefits, payment rates, and other program features. If a state seeks to change any of the policies or procedures contained in the approved state plan, it must submit a state plan amendment—and

receive HCFA approval—before implementing changes in its program.

One way that Idaho could achieve a higher federal participation rate for its administrative costs is to prepare and submit a state plan amendment to HCFA detailing and justifying a change in its procedures for billing certain Medicaid case management activities. Specifically, the department would detail the “targeted case management” duties and functions as services only available from state employees. A federally acceptable process for determining the rate for these services is calculated and paid from random moment time studies (a mechanism used to capture staff time and effort devoted to various functional or programmatic activities to which salary and benefit costs are charged), not individual claims. While in the past, private providers have opposed practices that allowed the state to pay itself as a direct service provider, these particular services are already performed as state-sponsored targeted case management services and can be defined in the state plan amendment as available only from the state, based on its unique ability to serve persons in certain situations. This amendment does not change the level of services provided by the state and, therefore, would not compete with private providers; rather, it would appropriately recognize direct services for reimbursement purposes and would enhance the federal participation rate for existing, on-going activities performed by the state.

Other states have found success with this technique. For instance, Oregon has an approved state plan where state employees at its Office for Services to Children and Families are paid for assessment and case management of children in institutional care. Because the state staff are the only individuals eligible to provide these targeted case management services—due to the fact that the state has a custodial responsibility and relationship with the client—the state can pay itself for these services without altering the fee schedule it uses for other case management services offered by private providers. Similarly, in New Mexico, the federal HCFA approved a state plan amendment for Medicaid-eligible adults in need of adult protective services. The state asserts that only the state department could qualify as a “protective services agency,” and thus can uniquely provide these services. Using a random moment time study, the agency is reimbursed a specified monthly amount for each eligible adult

Certain state-provided “targeted case management” services could be billed at a higher federal match rate.

Nearly \$1.3 million in cost savings could be realized by capturing case management efforts separate from general administration.

with an open protective services case thereby eliminating the need to submit claims for individual case management sessions.

Using existing random moment time studies, DHW calculates an annual amount spent on “administrative case management” services. While some portion of this activity involves direct services elements, another portion is purely administrative in nature. Because the coding on the time study mixed both elements, it is extremely difficult to extract the portion that could truly be claimed as direct services. However, as discussed earlier in this section, we estimate that if Idaho could bill at least half of the \$12.9 million as direct services at 70.76 percent financial match rate in fiscal year 2001, the state could realize nearly \$1.3 million in costs savings at a minimum. Moreover, this shift would help realign administrative cost spending from approximately 8.14 percent of the Medicaid spending to approximately 7.9 percent. Although the “adjusted” administrative costs may still be on the high end, this issue should not cloud other reform efforts from being employed.

Information Systems and Specialized Providers Garner Higher Federal Reimbursements

Generally, Medicaid stipulates that administrative activities be funded with 50 percent of federal monies; two notable exceptions to this rule are for automated information system implementation and operation and for employing skilled medical professionals. Currently, the department includes qualified activities under these exceptions as general administrative costs, thus missing opportunities for recouping additional federal funds.

Specifically, numerous employees at both headquarters and regional DHW offices have created and maintained auxiliary systems off the primary AIM system. Staff time and resources spent on programming and running these ad hoc reports and systems can be billed at a 75 percent federal match rate instead of the minimal 50 percent rate. While billing at the higher rate will require capturing activity, using a random moment time study or detailed time reporting/job costing system, we estimate that a minimum of \$218,000 per year could be recovered from the federal government for conducting these activities. Theoretically, if at least 1.5 full-time staff in each of the seven regions, plus another 1.5 staff in the central office, totaling 12 full-time staff, maintain ad hoc databases off the department’s automated system,

based on estimated annual salaries with benefits and overhead, total costs of these 12 staff would be over \$872,000. Presently, state funds pay 50 percent of these costs, or more than \$436,000. Charging these costs at the allowable federal 75 percent match rate would garner \$218,000 annually; thus reducing the state's match by that amount.

Even though the state could and should maximize federal dollars by claiming the time spent by regional staff creating their own databases, this practice of creating unofficial, uncoordinated and likely duplicative systems should not continue. Rather, these staff should devote their attention to performing assigned "program" activities that provide direct services to Medicaid beneficiaries. The department should provide information systems resources to the central office and to the regions for developing and maintaining uniform systems, coordinating subsidiary applications to provide needed data for day-to-day management purposes, accurately capture these efforts for maximum federal reimbursements. We discuss this in greater detail in Chapter 4.

Additionally, the state has not established its protocols to efficiently gather the activities of certain individuals who qualify for enhanced federal reimbursement. Specifically, Medicaid regulations stipulate that the federal government will contribute 75 percent of the funding for state hires of "skilled professional medical personnel and staff directly supporting those personnel," provided employees "have duties and responsibilities that require...those skills." Within the DHW, several positions meet the federal definition, but are not currently being claimed at the full match rate. For example, there are senior registered nurses (positions that require a nursing background), certain individuals performing in Medicaid alternate care coordinator positions, the Healthy Connections manager (given her nursing background), and others who qualify under the Medicaid provisions for the higher 75 percent reimbursement rate.

Similar to the aforementioned discussion related to information systems, the precise amount of savings relies on random moment time studies or time reporting systems. However, our estimates indicate that if the department recognized three full-time equivalent staff at the higher 75 percent match rate, based in a salary of \$58,200 or \$87,300 with benefits and overhead, total costs of these staff would be nearly \$262,000. Although the state is currently paying 50 percent of these costs—almost \$131,000,

Identifying all of Idaho's "skilled professional personnel" and their support can also be used to increase the federal match rate.

the DHW could bill these staff at the 75 percent rate and generate annual savings of more than \$52,000.

CONCLUSIONS

Faced with escalating costs and limited resources, Idaho must take definite steps towards reducing costs while maintaining quality of care. Currently, the department has several opportunities that, taken together, would result in cost savings in its Healthy Connections, veterans, and administrative programs. Expansion of the Healthy Connections program alone could reap annual benefits ranging from \$1.3 to \$3.1 million in state savings. Combined, initiatives to certify veterans' homes as Medicaid eligible and our recommendations to modify case management administrative billing should net an annual \$1.6 million in state savings each. Moreover, these cost saving techniques would still allow for the provision of quality medical care to Medicaid beneficiaries.

While the department has embarked on initiatives geared to capitalize on some of these opportunities, there is still more work to be done in these areas and great potential for additional cost saving protocols to be set in motion. However, without the inclination and cooperation from all stakeholders to modify practices in critical budget and program areas, Idaho's Medicaid expenditures will rise at steep rates. Given the projection of increased expenditures and limited budget resources, maintaining the status quo could eventually force the Legislature and the DHW to make dramatic, rather than proactive and well-reasoned, changes.

RECOMMENDATIONS

To lessen the current trends of increasing Medicaid expenditures, Idaho can capitalize on several cost saving opportunities. Specifically, the department should consider the following:

- Expand the Healthy Connections program and make the program mandatory in more counties within the state;

- Perform an in-depth cost-benefit analysis associated with its conversion of veterans' homes to Medicaid and consider fiscal, program, and societal impacts on the state and veterans;
- Leverage federal funds for those case management activities already conducted by regional staff through a targeted case management state plan amendment;
- Capture information systems and skilled medical professional activities and bill them at a higher federal match rate.

Chapter 2

Significant Opportunities Exist to Reduce Pharmaceutical Costs

Chapter Summary

Statistics show that nearly every state in the union is struggling with rising pharmaceutical costs within the Medicaid programs. Many studies have attempted to explain the causes for the disproportionate cost escalation in pharmaceuticals, attributing increases to new, expensive branded drugs, higher unit costs, and increased drug usage due to the availability of prescribed drugs, the aging population, manufacturer advertising, and changes in therapeutic protocols. Spending on pharmaceuticals has increased steadily—HCFA reports that nationally expenditures have grown from \$50.6 billion of Medicaid budgets in 1993 to \$90 billion in 1998; reflecting annual double-digit escalation. In fiscal year 2000, Idaho spent nearly \$77 million on pharmaceuticals.

Pharmaceutical costs encompass over 12.4 percent of Idaho's Medicaid spending—comprising a sizeable element within the program. Between fiscal years 1994 and 1998, total drug costs have grown nearly 17 percent with the average amount spent annually for pharmacy services by each beneficiary growing from \$361 in 1994 to \$641 in 1998. During this same five-year period, Idaho's total Medicaid pharmacy costs grew from \$29 million to \$55 million—an 87 percent increase—double the average regional increase of 39 percent. Nationally, drug costs for all health care sectors rose approximately 52 percent for the same period.

Although it is clear that drug costs are on the rise elsewhere, Idaho's pharmaceutical program has many dissimilarities with other programs. Idaho is paying pharmacists more than other states to dispense prescription drugs to its Medicaid recipients. Additionally, it has not adopted many available cost containment protocols, such as aggressive programs for generic drug use, adopting a formulary or preferred drug list, or co-payment options. At Idaho's current rate of growth, pharmaceutical drug

In Idaho, and throughout the nation, pharmaceutical costs are increasing at a double-digit annual rate.

spending will continue to consume a larger share of the overall budget at the expense of other Medicaid programs. To reduce costs, bring drug expenses in line with comparable states, and harness total Medicaid spending, Idaho has several opportunities at its disposal. In total, we estimate more than \$380,000 could be saved in this area as shown in Figure 6.

\$153,000 Can Be Realized by Reducing Dispensing Fees to Rates Comparable Nationally

Pharmacists receive a fee for dispensing prescription drugs to Medicaid beneficiaries that is essentially a “service charge” to reimburse for a pharmacist’s time and expertise. Specifically, the dispensing fee is designed to cover pharmacies’ overhead expenses plus a reasonable net profit. However, with the volume of prescriptions rising and the total dispensing fees increasing, the DHW should consider lowering dispensing fees paid to pharmacists. Dispensing fees comprise approximately 8.8 percent of the pharmaceutical budget and nearly 12 percent to the cost of the average prescription. Moreover, at \$4.94 per prescription, Idaho is currently paying almost twice the average commercial rate—what private insurers pay pharmacists—for dispensing prescription drugs provided as part of the state’s Medicaid benefit package.

In a study commissioned by the department in November 1998, a consultant surveyed over 300 private payors nationwide and found that the median dispensing fee was only \$2.50. There are no other healthcare service areas in Idaho’s Medicaid program where the Medicaid program is paying this much more for services than the commercial rate. Moreover, with its high fee

At \$4.94, Idaho’s dispensing fees are nearly double those paid by the private sector.

Figure 6: Total Savings in Pharmaceutical Area

Dispensing fee reduction	\$153,000
Drug reimbursement changes	\$37,500 to \$125,000
Minimal copayments	\$60,000 to \$118,000

Source: The Lewin Group analysis of data corrected from the Department of Health and Welfare and the federal Health Care Financing Administration.

level of \$4.94, Idaho is in the upper range of Medicaid program dispensing fees across the nation and ranks among the highest when compared to regional states. According to the study, Medicaid dispensing fees provided to pharmacists nationwide range from \$2.50 to \$5.77, while regional states pay \$4.42 on average.

Although Idaho purposefully increased its dispensing fees by forty cents about two years ago during a change in reimbursement methodology as an incentive for pharmacies to remain in the program, if Idaho were to reduce its dispensing fees by fifty cents to \$4.54—closer to the regional average—it could realize a total cost savings of at least \$511,000 annually, or more than \$153,000 in state savings. This number is based on an average volume of approximately 983,500 prescriptions for fiscal years 1996 through 1998.

In the past, department officials believed that higher fees were necessary to maintain pharmacists' participation in the Medicaid program. However, we believe that Idaho's provider participation rates are strong enough to absorb some movement and have little to no impact on the availability of pharmacy services to beneficiaries. Currently, 84 percent of Idaho's pharmacy sites participate in the Medicaid program. This rate is on par with participation rates ranging between 85 and 100 percent in three regional states—Montana, Washington, and Wyoming—each currently having lower dispensing fees than Idaho. Moreover, with the quantity of prescriptions increasing, pharmacists should see some increase in their Medicaid volume. While pharmacists would see a reduction in the reimbursement rate, they should still profit from the program and the affiliated customer traffic generated from the Medicaid program. Given this, pharmacists are less likely to leave the program.

Another option for the department is to incorporate a 'tiered' or sliding scale dispensing fee based on volume of prescriptions filled. For example, smaller pharmacies that fill fewer prescriptions could receive the full \$4.94 of the dispensing fee, while larger pharmacies, such as chain drugstores, that fill a heavy volume of prescriptions could receive lower dispensing fees per prescription depending upon volume. Washington utilizes a tiered method for paying dispensing fees. This arrangement is premised on the basis that larger providers can leverage their high volume of prescriptions with pharmaceutical manufacturing companies to negotiate lower drug prices.

Pharmacy participation rates are between 85 and 100 percent in three regional states with lower dispensing fees.

While any decrease in the dispensing fees paid to pharmacists would ultimately result in state Medicaid savings, it is difficult to quantify the impact of a sliding scale initiative without conducting a detailed analysis of transactions from each pharmacy over a period of time. However, it is safe to assume that, provided the fifty-cent reduction to change the dispensing fee to \$4.54 is applied across the board without regard to volume, the results of the additional reductions due to a sliding scale will exceed our initial half-million dollar estimate. However, if the sliding scale alternative is adopted without the across-the-board reduction, then the savings will be far more modest, depending upon the tiers of volume and the level of reduction applied to the dispensing fees.

It is important to note that to put a sliding scale payment program into practice, DHW would need to make information system adjustments enabling the department to track prescription volume by pharmacy. Periodic, such as quarterly or semiannual, reviews to adjust actual fees to actual volumes would require instituting a formal reporting and adjustment process that could be supported through technology. Before the department chooses to adopt this sliding scale initiative, it needs to carefully weigh the costs against the benefits of this decision.

By Increasing the Discount on Acquisition Costs, an Estimated \$125,000 Could Likely Be Saved Annually

In addition to dispensing fees, pharmacies participating in the Medicaid program are reimbursed for the cost of the prescription drug—the product itself. In Idaho, pharmacies are reimbursed for drugs at the lowest of the following three methods: federal upper limit, manufacturer’s list price, or estimated acquisition cost based on the average wholesale price (AWP) minus a discount factor. The federal upper limit, set by the federal government, and the manufacturer’s list price are drug prices established for each pharmaceutical dispensed. However, the “AWP” is more fluid, being an “average” and can be likened to the automotive industry’s model of “sticker price.” DHW policy is to pay pharmacies the AWP less an 11 percent discount. This concept assumes that pharmacies can buy or negotiate pharmaceuticals for at least 11 percent below the “sticker price.” In actuality, if pharmacies buy the drugs for less than this price, then the pharmacists profit from the difference between the amount the state reimburses and the price they pay the manufacturers for the product.

Statistics indicate that greater discounts are possible than the level Idaho currently pays.

Statistics indicate that greater discounts may be possible. Moreover, some states even mandate drug rebates based on volume in addition to customary discounts. In a study commissioned by the department, an external consultant found that pharmacies are typically able to purchase pharmaceuticals at prices well below the AWP. Specifically, the consultant estimates that pharmacies nationwide purchase drugs at a 16.5 percent discount of the AWP. Moreover, an audit completed by the U.S. Department of Health and Human Services' Office of the Inspector General revealed that brand drugs typically are sold for 18.3 percent below the AWP, while generic or multi-source drugs are acquired by pharmacies at 42.5 percent below the AWP. When Idaho's 11 percent discount is considered in the full context of the likely actual acquisition price, an additional discount appears warranted. At a minimum, there is still a 5.5 percent profit margin on average being realized by most pharmacies and provides much latitude for the state to realize pharmaceutical savings.

The growth of managed care in the private insurance sector has also impacted the pharmacies. Competition has lowered pharmacists' fees as managed care plans leverage the potential volume of their enrollees' prescription to obtain concessions from the pharmacists. In the department's recent study, the consultant reported that, in a survey of approximately 300 private payors nationwide, the median reimbursement was the AWP less a 12 percent discount.

The aforementioned data reveals that there is strong rationale for Idaho to increase its acquisition discount at least one percent from 11 to 12 percent. Clearly, statistics indicate that pharmacists still will realize strong profits despite the reduction, especially as Idaho encourages the use of generic drugs, as described later in this chapter, which have a much higher potential for dispenser's profit. The complexity of pricing methodologies for pharmaceuticals presents significant difficulties in quantifying the savings of increasing the AWP discount; however, we designed a model presenting three scenarios to estimate the potential savings. The following discussion describes that estimates based on these three scenarios indicate total Medicaid savings ranging from \$125,000 to \$375,000 annually, or between \$37,500 and \$112,500 in state savings.

Discounts on generic drugs, whose increased rise is contemplated in Idaho's program, are significantly greater than the current 11 percent level.

To estimate the potential cost savings associated with increasing the discount on drug reimbursements, we summarized Idaho's pharmaceutical data using the federal HCFA's Annual Drug Utilization Report and divided the total drug units prescribed (more than 58 million) by the total cost reimbursed (approximately \$45 million) to arrive at a cost per drug unit of nearly 77 cents. Because we could not determine the true proportion of drugs reimbursed in Idaho using the AWP discounts, we projected the amount and probability that prescription drugs would be reimbursed using this one of the three federally sanctioned reimbursement methods.

We determined the full amount of the AWP to be 86 cents per each unit of drug reimbursed. We then determined that a 12 percent discount would equate to an average unit reimbursement of 76 cents, or one cent less than an 11 percent discount rate. As presented in Table 3, we then compared the two unit reimbursement rates at various levels—25, 50 and 75 percent volume—to ascertain the potential ranges of cost savings. While one scenario shows possible total savings as significant as \$375,000 annually, the most conservative scenario reveals annual savings of \$125,000.

Using a Minimal Co-Payment Technique Could Realize Additional Benefits

Throughout the health care industry, co-payment techniques are used to control increasing costs of pharmaceuticals. This technique requires the consumer, or beneficiary, to pay a small portion of the cost on the premise that it will discourage unnecessary utilization of health care services while simultaneously reducing the insurer's financial burden. Specifically, more than half of all states in the U.S., including Colorado, Montana, and Wyoming in Idaho's region, require some form of cost sharing from their Medicaid beneficiaries for prescription drugs. These cost sharing arrangements are typically minimal, ranging from fifty-cents to one dollar per prescription for generic drugs and between one dollar and three dollars for brand name drugs, which is appropriate once the state takes into account the relative socioeconomic disadvantages of Medicaid beneficiaries. This is substantially less than co-payments in the private sector, averaging \$5.50 for generic and \$7.50 for brand name drugs.

More than half of all states in the U.S. require some form of cost sharing from their Medicaid beneficiaries.

Table 3: Potential Savings From Increasing Discount on Drug Reimbursements (change from 11 to 12 percent discount from AWP*)

Number of Prescription Drugs Dispensed in Fiscal Year 1999	Estimate of Drugs Dispensed Subject to AWP Reimbursement		
	Scenario #1	Scenario #2	Scenario #3
58,120,139	<u>43,590,104^a</u>	<u>29,060,070^b</u>	<u>14,530,035^c</u>
AWP less 11 percent (\$0.77 rounded)	\$33,352,787 ^d	\$22,235,191 ^d	\$11,117,596 ^d
AWP less 12 percent (\$0.76 rounded)	\$32,978,037 ^e	\$21,985,357 ^e	\$10,992,679 ^c
Potential Savings	<u>\$374,750^f</u>	<u>\$249,834^f</u>	<u>\$124,917^f</u>

* = AWP is the average wholesale price.

^a = 25 percent of the drugs prescribed in fiscal year 1999 were subject to the federal upper limit reimbursement methodology; therefore, 75 percent of drugs dispensed might be reimbursed using the AWP method.

^b = 50 percent of the drugs prescribed in fiscal year 1999 were subject to the federal upper limit reimbursement methodology; therefore, 50 percent of drugs dispensed might be reimbursed using the AWP method.

^c = 75 percent of the drugs prescribed in fiscal year 1999 were subject to the federal upper limit reimbursement methodology. therefore, 25 percent of drugs dispensed might be reimbursed using the AWP method.

^d = Calculated amount is "AWP less 11 percent" multiplied by estimated number of drugs subject to AWP method.

^e = Calculated amount is "AWP less 12 percent" multiplied by estimated number of drugs subject to AWP method.

^f = Potential savings are calculated as the difference between the "AWP less 11 percent" calculated amount and "AWP less 12 percent" calculated amount.

Source: HCFA annual drug utilization report; The Lewin Group analysis of data collected from the Department of Health and Welfare and the federal Health Care Financing Administration.

Because certain groups of beneficiaries are excluded from cost sharing provisions, only a segment of the pharmaceutical budget will be eligible for a co-payment. Federal mandates specifically forbid states from applying co-pay programs to certain Medicaid populations such as children under 18 years old, pregnant women, institutionalized individuals (in hospitals or long-term care facilities), and clients receiving emergency services or family planning. Despite this, if even 40 percent of the drugs prescribed could be subject to cost sharing, at a fifty-cent per prescription co-payment, Idaho could realize total savings of nearly \$200,000, which would double if the co-payment were raised to one dollar.

Using the same number of prescriptions, an increased co-payment of seventy-five cents would realize \$295,000, while a one-dollar co-payment could result in \$393,400, creating a direct savings to the state of more than \$118,000.

Alternatively, other approaches to implementing such a program could allow zero or a very low co-payment for generic drugs, higher co-pay for medically necessary branded drugs, and the highest co-pay for brand drugs with generic alternatives. The department could allow pharmacists to keep the co-pay and reduce the reimbursement to the pharmacist by that amount. Alternatively, co-payments could be collected from patients by pharmacists and remitted to the state. The cost avoidance or savings realized by the state can be used to offset the growing Medicaid costs or provide additional benefits to Medicaid beneficiaries.

Recently, the department and Legislature have developed initiatives to institute a co-payment protocol in the Medicaid program. Specifically, the intent is for clients to share a portion of the cost of providing certain health care services by implementing reasonable co-payments and other cost-sharing methods. Because the initiative allows providers and pharmacists to retain all co-payments but does not reduce provider reimbursements, the proposed approach will not accrue any savings to the state. In light of the department's budget constraints and the legislature's intent to reduce Medicaid spending, the proposed co-pay approach will not accomplish these goals.

Further, it is possible that the imposition of financial participation may have other implications. The department should define any income or health-related exceptions to the cost sharing provisions to mitigate the potential of the program translating to financial hardships for beneficiaries or unintended barriers to pharmaceutical therapies. Studies indicate that co-payment programs that encourage beneficiaries to use generics can boost cost savings. However, if co-payments decrease the use of needed medications, hospitalizations and emergency room usage could increase.

In January 2000, the DHW conducted a telephone survey of comparable states to determine the extent that states employ Medicaid cost sharing programs. While this survey included co-

The current co-payment initiative will not reduce Medicaid spending since collections are kept by the providers.

pay programs for health care services as well as drugs, by-in-large, several of the eleven states responding cited positive aspects of their cost sharing program, such as the promotion of responsibility of its clients and decreased social stigma of public handouts. And, while not realizing full compliance, these states generally cited that beneficiaries accepted the co-pay provisions as part of Medicaid. Moreover, because Medicaid provisions specifically preclude some beneficiaries from cost sharing provisions, the state could establish its own threshold for certain groups deemed indigent, thus deterring unintended negative impacts. Further, most responses to the department's survey indicated that co-pay programs had no adverse affect on client access.

Drug Utilization Management Initiatives Can Generate Savings

Generally speaking, Idaho's pharmacy benefits provided to its Medicaid beneficiaries are similar to comparable states in the region. Idaho uses an open formulary, under provisions of the federal 1990 Drug Rebate Act, that reimburses most covered outpatient drugs (those which have been approved for safety and effectiveness by the federal Food and Drug Administration) while employing certain coverage restrictions for those products cosmetic in nature or unrelated to medical necessity.

Additionally, with few exceptions, Idaho's program does not cover over-the-counter drugs. In a recent study, the Office for Oregon Health Plan Policy and Research found that while most western states Medicaid programs have some sort of limitations, through a formulary or not, prescription drug exclusions and limitations within programs actually vary little from state to state among those with an open formulary.

While closed formularies allow states to more closely control the dispensing of more expensive pharmaceuticals, states with open formularies can also implement cost saving protocols. One such utilization management tool is the use of a prior authorization program. Recent budget intent language introduced in the 2000 legislative session encourages the use of less-costly generic drugs by requiring prior authorizations for brand name prescriptions with generic equivalents. Previously, Idaho only required prior authorization for four limited drug categories. Intent language will expand the prior authorization requirements and cover more brand name drugs with therapeutic equivalents.

Recent budget intent language encourages the use of less-costly generic drugs.

One of the driving expectations of requiring prior authorization is that the paperwork required for authorization of a brand name drug will deter the provider from using it—thus creating a deliberate and conscious decision regarding the drug to be dispensed. Through education and exposure, the department anticipates that beneficiaries will realize and become familiar with the facts that generics are typically therapeutically identical or just as effective as brand name drugs and are a fraction of the cost. Although much of the country in private pay and public programs has already adopted the generic alternatives, the department will need to re-educate both the providers and public on the benefits of this expanded program.

Although prior authorization requests will likely increase initially, once practitioners become accustomed to the new protocols, the use of brand name drugs when generics are available will decrease.

Along with potential savings, the department will likely experience, at least initially, increased costs to process the prior authorization requests because many drugs currently prescribed would need an authorization. Overall, it is likely that, similar to other states, the volume of requests for preauthorization will increase. If the numbers rise dramatically, the department may need more staff to approve the requests within the established 24-hour timeframe. Using claims data from June 1999 through December 1999, we estimate that the department could initially experience approximately 35,000 additional preauthorization requests. Because 40 percent of the prescriptions dispensed within Idaho's Medicaid program have generic equivalents, it is likely that the volume of preauthorizations will jump.

Currently, one pharmacist approves all requests. Based on our estimates, this reviewer's workload could increase from 1,200 requests to over 35,000 requests per year. If the projected authorization level were realized, workload for Idaho's one reviewer would exceed that of other states with similar prior authorization protocols. Specifically, in Colorado, the workload is 12,000 requests per reviewer; in Washington, the workload averages 23,500 requests per reviewer. Thus, until practitioners and beneficiaries become accustomed to the new protocols, the department may need additional staff, at least on a temporary basis.

We anticipate, however, that although the department will initially receive many more requests, as providers and clients learn more about the program, the elevated level of prior authorizations will likely taper off. Since the proposed drug policy encouraging generic use makes it more difficult to justify

brand drug use when generic equivalents are available, it is likely that provider behavioral changes will lower the number of brand drugs deemed medically necessary—thus lowering authorization requests. Until the department determines the true authorization volume, it should be cautious about filling long-term, full-time preauthorization positions.

Other costs associated with the expansion of prior authorizations and encouragement toward generic drugs relate to system changes that will be needed. Some of these changes have been accomplished and many of the minor system changes will be completed as part of the department's contracted services at minimal cost. However, it is likely that changes to the system to accommodate some of modifications that we suggested earlier in this chapter could result in sizable additional costs.

Research and Incorporate Other Opportunities

Innovative techniques and a quest for continual improvement will be needed by the department as it continues with the Medicaid program. Without this proactive focus, Idaho will always be in a position of reacting to cost increases or health care issues. Therefore, in addition to the opportunities we have discussed in the previous sections, the department should continue to research other best practices and determine how they fit into Idaho's Medicaid program.

For instance, the DHW should continue to research opportunities for creating a preferred drug list that involves paying prescribing physicians and pharmacists incentive fees to authorize preferred drugs within specific drug categories. Research requested by the DHW and conducted by the College of Pharmacy at Idaho State University shows that preferred drug programs assist physicians and pharmacists in using the lower cost, therapeutically equivalent drug therapies, but does not penalize for the occasional justifiable use of more expensive drugs. Additional literature reported that the use of preferred drug lists is a helpful selling point for states in negotiating discounts with manufacturers.

Currently, the department is considering a proposal to develop a preferred drug list that groups commonly prescribed drugs with proven effectiveness into broad drug classes. Within each drug class, the proposal suggests identifying 12 to 15 drugs that will be considered "preferred." Physicians and pharmacists may be

**Identifying
"preferred"
drugs within a
broad class of
drugs and
encouraging
their use by
providers can
manage drug
utilization and
generate
savings.**

encouraged through financial incentives to prescribe and dispense drugs within these groups. According to a 1999 drug utilization report, Idaho's Drug Utilization Board will seek input from the physician and pharmacy community on evaluating the effectiveness and therapeutic appropriateness of the preferred drugs. Further, initial departmental estimates reveal potential savings of approximately \$4.1 million annually from this utilization management protocol.

However, it appears that changes to the department's automated system to allow for the monitoring of a preferred list and tracking of incentive payments might be quite extensive and potentially expensive. For instance, changes might include adding automated edits to enforce provisions, building of prices, and reference tables for the preferred drugs, developing an incentive payment tracking system, and interfacing the tracking system with other claims records. As part of its research on the feasibility of a preferred drug list, the department should evaluate whether potential benefits outweigh these additional costs.

CONCLUSIONS

Although the department is in the process of implementing some cost containment protocols over pharmaceuticals to comply with legislative intent language, many additional opportunities exist for the department to accrue cost savings in its Medicaid pharmaceutical program. Specifically, through lowered prescription dispensing fees and adjusted drug acquisition reimbursement rates, DHW could realize more than \$265,000 annually in state fund savings. Additionally, by using minimal co-payment techniques, the department could realize additional state benefits of \$118,000 annually. Other drug utilization management techniques are likely to generate savings in the pharmaceutical area, but we were not able to quantify these savings.

RECOMMENDATIONS

To incorporate stronger utilization controls over pharmaceuticals, Idaho can benefit from several cost saving opportunities. Specifically, the department should consider the following:

- Lower the pharmaceutical dispensing fees paid to pharmacists by fifty-cents from \$4.94 to \$4.54; alternatively, the department could reduce dispensing fees through a tiered or sliding scale based on volume of prescriptions filled;
- Increase its drug acquisition discount paid to pharmacies from 11 percent to at least 12 percent;
- Implement co-payments for pharmaceuticals ranging from fifty-cents to one dollar and provide collections to pharmacies to partially compensate for suggested dispensing and drug product reductions or keep collections to offset growing state Medicaid costs and provide additional benefits to Medicaid beneficiaries;
- Continue with current plans to encourage the use of generic drugs by requiring prior authorizations for brand name pharmaceuticals;
- Continue to research opportunities for creating a preferred drug list and consider the feasibility of incorporating it into Idaho's Medicaid program.

Chapter 3

To Contain Medicaid Costs, Rigorous Utilization Management Tools Must Be Implemented

Chapter Summary

In the first two chapters, we discussed the urgency and importance of taking advantage of cost saving opportunities. While these prospects encourage change in several areas within Idaho's Medicaid program, the department also needs to implement stronger protocols and tighten its management in other areas—changes that are likely to result in yet unquantified cost savings. We believe that better utilization management techniques will result in more consistent and effective service. And while more effective techniques should accrue cost savings, we were unable to calculate the potential results of these efforts. Nevertheless, without these rigorous tools, the success and effectiveness of the Medicaid program could be at risk.

STRONGER PROTOCOLS OVER DEVELOPMENTAL DISABILITY, MENTAL HEALTH, AND CASE MANAGEMENT WILL HELP ENSURE EFFECTIVENESS OF THESE PROGRAMS

With costs increasing for developmental disability and mental health services, Idaho needs to implement stronger utilization protocols, guidelines, audits and oversight to ensure comparability of care and effectiveness of programs. During its most recent session, the Legislature put in place several initiatives that required the department to develop stronger utilization management techniques over these areas. Many of these are underway or planned; however, additional improvements are warranted to better manage costs in the developmental disability and mental health areas and provide more effective quality of care.

Better utilization management is essential for Medicaid program effectiveness.

Mental Health and Developmental Disability Enrollment Growth Exceeds Other States

As part of its Medicaid program, Idaho provides adult and child developmental disability services, adult and child mental health services, and personal care case management. Through benefits ranging from clinical psychiatric services to psychosocial rehabilitation and at-home services to speech therapy, providers of mental health and developmental disability services include psychiatric hospitals, physicians, psychiatrists, outpatient facilities, residential treatment centers, and nursing homes facilities.

Fiscal year 1999 statistics reveal that the Medicaid program served 7,960 mental health clients, including 2,349 children and 5,611 community clients, and 8,645 individuals in developmental disability programs. Developmental and mental health expenditures during fiscal year 2000 totaled nearly \$73 million, comprising over 12.7 percent of Medicaid spending. Over the past five years, Idaho has experienced tremendous growth in these expenditures—developmental disability service costs have grown approximately 114 percent and mental health services over 239 percent.

This escalating rate of growth itself should cause DHW to evaluate the propriety and level of services ordered and diligently explore proactive measures to control and manage these costs while still providing appropriate health care to the developmental disability and mental health populations.

Limited Utilization Management Creates An Environment Susceptible to Inconsistency and Overuse of Services

For all its programs, one overarching departmental goal is to “use limited resources wisely” by seeking to operate efficiently, improve the cost-effectiveness of services, and strive for continued improvement. At more than 12.7 percent of total Medicaid spending and an increasing expenditure rate, the department must deploy all available tools and techniques to best manage its developmental disabled and mental health programs. A comprehensive utilization management system comprised of various controls and protocols helps ensure the delivery of appropriate, quality care, and improve the care provided while eliminating waste and controlling costs. Specifically, appropriate

Over the past five years, Idaho has experienced a 114 percent growth in developmental disability service costs and a 239 percent growth in mental health services.

utilization management techniques include prior-authorization for services, case management, and outcome measurement.

Although some current processes differ slightly between the developmental disability and mental health programs, we found that the department uses some utilization management techniques. For instance, protocols require regional staff to act as “gatekeepers” and prior-authorize certain services within the developmental disability and mental health programs. Using client assessments and services plans, Idaho regional clinicians pre-authorize service amounts that are then entered into the DHW’s automated claims payment system. This system validates the authorizations against certain programmed data fields and edits check to ensure the information entered is accurate and valid. Once validated, the system generates letters confirming the authorizations that are sent to the regional offices, providers, and clients. Without validated, prior-authorization of services, providers cannot receive reimbursement for services rendered. Integrated into the prior-authorization process are ceilings to cap the amount or level of services allowed. However, while weekly or monthly caps exist for certain services, no caps exist for others such as psychosocial rehabilitation. Moreover, few guidelines exist delineating between appropriate or inappropriate Medicaid services for individuals with differing levels of physical or behavioral health and functional or social needs.

Although the department and its regions have some appropriate controls in place, a lack of others allows for an environment that is potentially susceptible to abuses. For instance, because the DHW’s program operates under only broad guidelines, some conflicts of interest are inherent within the current system. Idaho Administrative Code stipulates that a case manager cannot be a service coordinator for any recipient for whom the case manager has an individual responsibility for providing care or treatment. Our review of nearly 34 internal reviews conducted on targeted case managers during fiscal year 1998 revealed several instances where the private case manager provided both case management services and direct health care to Medicaid beneficiaries. The reviewers identified these noncompliance issues and discouraged the practice. Not only does this dual role violate Idaho rules and state plan directives, but it creates a situation where providers’ case management responsibilities to authorize services are incompatible with their responsibilities to provide the authorized services. By allowing these conflicting roles to exist, the DHW is

While utilization controls exist for certain services, no caps exist for others.

Contrary to Idaho Code, some case managers are providing both case management services and direct health care, clearly a conflict.

weakening an internal control and increasing the risk that abusive or improper activities could occur and go undetected. Because of their responsibilities to manage cases as well as directly deliver developmental disability or mental health services, these providers may not have the requisite independence to protect the state's interests in acting as a "gatekeeper" to contain unnecessary Medicaid spending.

Another control deficiency exists in the process to minimize opportunities for duplicative services. Specifically, developmental disability services, mental health services, and case management prescribed under individual care plans require prior authorization; however, similar services not part of an individualized care plan may be provided simultaneously by other providers without prior approval. Thus, Medicaid could be paying for duplicate and potentially over utilized services. For example, an individual may receive psychosocial rehabilitation services for 20 hours a week as part of an individual service plan developed and approved by the Regional Mental Health Authority (RHMA) on behalf of Medicaid. At the same time, the client may be visiting a private mental health clinic or receiving targeted case management from a private provider. The services provided by the clinic or targeted case manager may duplicate the services provided under the individualized psychosocial rehabilitation plan and may be inappropriate given they are provided outside the individualized psychosocial rehabilitation plan. We are unable to quantify how often this situation might occur or the dollars associated with this potential over utilization, but appropriate data systems and utilization management controls can prevent this potentially abusive situation from occurring and effectively reduce, if not eliminate, those services not envisioned in the individualized plans.

Adequate controls to deny duplicative services do not exist when some services require prior authorization and others do not.

Although we found utilization management procedures more similar than different between regions in theory, audit reports for mental health and developmental disability services revealed a number of inconsistencies. The variation in practice of protocols and activities can result in discrepancies in types and levels of care depending upon where the services are delivered. Therefore, two individuals having identical diagnoses and degrees of impairment living in different regions could receive very different levels of care and service from the system.

Specifically, seven internal audits of RMHAs revealed that they are not always in compliance with Medicaid rules and policies and appear to implement these rules and policies inconsistently across regions. Similar findings were noted in developmentally disabled waiver assurance reviews. These DHW reviews of utilization management also indicate the need to develop standardization of the assessment and intake processes to ensure uniformity and consistency across regions and among clients.

During the course of our regional reviews, certain issues were continuously noted by regional interviewees and program audits. Specifically, some services were managed by authorizing care by the week while others were authorized by the month or by the year. This practice not only allows for different levels of care in each region, it creates a potential of unchecked services and utilization. Monitoring quality of care and outcomes by physician and region will be a helpful first step in identifying these discrepancies and determining if they are system-wide implementation issues or physician practice patterns.

Because of the escalating growth in the mental health, developmental disability services, and case management programs and the weaknesses identified across the regions, implementing additional utilization management techniques—including treatment protocols and guidelines—can help ensure uniformity of service and bring costs under control. It is important to note, however, that any attempt to tighten utilization controls may be resisted by some provider groups. Focus group sessions informing the scope of this engagement revealed that some providers feel that DHW already engages in excessive “micro-management,” ignoring provider expertise in the process. Other providers expressed concerns that Medicaid reimbursement rates were too low and feared that the outcome of this evaluation would be even tighter service restrictions and reductions in reimbursement.

Stemming From Recent Legislative Initiatives, the Department Has Adopted Broad Strategies That Should Help Tighten Controls and Improve Care

Earlier this year, the Idaho Legislature directed the DHW to address the increasing costs of developmental disability and mental health services provided under the Medicaid program, and approved intent language with four directives that are specific to

Differences among the regions in authorizing treatment periods could result in differing levels of care, creating a potential for unchecked services and utilization.

developmental disability and mental health for the department to focus its efforts on. In response, the department established a utilization management project (UMP) oversight committee to seek input from stakeholders, contract with a private utilization specialist, coordinate internal work groups to identify changes needed, and develop strategies to contain costs. After a series of focus groups, analyses of current processes, and input from the private specialist, this effort resulted in the adoption of eight broad recommendations related to more effective utilization management. As shown in detail in Appendix E, these recommendations cover a wide-array of strategies including instituting accountability checks, structuring progress toward desired outcomes, and establishing a coordinated approach to the administration of utilization management.

The department's oversight committee recommendations appear reasonable, although implementation strategies are just now being developed.

The UMP oversight committee recommendations related to stakeholder-driven quality improvement, supporting consumer empowerment, accountability, outcome-based progress goals, public outreach and education, and provider training appear to be equally reasonable in light of the department's desire and intent to assure that services delivered across the state meet standards for appropriateness and quality. However, it is important to note that the UMP's committee report was issued literally weeks before the end of our fieldwork. As such, little has been accomplished toward achieving the recommendations. Without detailed objectives and action plans, at this early stage of developing the implementation strategies for all eight recommendations, we cannot objectively assess the likelihood that any of these strategies will achieve desired results.

However, we are in agreement with the overall direction the department is heading with most of its broad strategies. Two of the eight strategies recommended by the UMP oversight committee appear to address some of the problems with the current system that we discussed earlier in this section. First, the committee recommends, "a coordinated approach to basic administrative structures required to implement utilization management...finalizing and enforcing statewide criteria that reflect Idaho stakeholder values and national best practice standards for the appropriate use of Medicaid behavioral health services." A coordinated approach and statewide utilization management criteria would—if properly developed and implemented—address the current lack of sufficient treatment and utilization guidelines to ensure regions uniformly and adequately provide Medicaid services.

Second, the recommendations advocate a “separation, at the regional office level, of the direct provision of care—including consumer assessment, service plan development, and therapeutic support services—from provider contracting, quality monitoring, and authorization functions.” This recommendation speaks to the conflicts of interest that exist in that certain clinical staff in the regional offices have the dual responsibilities of advocating for consumers and, at the same time, gatekeeping to ensure the Medicaid services are allocated appropriately.

And, while the intended protocols will likely benefit the Medicaid program, we believe that two other strategies need careful consideration. First, any plans to centralize utilization management functions and/or remove intake, assessment, service planning, and prior authorization functions from the regions should be carefully evaluated in light of not only the weaknesses inherent in the regional system (e.g., uncoordinated approaches, few guidelines, inconsistent implementation of rules), but also the strengths of the current system (e.g., provider responsiveness and accountability, linkage to community resources). We believe the DHW should consider designing a comprehensive utilization management plan that rectifies current weaknesses without giving up the benefits inherent in the system. If statewide criteria for the appropriate use of Medicaid behavioral health services are developed and implemented, it appears reasonable that regional staff, although organizationally separated from the clinical staff assessing individual needs and developing service plan, and reporting directly to Medicaid central, could continue to play a role in the authorization of services.

We agree with the principle of supporting consumer empowerment through allowing consumers and family members to develop their own individualized service plans, but the lack of an arms-length relationship within various roles in the process requires careful consideration. When private providers fulfill all the roles, including facilitating an individual’s intake assessment, establishing service plans, and delivering treatment—as we addressed earlier in this chapter—not only are Idaho’s rules violated, but it creates a potential weakness in the process. Strong control processes suggest that persons assisting in the intake, assessment, and service planning should be independent of those having a financial interest in the delivery of services.

Designing a comprehensive utilization management plan that rectifies current weaknesses while continuing to include regional staff seems the most reasonable approach.

Moreover, to generate success using any of these utilization management strategies, coordination between the DHW management, regions, and utilization committee is crucial. Furthermore, coordination of these activities should also be clearly communicated to the department's various external contractors responsible for the claims payment system, utilization management reviews, and utilization management reform efforts, to ensure a level of compatibility and to eliminate possibilities of duplications and gaps.

Moreover, we believe communication and feedback loops are essential to avoid redundancies and inconsistencies, particularly in utilization management activities. For instance, if a new standard for Medicaid behavioral health outpatient services is implemented then this may directly impact the provision of services by one of Idaho's external contractors that manages utilization for behavioral health inpatient services. Additionally, the department should consult with its external contractor responsible for maintaining the Medicaid automated system to assess the current functionality and capability of the DHW's system and perform any necessary system changes in order to implement newly developed utilization management activities.

Communication, coordination, definition of roles and responsibility, accountability, follow-through and follow-up are all essential to the potential attainment of the goals of the utilization management initiatives. Success will rely in the level of commitment and direction given by top leaders and is dependent on partnering among the central offices, regions, service providers, and advocates.

The Adoption of New Utilization Management Techniques May Require System Changes at Additional Cost

As detailed utilization processes, roles, and responsibilities have just begun to be addressed in mid-September and have not yet been finalized, we are unable to conduct a complete assessment of what functionality is needed to perform the expanded utilization management approaches such as prior authorization, client assessment, periodic review, and outcome measures.

It is believed that some of the data (e.g., diagnostic codes and physician and beneficiary identification) are in the AIM system. However, through interviews we conducted and as discussed in

more detail in Chapter 4, it is unlikely that the current configuration of the system will allow users to easily obtain all needed information.

Regardless of what utilization management techniques are developed, we strongly recommend that the Department conduct an assessment of what functionality the system has to offer and to verify that the data does not already reside in AIM. Additional software or software programming will be needed if extra functionality is required. As new utilization management activities are implemented, it is critical that the UMP committee work closely with the department's external contractor responsible for the AIM system to determine what system requirements are needed and whether additional software should be purchased or written.

CONTINUED IMPLEMENTATION OF UTILIZATION MANAGEMENT TECHNIQUES WILL ENHANCE CONTROLS OVER NURSING FACILITY AND INPATIENT SERVICES

Over the past few years, the DHW has implemented several tools to provide better controls of Medicaid services and costs in Idaho's nursing homes and hospitals. The programs over these services include several utilization management techniques missing in the mental health and developmental disability programs. In particular, the DHW uses an external consultant, a physician-sponsored peer review organization, to perform utilization management reviews of inpatient services looking for unnecessary expenses while assessing the quality of care delivered. Moreover, it adopted a Uniform Assessment Instrument (UAI) for its nursing home services that is showing positive early returns for promoting more equitable and defensible eligibility determinations for long term care. Additionally, the department actions changing its reimbursement method for nursing facility services, combined with its home and community based service waiver, show promise for controlling the growth of these costs in the future.

The Department Has Implemented Several Utilization Management Tools

With nursing facility services comprising 19.6 percent of Medicaid spending in fiscal year 2000 and inpatient services

Data requirements for a comprehensive case management program will likely challenge the current information system's functionality.

The use of a uniform assessment tool and changes in nursing home reimbursement methodology show promise.

making up an additional 16 percent of the spending, management of these services to control cost and service utilization are critical.

As part of its utilization controls, the DHW contracts with an external physician peer review organization tasked with preventing unnecessary spending and assessing quality of acute care given to Medicaid beneficiaries. Idaho Medicaid providers must obtain prior authorization from the contractor for some medical and surgical procedures and for certain types of admissions—as specified on the department’s pre-certification list—such as psychiatric or chemical dependency treatment and all physical rehabilitation admissions. By clearly defining its expectations for allowable services through detailed guidelines, the DHW assists physicians, providers, and its contractor in quickly understanding those services allowable and procedures requiring prior approval as part of the department’s utilization management.

Another major component of the inpatient management program involves a series of reviews—concurrent and continued stay reviews, retrospective reviews, and focused case reviews—to evaluate services and utilization patterns. When beneficiaries stay in the hospital beyond four days or exceed the length of stay determined in the prior authorization process, the DHW’s external peer review contractor proactively conducts a concurrent and continued stay review to determine if the facility confinement and associated physician services are medically appropriate and necessary. For the six-month period ending June 2000, more than 2,200 reviews were conducted.

Inpatient management controls include concurrent and continued hospital stay review by an external peer review contractor.

Occasionally, especially in emergency situations, a patient may be admitted to and released from the hospital before Medicaid eligibility was established or the proper treatment authorizations were obtained. Although approving eligibility after services are provided is not advantageous to the department, the contractor will conduct retrospective reviews when it is expected that the medical procedure or hospitalization would have required prior authorization. In the first six months of calendar year 2000, the contractor performed approximately 720 of these reviews. Finally, there are special circumstances when the DHW might request the contractor to conduct special analyses as part of focused case reviews. In these quality assurance reviews, the contractor reviews client medical records to ensure the hospital provided quality care and the treatment or length of stay was

medically necessary. During the six-month period from January 2000 through June 2000, the contractor performed eight focused case reviews. In its July 2000 report for the state fiscal year 1999, the contractor calculates its management techniques resulted in an annual reduction of 897 hospital days for a gross savings of nearly \$2.4 million. After considering the cost of their services, the contractor reports a net savings resulting from their efforts of \$725,000 for the year.

To better define and attempt to bring more uniformity and equity to the provision of long-term care, in 1996, the State Legislature directed the DHW to develop uniform assessment criteria for the appropriate placement and funding for Medicaid beneficiaries. In response, a statewide departmental committee was formed to design and implement what is now termed the Uniform Assessment Instrument (UAI). In June 2000, the tool was implemented in three regions where Regional Medicaid Unit managers administer the UAI to individuals within ten days of admittance to a nursing facility. Although the DHW has only brief experience using the UAI, some believe that it has promoted more equitable and defensible eligibility determination for those regions.

Another technique available to states to control growth in nursing home costs and increase efficiency is to change reimbursement methods. Because federal mandates provide states a significant amount of flexibility in setting nursing home reimbursement methods, we found that variation across states is substantial. Several states use prospective reimbursement vehicles that traditionally set rates in advance, by setting a flat rate for groups of facilities or setting rates based on historical costs; however, many states increasingly use case-mix reimbursement methods designed to base rates upon the unique characteristics of a specific facility's patients. This method better accounts for differences in the costs of providing for various patients' needs. According to joint research conducted by the University of California, San Francisco and Wichita State University, this method enhances quality and access for patients and allows states to treat nursing facilities more equitably based on patients admitted.

Until recently, Idaho used a "prospective reimbursement" model that set payment rates largely based on historical costs with only one level of care assumed across all facilities. But, as of July 2000, the DHW changed methods and now uses a case-mix

Changing from a "prospective reimbursement" payment model for setting nursing home rates to a "case-mix" reimbursement approach enhances quality and access for patients while more equitably treating facilities based on their patients' needs.

reimbursement model that is premised upon facility-specific rates reflecting each facility's patient case-mix. Rates are amended and updated quarterly.

In addition to the utilization management and cost control aspects of the UAI and the shift in reimbursement rate methodology, the movement in long-term care is out of facilities and into community based programs. To facilitate this shift that garners more independence for the client and is less costly to the state and federal government, Idaho sought and obtained a federally approved home and community based service waiver for its aged and disabled population. The waiver affords states the flexibility to develop and implement creative alternatives to placing individuals in nursing facilities and institutions. Idaho's waiver program, that began in April 1999, recognizes that many individuals at risk of being placed in a nursing facility can be cared for in their own homes and communities and, in turn, preserves their independence and ties to family and friends creating a better quality of life at costs lower than institutional care. One of the unique features of the waiver is the broad variety of services provided within the program including adult habilitation services such as cooking and work skills, assistive technology such as wheelchairs and ramps, electronic communication devices and door handles, and personal care attendants to provide services such as paying bills and grocery shopping.

Increased use of community-based services has successfully provided the most appropriate care while reducing nursing home spending.

Although some debate exists about the potential cost savings from the home and community based service waiver, research indicates that states similar to and located near Idaho—namely Oregon, Washington, and Colorado—have successfully provided clients with more appropriate care in the community and, at the same time, reduced spending on Medicaid-funded nursing facilities. Despite the influx of more people now being served in community-based settings, substantial overall savings have been realized by each of these states.

Even in the short time since Idaho fully implemented its waiver and Uniform Assessment Instrument, the state has experienced a reduction in nursing home caseload which has also lowered overall long-term care spending. Specifically, over a thousand individuals who previously would have been placed in a nursing home or residential care facility are now using "waiver" services in their own communities. While the state would have incurred

monthly costs greater than \$415,000 to serve these clients, Idaho is now paying approximately \$240,000 per month by providing more appropriate services to the same individuals, saving roughly \$177,000 per month.

Results Are Pending to Evaluate Success of Techniques Put in Place

Although Idaho has incorporated useful utilization management techniques into its nursing and residential care service program that should better align it with comparable states in the region, most of these tools have just recently been implemented. And, while early estimates may indicate substantial savings, it is too early to fully evaluate the success of the techniques. However, in light of trends suggesting that nursing facility costs will continue to rise—in both Idaho and the nation as a whole—continued support for these initiatives is warranted.

CONCLUSION

The department must seriously tackle several weaknesses in its utilization management over developmental disability, mental health, and case management. Effective safeguards in this area are necessary to ensure that beneficiaries receive consistent and necessary quality care and the department avoids providing unnecessary care. Although a quantifiable effect of stronger protocols is unknown, tighter utilization controls should accrue cost savings.

Moreover, spending on inpatient hospital care and nursing facility services remains a significant portion of Idaho's Medicaid budget. As such, it is crucial that Idaho continues to deploy measures intended to contain costs and manage utilization. In recent years, several initiatives put in place have delivered many needed improvements in the department's utilization management of acute care and nursing homes. With its Uniform Assessment Instrument, utilization management contractor, change in reimbursement method for nursing homes, and home and community-based waiver program, the DHW is on the right track to better manage its skilled nursing and inpatient service areas.

RECOMMENDATIONS

To continue its efforts to contain costs and capitalize on all available opportunities, the department should consider the following:

- Consider designing a comprehensive utilization management plan that rectifies current weaknesses without giving up benefits inherent in the system. Specifically,
 - ✓ Establish protocols to ensure case managers cannot be service coordinators for recipients to whom they also provide care and treatment;
 - ✓ Develop practices to minimize the potential for duplicate services to be provided and consider implementing system changes that will prevent these occurrences;
 - ✓ Require standardization of the assessment and intake process to ensure uniformity and consistency across regions and among clients;
 - ✓ Establish criteria related to appropriate and inappropriate care for medical necessity;
 - ✓ Develop clear guidelines for prior-authorized services based on varying health care needs;
 - ✓ Reconsider future protocols to empower consumers to develop their own individual service plans because strong controls suggest that persons assisting in service planning should be independent of those having a financial interest in the services;
 - ✓ Coordinate and communicate often with the regions, UMP committee, and the department's various external contractors responsible for implementing utilization management reform efforts to ensure a level of compatibility and eliminate possibilities of duplications and gaps.
- Continue support of inpatient and long-term care initiatives and regularly monitor success of the techniques instituted.

Chapter 4

Some Improvements Could Be Made in Other Administrative and Management Areas

Chapter Summary

Throughout many areas of government, better management practices can result in advancements to programs or services provided. We identified three areas where some of the department's practices seem to reduce effectiveness and, in the spirit of continual improvement, it could further boost their success.

For instance, although DHW's automated systems have controls to appropriately process and pay claims, regional decision-makers may not have adequate access to the AIM system because they are not physically "connected" to DHW's local area network and many are not aware of the department's ad hoc reporting process. Moreover, some regional staff has become frustrated and has created numerous cottage or "homegrown" automated databases to meet their needs. While they may be filling the void of needed data for program management, systems developed outside standard protocols and controls may lack integrity and are developed at some cost. Additionally, some central program users complain that the multitude of reports generated from DHW's automated system no longer suit the users' needs. Thus, the department should work toward providing local and central decision-makers access to pertinent data needed to effectively manage their Medicaid program areas.

Additionally, although the state could receive a higher federal reimbursement rate if it operated a fraud unit external to the Medicaid agency, the state actually realizes a cost savings by operating its fraud unit internally. Further, we found that the internal fraud unit is successful and is praised for its efforts in investigating abusive Medicaid practices. However, minor modifications in its reporting structure and billing/collection practices could further augment the unit's activities and continual

efforts to incorporate progressive practices used elsewhere in the Medicaid fraud sector should be fruitful.

While the dollar effects of streamlining business protocols and tightening controls in these areas are often difficult to quantify, efforts typically offer benefits such as the avoidance of wasteful practices, consistency in program delivery, and enhanced effectiveness in job performance.

WHILE AUTOMATED SYSTEMS CAPTURE A WIDE ARRAY OF DATA, MANY USERS NEED ACCESS TO MORE USEFUL INFORMATION TO BETTER MANAGE THEIR PROGRAMS

Although DHW's automated claims processing system summarizes data in a myriad of reports, some users and decision-makers are frustrated with the adequacy of reported data and are not tapping into the full potential of system data needed to run an effective healthcare program. Without adequate data, the potential for poor management decisions based on flawed or outdated data is augmented. Many regional users created "homegrown" systems to assist them in running their programs to meet the need of access to data that exists in the central system. Given this, many opportunities exist to improve management information and provide more useful data from automated systems to help users effectively run programs.

Various Systems Assist DHW in Operating Its Medicaid Program

In states nationwide, the Medicaid program has been highly dependent on extensive and complex computer systems designed to determine eligibility and process claims for benefit payments. Moreover, recently, states have become more dependent on these data systems for measuring health care outcomes of services provided to beneficiaries. In Idaho, its Medicaid Management Information System—a claims processing and information retrieval system required by federal mandate—is known as the Advanced Information Management (AIM) System which makes use of networked personal computers. One of the primary objectives of Idaho's system is to provide on-line, real-time information, and to enable customer service functionality for system users. DHW draws on an external contractor, Electronic Data Systems (EDS), to operate and modify the system that

An objective of the AIM system is to provide on-line, real-time information for system users.

includes two primary subsystems—the management and reporting (MAR) subsystem and the surveillance and utilization review system (SURS).

The department uses the MAR subsystem, which is a query-based data retrieval tool, to obtain summary-level information on claims data and other financial transaction information. The MAR is updated weekly with current financial transaction data and maintains up to 60 months of data. MAR also generates detailed expenditure reports by federal service category, claims processed summaries, and many other financial reports on a regular basis. Additionally, this subsystem has on-line screens reflecting claim payments by service category, provider participation, drug usage, client status, and hospital days by client category. In total, MAR has 65 query screens and about 148 standard management reports run on a monthly, quarterly, or annual basis.

The SURS is a surveillance and utilization review tool that assists in identifying and tracking patterns of services and changes that are potentially indicative of fraud or abuse. The SURS currently produces approximately 92 reports which are standardized and limited to predetermined topic areas. Unlike MAR, that is updated weekly, the SURS module data is loaded every quarter.

The AIM system also includes a functional area specific to the Healthy Connections program. Client and provider enrollment into the program is directly entered into the subsystem by program staff. System users can directly access information related to specific aspects of the Health Connections program. For example, users can query to find individual affiliated providers or, through other screens, users can track notifications of enrollment, disenrollment, or change in a case manager. Additionally, the Healthy Connections subsystem can generate 42 management reports providing basic, summary expenditure and service data.

Regional Decision-Makers Do Not Have Access to Critical Program Information

Although DHW's automated systems have controls to appropriately process and pay claims, regional decision-makers may not have adequate access to the AIM system although they are the first point of contact with Medicaid beneficiaries. Regional program managers, organized by program functional

Although AIM subsystems can generate hundreds of reports, some regional staff do not have useful data to make health care decisions.

areas such as developmental disability, mental health, and Healthy Connections, make decisions directly impacting client care and services. These pivotal decisions include establishing Medicaid eligibility, encouraging enrollment in Healthy Connections and providing support to individuals enrolled, completing or approving individual treatment plans, and authorizing levels of care and treatment. Moreover, their program management decisions are a critical step in the success of DHW's utilization management program. As such, managers often need information related to a client's treatment history or patterns of services used before they can assess the need and authorize new or additional services. Without critical data such as a beneficiary's medical history, regional managers could be making critical decisions with outdated or inaccurate data, which can result in approving inappropriate care and unnecessary services and treatment.

We found that regions are not physically "connected" to DHW's local area network to allow direct access to MAR data and other reports available from the AIM system. As a result, regional staff rely on a standard report that is generated monthly by the central office and distributed to the regions. The Executive Management Information Report contains high-level statistics on each DHW program such as Medicaid enrollment expenditures, and utilization of services. While this report has merit, staff find that due to the standardized nature and lack of detail, few, if any, of these reports provide the management information and underlying data essential to better manage their programs. Report users contend that because the AIM system is fundamentally designed to pay claims, reports are not relevant for their purposes and lack components or analyses of underlying data or provisions necessary to assess methodology used to compare the reports. Regional staff stated they need data and reports along different dimensions such as services delivered for each client by provider.

To obtain additional information or other management data contained in the AIM system, regions must request special ad hoc reports through the central office's Medicaid Automated Systems unit. The unit reviews each request and prioritizes it considering the log of other requests submitted. Each request is prioritized based on its urgency, its relative importance when compared to others, the unit's current workload and programming hours available. Some ad hoc reports are created using DHW staff and others are prepared by external contracted staff. Despite the

Because regions are not "connected," they must rely on standardized reports that are often not relevant to their needs, outdated, or contain inaccurate data.

availability of this resource many regional staff are not aware of the AIM system's ad hoc capabilities or of the protocols related to these reports.

Mostly, the department uses an external contractor to program the system and run the customized reports. However, only a handful of central Medicaid staff have access to the automated system, have been trained in data manipulation, and can run ad hoc reports in house. The number of these "uniquely trained" individuals is limited because the department initially believed that a high volume of ad hoc users would slow down AIM's capability to pay claims timely. Thus, the department limited the maximum number of ad hoc specialists to the 28 licenses purchased to access and use ad hoc software. Because only seven individuals at DHW are currently using the software, the department should consider training another 21 key individuals on ad hoc processing.

Notwithstanding their access and license to use the system, the effectiveness of the ad hoc specialists is also limited. These staff do not have access to the full five years of claim data available within the AIM system and cannot run the more complex queries that link multiple files and subsystems within AIM. Moreover, although some staff have desktop access through the AIM system to the ad hoc reporting tool, these users can perform only simple and single level queries (they cannot request data elements residing in different AIM files) and can only retrieve six months of claims history.

In addition, regional staff has complained that the turn around time for ad hoc reports is too long. While the Medicaid automated unit staff contend a two-week turn around exists for ad hoc reports, other DHW staff maintain the wait is closer to a month long. Moreover, because of the remote nature of the request process and the lack of involvement with the AIM system, in particular the request prioritization process, some have become frustrated and may be disinclined to use the tool at all.

With the Absence of Critical Data, Regions Have Created Cottage Systems

Perhaps out of growing frustration over the lack of access to management data, we found that regional managers have reverted to their own resources and creativity to gather and create some of

Although the department uses internal staff and an external consultant to run customized ad hoc reports, some users are frustrated by turn-around time and the inability to run complex queries.

Reports generated from “homegrown” systems are redundant between regions, waste staff time and budget resources, and may lack integrity.

the management data needed. Specifically, staff at three regional offices we visited have created numerous cottage or “homegrown” automated databases to meet their needs. One region in Idaho Falls built a database to track timeframes and outcomes for client service plans for developmental disability and mental health services. Another region in Boise built a separate database to track services provided by contractors. Additionally, this same region created another system to monitor timeframes on client services plans similar to and duplicative of the one created by the Idaho Falls region. It is likely that regions providing similar services have similar data and management information needs. Therefore, although we did not identify all instances of duplicated efforts, the previous examples demonstrates instances of such practices.

Also, many of the databases reside on stand-alone personal computers and do not interface with other systems. Moreover, because the offices are not networked, the databases also are not accessible to most staff in other programs or the other regions. Building and maintaining these redundant systems can consume staff time and budget resources that could otherwise be spent providing services directly to Medicaid beneficiaries. At a minimum, improved coordination is needed to reduce duplication of efforts and to share existing applications across regional boundaries and between the central office and regional systems. And, while they may be filling the void of needed data for program management, systems developed outside standard protocols and controls may lack integrity. Therefore, each of these systems has the potential of producing faulty or erroneous data on which decisions are made. Clearly, these homegrown databases were developed in response to specific business needs of individual programs.

The AIM System Generates Some Unused Reports and Does Not Meet All Central Healthy Connections and SURS Staff Needs

While the AIM system generates a multitude of reports for use by the Healthy Connections and the SURS programs, many were carried over from the previous Medicaid automated system or legacy system, and no longer suit the users’ needs. The problem seems to be related to the reports themselves rather than to the adequacy of the data residing in the system.

Most reports produced from the AIM system provide basic, summary-level data related to expenditures or services that is not particularly useful to program managers. Specifically, Healthy Connections staff convey that they infrequently, if ever, use these reports, and rely instead on the ad hoc reporting process to obtain needed data. Moreover, we found that AIM lacks some of the functionality that is commonly tracked by managed care organizations—such as the number of office visits, the severity of patients for each PCP, and the number of referrals generated per PCP—although Healthy Connections is Idaho's form of managed care. Further, unlike databases for similar programs, AIM lacks a comprehensive outcome-based data application to track the quality and effectiveness of care such as childhood immunization status, cancer screens, and first-trimester prenatal care. While Healthy Connections can track four indicators, this is far fewer and less comprehensive than those found in similar programs in other states. Moreover, staff state that the AIM system lacks an automatic disenrollment feature for Healthy Connections. According to DHW staff, this results in a need to manually disenroll clients, taking approximately 80 hours of staff-time monthly.

Additionally, SURS unit staff believe that surveillance reports generated from AIM—approximately 92 reports in total—are not useful for their surveillance and monitoring functions. Moreover, they report that the ad hoc process does not adequately fill the gap. For example, SURS wanted to study whether Medicaid patients with Alzheimer's disease residing in nursing facilities were receiving appropriate psychotherapy services. Because of the complexity and number of queries required to extract needed data, SURS staff stated that they did not receive the report for eight months after the initial request.

Moreover, the reports are not necessarily comparing needed components. The system lacks a summary of providers by number of clients, level of expenditures and growth of spending over a period—all needed features to identify abusive practices. Also, since claims data is only loaded into the SURS module quarterly, reports are stale when received—making them less effective for uncovering abuse.

Department Should Work Toward Providing Local and Central Decision-Makers Access to Pertinent Data

Even at the central Medicaid office, staff contend automated reports are not useful for surveillance functions or to track quality and effectiveness of care.

Given the issues related to the lack of regional access, the growth of “homegrown” systems, and the cumbersome and slow ad hoc reporting process, the department should work closely with its regional decision-makers to ensure access to information critical to program management. Although the AIM system is essentially a claims processing system, it contains a vast amount of data on beneficiaries, providers, services provided, and treatment costs. Thus, it appears that the AIM system contains some of the data desired and the department may need to provide routine re-programming to allow flexibility in extracting data or in creating more useful, detailed reports.

Yet, to capture data that most commercial health plans readily collect, the department needs to overhaul the standard reports and ad hoc reports in AIM to capture needed information. The department considered these types of reports during the initial design phase of AIM, but dropped them due to cost issues. Because regions and central program staff need more useful data and are spending time creating homegrown systems to capture these data, DHW should revisit incorporating more flexibility into its AIM reporting structure.

However, before the department implements any new reporting protocols or makes changes to its system, it should first perform a thorough system-wide assessment to identify user needs and ensure decisions are based on an “in-house participatory process” involving the regions. As part of this assessment, the DHW should consider revamping its ad hoc process and ensuring regions have access to the data. This may require expanding physical network connections or ensuring flexibility and timeliness of ad hoc reporting—both actions that are likely to involve a significant financial investment. However, the future cost of not improving the system could be even greater if program managers do not have useful data when making decisions affecting beneficiaries’ health needs.

IDAHO REAPS BENEFITS FROM ITS INTERNAL FRAUD UNIT, ALTHOUGH MINOR IMPROVEMENTS COULD BE MADE

Federal law requires states operating a Medicaid program to have established practices and policies for identifying and investigating potential Medicaid fraud and abuse. Nationally, some experts project the amount of fraud around six percent of the Medicaid

budget annually, while others claim that it is as high as 15 percent. Idaho's program includes the requisite fraud programming, however, unlike most states, under provisions of a federal waiver it operates an internal fraud unit rather than an external certified unit. This model appears reasonable for Idaho and allows the state to achieve notable efficiencies. In addition to having appropriate controls, policies, and procedures in place, the internal fraud unit's efficacy in identifying fraud and obtaining recoveries is comparable to other states. And although external certified fraud units are eligible for higher levels of federal financial participation, our calculations reveal that operating an internal unit would not generate more federal funding or result in state savings with an external unit because of the necessary additional personnel required to staff a certified unit. Our review did identify some minor areas where the unit could improve its practices, however.

Waiver Allowing Internal Fraud Unit Reflects Results Similar to External Units

Concerned by the increase in suspected fraud and abuse in the Medicaid program, Congress passed legislation to address the rising tide of criminal activity by providing increased funding to states establishing external Medicaid fraud and abuse units. Fraud activities are part of the overall effort to provide quality care while holding accountable the health care community for controlling spending of taxpayer dollars. In 1995, Idaho obtained a Medicaid Fraud Control Unit waiver from the federal Health Care Financing Administration. The waiver allows the state to operate its fraud unit within the department responsible for the Medicaid program, rather than externally to the Department of Health and Welfare. Only two other states—Nebraska and North Dakota—operate under this waiver and, similarly to Idaho, the fraud and surveillance functions are combined within one unit.

All states, including Idaho, use a surveillance and utilization review subsystem (SURS) unit to ferret out fraud by conducting preliminary reviews of providers and beneficiaries with aberrant claims or billing patterns. A key responsibility of the SURS unit is to analyze provider activity over 15-month periods and assess the appropriateness of provider utilization. Specifically, staff research and review claims history and medical records as part of their evaluation. When the SURS unit uncovers potential cases of provider misutilization or a pattern of excess payments, staff

Idaho operates an internal fraud unit under an approved federal waiver, a model reasonable for the state.

By operating a combined fraud and SURS unit, Idaho may avoid "turf wars" common in other states.

refers the matter to the fraud unit for investigation. Investigators located in the fraud unit's central office pursue suspected provider and consumer fraud and abuse, while staff located in the seven regions mainly investigate consumer eligibility fraud.

According to a federal HCFA official, many non-waiver states experience "turf wars" between the internal SURS units and external fraud units over the ownership of the initial identification and referral of potential fraud cases and the subsequent investigation of these abusive practices. Results from our research also indicate evidence of the turf wars between these units as commonplace occurrences. However, HCFA believes that by having the combined unit, Idaho has avoided these territorial battles because they work cohesively as a team to identify and investigate cases—occasionally, SURS staff accompanies the fraud team on investigations at providers' on-site locations.

When we compared Idaho's performance against statistics from the other two states operating with internal fraud units—Nebraska and North Dakota—and against seven similar states that operate with external units—Nevada, Utah, Montana, New Mexico, Maine, Vermont, and New Hampshire—we found that Idaho's accomplishments were comparable to these other fraud units as shown in Table 4. Specifically, we found that Idaho recovered more than \$33,000 per fraud staff person in fraudulent payments for fiscal year 2000. Other states with internal fraud units report recoveries averaging \$46,000 per staff person. Although, Idaho's recoveries average 72 percent of the other internal fraud unit recoveries, we believe its rate is comparable when compared to seven other states with similar Medicaid caseloads. Specifically, recoveries per staff person in this second group of states ranged from approximately \$2,400 to \$65,000.

Idaho's fraud recoveries of \$33,000 per fraud investigator are comparable to nine similar states.

Idaho's fraud unit employs many of the best practices utilized in non-waiver programs. We found most staff have investigators with law enforcement backgrounds and experience. Ongoing training, comparable to external fraud units, is an integral part of their program. Further, the fraud unit operates a client and consumer toll-free hotline to facilitate the receipt of complaints. Also, for over six years it has joined efforts with the state Health Care Fraud Task Force to identify and pursue potential Medicaid abuse. Although the statistical and trend data generated by the DHW's AIM system is dated when received, the unit's operations

Table 4: Comparison of Idaho Fraud Recoveries Per Investigators With Other States

<u>State</u>	<u>Amount of Recoveries (rounded)</u>	<u>Number of Staff/Investigators</u>	<u>Recoveries Per Staff Person (rounded)</u>
With internal fraud units:			
Idaho	\$365,000	11	\$33,000
Nebraska	641,000	7	92,000
North Dakota	Minimal	1	N/A
With external fraud units:			
New Hampshire	\$389,000	6	\$65,000
Maine	372,000	6	62,000
Montana	363,000	7	52,000
Vermont	150,000	6	25,000
Nevada	287,000	13	22,000
New Mexico	153,000	13	12,000
Utah	31,000	13	2,000

Source: DHHS Office of Inspector General, *Annual Report on State Medicaid Fraud Control Units*, June 2000; HCFA Utilization reports.

utilize the information to uncover potentially fraudulent practices. It appears that the internal fraud unit operates with procedures and controls to appropriately meet its goals to safeguard against inappropriate use of Medicaid services and to identify and investigate potential fraud and abuse. Moreover, its use of proactive guidelines to identify and recoup fraudulent billings indicates its efforts result in performance levels that compare favorably with other states.

No Cost Savings Would Accrue From Moving the Fraud Unit Out of the DHW

Congress' commitment of additional federal funds to provide higher participation rates to detect and prevent fraud in the Medicaid program has resulted in many states realizing cost savings from operating a certified Medicaid fraud unit. Specifically, external fraud units receive 90 percent federal funding for the first three years that the certified unit is in

operation—and 75 percent thereafter—compared to the 50 percent federal funding rate available to states operating internal fraud units. However, the increased level of federal funding requires certified units to have specific levels of staffing; for example, full-time auditors and attorneys. When considering the cost effectiveness for operating an external unit in Idaho, our calculations indicate no cost savings.

To evaluate whether Idaho should seek the opportunity for a higher federal funding rate, we compared the current cost of DHW’s internal fraud unit with an estimated cost of having an externally certified unit. Our comparisons included SURS unit costs because the department’s combined fraud and SURS unit shares some resources while performing its functions. Using the department’s fiscal records, we identified the cost of operating Idaho’s internal fraud unit for fiscal year 2000 at \$230,000. These costs are eligible for a 50 percent federal match, resulting in a cost of \$115,000 to the state. Additionally, we found that SURS unit costs, eligible for a 75 percent federal match, were \$305,000 for fiscal year 2000—or \$76,000 in state costs. Thus, the state paid approximately \$192,000 in operating the combined unit for one year.

Certified external fraud units garner a higher federal match, yet Idaho realizes more than \$26,000 in annual cost savings by operating an internal unit.

Assuming operating and equipment costs remain constant, we estimate total costs of operating a certified fraud unit to be over \$579,000 in the first year, but drop to \$534,000 in subsequent years. These operating projections are not adjusted for inflation and are eligible for federal reimbursement at a 90 percent rate for the first three years and 75 percent thereafter. Additionally, as part of capturing the full cost and fiscal impact to the state, our estimates consider the effect of additional staffing requirements for a full-time auditor and attorney to be housed in an external unit. Using salary estimates reviewed by HCFA in Idaho’s waiver request, we calculated the annual auditor and attorney costs at \$50,000 and \$76,000, respectively.

Combined, the total cost of operating an external certified fraud unit and a separate SURS unit is approximately \$917,000 in the first year of operation, and is estimated to be approximately \$872,000 after the fourth year, not adjusted for inflation. Of this fourth year amount, the federal government would pay 75 percent of the cost, or \$654,000 leaving the state with general fund costs of nearly \$218,000. Conversely, the total cost of an internal combined fraud and SURS unit of \$536,000, after the fourth year,

matched at a 50 percent federal match rate for fraud activities and 75 percent for SURS activities—costing the state approximately \$192,000. Comparing these two calculations, we find that Idaho actually realizes a slight cost *savings*—more than \$26,000 annually—by operating an internal unit.

Minor Improvements Will Tighten Controls and Contribute to the Unit's Success

Our review of the fraud unit operations did reveal some opportunities for minor improvements—including separating certain conflicting duties, modest changes in the organizational structure, and implementing best practices—that could be incorporated to help ensure the unit's continued success.

For instance, as part of investigating a case, the fraud unit often takes remedial action against providers. Such action can include the issuance of warning letters, denial of claims submitted by the provider to the DHW for payment, suspension of the provider, recoupment of improper payments, and referral for prosecution. When the unit needs to recoup payment from a provider, the fraud unit prepares the invoice billing the provider for the unwarranted payments. Once the provider remits the billed amount, the fraud unit is also tasked with collecting the money. However, to protect financial resources, good fiscal management practices suggest that incompatible internal control functions, such as billing and collecting, should be appropriately segregated.

Operating the fraud unit as a function internal to the Medicaid program creates inherently conflict of interest situations by encompassing advocacy activities, such as encouraging provider participation in the Medicaid program, and fraud investigation activities—geared to deter, control, and take action against provider fraud—under the same Medicaid agency. For instance, the federal government warns that Medicaid providers and their associations can exert powerful political influence over Medicaid agencies that often undermines state's fraud efforts. DHW believes that this situation is controlled by staff signing conflict of interest statements designed to identify situations in which staff may have a financial or personal interest and, therefore, may have the potential for bias.

While several controls and safeguards are in place, we believe that a change to the organizational structure could provide a

Potential conflicts of interest can be reduced and stronger levels of independence achieved through a change in organizational structure.

stronger level of independence and reduce potential conflicts of interest between the fraud unit and the Medicaid Division. Specifically, the reporting responsibility of the fraud unit could be shifted from the Medicaid Division to a different division within the department—possibly an internal audit function or to the DHW Director. Having more separation between these two areas will allow the Medicaid Division to more freely function in its “provider advocacy” role, while the fraud unit can function in its “provider enforcement” control role.

Some DHW staff caution that a change in the reporting structure could negate some of the benefits achieved by the close working relationship that exists between the fraud unit and the Medicaid Division. In addition to the direct communication and feedback received from the fraud unit, the Medicaid Division also benefits from the fraud unit’s assistance in commenting on proposed rules and policy changes. However, the division can still reap these benefits even with the fraud unit reporting to a different section. Thus, the practice of working with the Medicaid policy section and communicating common provider practices found during investigations should continue.

Additionally, the DHW should develop standards and guidelines for negotiating settlements with providers. Detailed procedures and practices would aid the negotiations and settlement process and would allow for more consistent treatment of provider cases and minimize the ability of outside influences to sway the results of negotiations. Another potential technique in this process is an established “negotiation team,” consisting of representatives from the fraud unit, Medicaid Division, executive management, and the State Attorney General’s Office, that could discuss substantiated fraud cases and ensure that negotiations reached are fair and unbiased.

Also, there are a few other practices currently being used in the fraud arena that the fraud unit should consider implementing. Specifically, to heighten awareness of fraud, the DHW could require its providers to incorporate formal commitments, within their contractual agreements, to detect and report potential fraudulent and abusive practices. As part of these agreements, the DHW should clearly define and ensure providers fully understand what activities constitute fraud and abusive practices. Also, protocols should be developed to ensure that Medicaid beneficiaries are effectively educated on fraud and abuse, fully

understand their responsibilities, and know where and how to report abusive practices. Finally, the fraud unit could proactively interview a randomly selected group of beneficiaries receiving Medicaid services to determine if services were appropriately rendered or whether they encountered any abusive practices while receiving care from the Medicaid program.

CONCLUSION

In addition to the major initiatives and opportunities for cost savings noted in Chapters 1 through 3, the DHW could strengthen its management over the Medicaid program by making some minor improvements in other areas. Specifically, it needs to ensure that regional decision makers have access to critical management information from its automated systems and needs to incorporate organizational changes and best practices over its fraud activities.

Along with the local and federal governments, Idaho must continually seek to make improvement in its Medicaid program's quality, effectiveness, and extent of health care services. To this end, the state must decide how it should function within the constraints it faces from serious economic, social, and political factors. These decisions will not—and should not—come easily or without deliberative processes that attempt to consider all impacts and ramifications of proposed operational changes weighed against the cost and consequence of inaction. However, the state should seriously consider incorporating many, if not all, of the techniques suggested throughout this report into a comprehensive plan to help keep Medicaid costs down and provide quality care.

RECOMMENDATIONS

To continue on its path of continuous improvement and efforts to streamline business protocols, the department should consider the following:

- Perform a thorough system-wide assessment, especially involving staff from the regions and key central office program areas, to identify user management data and reporting needs;

Best practices that could be implemented include the establishment of guidelines for negotiating settlements and the cooperation of beneficiaries in reporting abuse.

- Overhaul AIM's reporting capabilities to adjust standard and ad hoc reports as necessary, including revamping the flexibility and timeliness of the ad hoc priority process;
- Consider expanding physical network connections to the regions;
- Separate incompatible internal control functions in the fraud unit's billing and collecting activities;
- Change the fraud unit's organizational reporting structure to provide stronger appearance of independence and reduce potential conflicts of interest between the fraud unit and the Medicaid Division. Specifically, have the unit report to a different division or to executive management directly;
- Expand guidelines used for negotiating fraud settlements and consider instituting a "negotiation team" to ensure fair and unbiased negotiations;

Incorporate progressive best practices over fraud activities such as obtaining provider commitments towards detecting and reporting fraudulent and abusive practices and proactively interviewing beneficiaries to determine if care received was appropriate and free of abusive practices.

Appendices

Appendix A

Medicaid Spending During Fiscal Year 2000

<u>Program Benefits^a</u>	<u>Costs</u>	<u>Percent of Program Benefits</u>	<u>Percent of Total Spending</u>
Inpatient Hospital	\$82,488,603	14.40%	13.23%
Nursing Facilities	110,105,122	19.22	17.66
Intermediate Care Facilities	49,570,296	8.66	7.95
Physician Services and Other Practitioners	40,066,697	7.00	6.43
Primary Care Case Management ^b	1,332,563	0.23	0.21
Outpatient Hospital	20,352,978	3.55	3.26
Drugs	76,969,366	13.44	12.35
Dental Services	14,282,226	2.49	2.29
Mental Health Clinic	29,542,559	5.16	4.74
Laboratory/Radiology Services	5,362,478	0.94	0.86
Home Health Services	6,649,587	1.16	1.07
Medicare Parts A and B	9,973,371	1.74	1.60
Personal Care Services	31,658,605	5.53	5.08
Developmental Disability	40,887,143	7.14	6.56
Targeted Case Management	10,243,571	1.79	1.64
Transportation	8,329,887	1.45	1.34
Other	34,912,883	6.10	5.60
Total Program Benefits	\$572,727,935	100.00%	91.86%

^a \$17 million of the program benefit expenditures are for ISSH services which are reimbursed as part of the federal Medicaid program, but appropriated under a separate state budget item.

^b Healthy Connections.

Continued on next page

<u>Administration</u>	<u>Costs</u>	<u>Percent of Administration</u>	<u>Percent of Total Spending</u>
Medicaid Policy and Operations	\$3,789,688	7.47%	0.61%
Eligibility Determination	13,995,536	27.57	2.25
Fraud	214,563	0.42	0.03
Accounting, Reporting, and Indirect	5,002,272	9.86	0.80
Contracted Services	11,898,539	23.44	1.91
Regional Administration	2,350,468	4.63	0.38
Service Costs ^c	12,871,876	25.36	2.06
Other	633,748	1.25	0.10
Total Administration	\$50,756,690	100.00%	8.14%
Total Spending	\$623,484,625		100.00%

^c Primarily at the regional level.

Source: MMIS ad hoc reports: *Medicaid Costs by Category 07/01/99–06/30/00* and *Actual and Forecasted Medicaid Expenditures by Fiscal Year: FY 2000–2002*.

Appendix B

Key Sections of Legislative Intent Language From 2000 Legislative Session

SECTION 7

It is the intent of the Idaho Legislature that the Division of Veterans Services and the Department of Health and Welfare take the steps necessary to make state veterans homes providers of services under the state's Medicaid Program on or before February 1, 2001. It is further the intent of the Idaho Legislature that for the period July 1, 2000, through June 30, 2001, the cost limits described in Section 56-102(7) and Sec. 56-102(11), Idaho Code, shall not apply to state homes for veterans. In addition, the Department of Health and Welfare is directed to provide a status report on making this conversion to the Joint Finance-Appropriations Committee at each of their regularly scheduled interim committee meetings.

SECTION 8

It is the intent of the Idaho Legislature that the total expenditure for transportation services provided to clients of the state's Medicaid Program for the period July 1, 2000, through June 30, 2001, shall not exceed the amount spent in state fiscal year 2000. The department shall consult with providers and advocates of persons receiving transportation services on how to achieve these savings.

SECTION 9

It is the intent of the Idaho Legislature that the number of beds in private intermediate care facilities for the mentally retarded funded by Medicaid, be capped at four hundred eighty-six (486) beds, including any beds planned or under construction. The department shall consult with providers and advocates of persons receiving ICF/MR services on how to implement the cap.

SECTION 10

Notwithstanding the provisions of Sec. 56-113, Idaho Code, it is the intent of the Idaho Legislature that for the period July 1, 2000, through June 30, 2001, rates, including special rates, of private

intermediate care facilities for the mentally retarded shall not exceed the rates in effect in state fiscal year 2000.

SECTION 11

It is the intent of the Idaho Legislature that the Department of Health and Welfare require the use of generic drugs to the extent feasible and allowed by law in the state's Medicaid Program. The department shall develop a process of prior approval when the physician prescribes drugs other than generic. The department is further directed to research the feasibility of implementing a closed Medicaid drug formulary.

SECTION 12

It is the intent of the Idaho Legislature that a defined process of prior authorization, client assessment and periodic review be implemented by the department for developmental disability agency services provided to clients of the state's Medicaid Program after consultation with providers and advocates of persons with developmental disabilities.

SECTION 13

It is the intent of the Idaho Legislature that for the period July 1, 2000, through June 30, 2001, the rates paid for durable medical equipment provided to clients of the state's Medicaid Program shall not exceed the rates in effect in state fiscal year 2000.

SECTION 14

It is the intent of the Idaho Legislature that physical therapy services, beyond a specified amount, be prior authorized and that a concurrent review process be established in order to manage utilization and cost.

SECTION 15

It is the intent of the Idaho Legislature that the Department of Health and Welfare actively oversee targeted case management services received by clients of the state's Medicaid Program to ensure that clients are receiving only needed services resulting in desired treatment outcomes. It is further the intent of the Idaho Legislature that private targeted case managers focus more on managing the utilization of services rather than maximizing services provided to clients. The Department of Health and Welfare is authorized to develop and include enforceable prior authorization and performance requirements in provider agreements for targeted case management services to carry out

these objectives. The department shall consult with providers and advocates of clients receiving targeted case management services on how to effect the transition to the prior authorization and performance requirements. It is further the intent of the Idaho Legislature that the Department of Health and Welfare develop a plan to be implemented over a period of time to better manage such services.

SECTION 16

It is the intent of the Idaho Legislature that mental health services provided to clients of the state's Medicaid Program shall be prior authorized and periodically reviewed through a defined process in order to achieve cost savings. The department shall consult with providers and advocates of clients receiving mental health services on the process for implementing such prior authorization and periodic review.

SECTION 17

It is the intent of the Idaho Legislature that clients participating in the state's Medicaid Program share a portion of the cost of providing services to the extent allowed by law. The Idaho Legislature authorizes the Department of Health and Welfare to implement reasonable copayments and other cost-sharing methods as allowed by law. Providers will retain all copayments collected, and the Department of Health and Welfare will not reduce provider reimbursement rates by the amount of the copayments.

SECTION 18

It is the intent of the Idaho Legislature that day treatment services provided to clients with mental illness through the state's Medicaid Program shall be limited to aiding in the transition from acute care to lesser levels of care and to stabilization as a means of preventing hospitalization. Such transition and stabilization services shall include, but not be limited to, a planned program of three (3) hours per day of group therapy, one (1) hour per day of individual therapy, at least two (2) psychiatric visits every six (6) days, and meaningful group recreational activities. The modification of day treatment services shall be phased in by January 1, 2001. The department shall consult with providers and advocates of clients receiving day treatment services regarding the means of modifying day treatment services to transitional and stabilization services by the target date.

SECTION 19

It is the intent of the Idaho Legislature that the Department of Health and Welfare research the feasibility of reducing Medicaid service coverage to more closely match private insurance coverage when practical.

SECTION 20

It is the intent of the Idaho Legislature that the department review the administrative costs of the Medicaid Program to assure cost-effectiveness, and wherever possible, reduce the cost to be more in line with the surrounding states.

Source: Idaho House Bill No. 797, 2000 Legislative Session.

Appendix C

State Medicaid Program Project Scope Summary

This evaluation will provide an independent examination of the state's management, oversight, and administration of the Medicaid Program. The study will assess key program and administrative areas, including utilization management, administrative operations, fiscal and budgetary control, and Medicaid system contract oversight.

Outside consultants with expertise in Medicaid evaluations and program operations will review and analyze data from the Department of Health and Welfare and other relevant sources, interview department personnel and other stakeholders, and utilize other analytical tools for program evaluation. Although Medicaid is a federally funded program for which data are collected, there are complications in comparing Idaho data and performance to the same in other states. To the extent possible, however, and as necessary, the consultants will identify benchmarks or comparative criteria from other state Medicaid programs, the Health Care Financing Administration, and the health care industry.

The evaluation will result in a report to the Legislature that will include descriptive program information to aid policy makers in their decisions and evaluative conclusions and recommendations about selected program and administrative operations and strategies. To the extent adequate data are available, the consultants will quantify the fiscal implications of current and recommended practices, identify potential cost savings, and offer realistic and beneficial recommendations to the Legislature and responsible administrative and operational officials.

To assure that no unnecessary duplication of effort occurs between the consultants' activities and the various initiatives (including Medicaid budget intent language studies) underway by the department, coordination is included in this evaluation's approach. The consultants will "build upon" and not duplicate the work of the department and its other consultants relevant to the scope of this evaluation.

Under **Program Operations**, the evaluation will assess:

- Utilization management and control
 - Developmentally Disabled and Mental Health services
 - Case management and prior authorization
 - Prescription drugs
 - Services not generally available from commercial health insurers

- Healthy Connections program
 - Primary Care Case Management opportunities
 - Program implementation

- Surveillance and Utilization Reviews (SURS) and fraud investigations
 - Quality control activities and placement

Under **Administrative Activities**, the evaluation will assess:

- Medicaid program management information and data availability
 - Adequacy, quality and timeliness of management reports
 - Availability and adequacy of information for program implementation, performance measurement, and oversight
 - Coordination of information systems

- Fiscal and budgetary operations and control
 - Administrative costs
 - Revenue maximization strategies and implications on Medicaid staffing/expenditures
 - Accountability

- Management and oversight of Medicaid system contracts
 - Fiscal intermediary operations, third-party recoveries and case management

- Veterans' Homes Medicaid eligibility
 - Implications on resident's benefits

Appendix D

Comparisons of the Rates of Occurrence of Certain Health Diagnoses Between Healthy Connections and Fee-for-Service Beneficiaries

<u>Health Diagnosis</u>	<u>Percent of Healthy Connections Beneficiaries Affected</u>	<u>Percent of Fee-For-Service Beneficiaries Affected</u>
Catastrophic claims	5.1%	5.0%
Diabetes	3.5	3.1
Asthma	5.7	3.6
Chronic heart disease	0.9	1.0
Serious and persistent mental illness:		
Schizophrenia and psychotic disorders	1.9	1.7
Depressive and bipolar disorders	4.8	4.9
Delusional disorders	0.1	0.1
Personality disorders	0.4	0.4
Developmental disabilities:		
Emotional disturbances	1.3	0.7
Developmental delays	3.4	1.4
Mild mental retardation	2.3	1.2
Moderate/severe/profound mental retardation	1.8	0.8
Cerebral palsy	1.2	0.6
Epilepsy	1.7	1.1
Brain damage	0.3	0.3
Down's Syndrome	0.6	0.3
Delivering babies	4.5	10.6
Delivering low birth weight babies	0.0	0.6

Source: The Lewin Group analysis of an electronic data extract from the Department of Health and Welfare's MMIS for calendar year 1999.

Appendix E

Eight Broad Utilization Management Strategies Recommended by the UMP Committee

- *Stakeholder-Driven Quality Improvement.* Develop formal quality improvement processes that engage consumers, family members, advocates, providers and government official in a constructive and ongoing endeavor to improve Idaho's public behavioral health system.
- *Supporting Consumer Empowerment.* Promote consumer empowerment by requiring independence goals as the central organizing force in development of individualized service plans; providing State funding for independent consumer-governed and operated advocacy and support services for behavioral health; and exploring consumer self-determination as a service model.
- *Establishing Utilization Management Administration.* Establish a coordinated approach to basic administrative structures required to implement Utilization Management such as enforcing statewide criteria that reflect Idaho stakeholder values and national best practice standards for the appropriate use of Medicaid behavioral health services.
- *Clarifying Regional Office Role.* Separate, at the regional office level, the direct provision of care- including consumer assessment, service plan development and therapeutic/support services- from provider contracting, quality monitoring and authorization functions.
- *Instituting Accountability Checks.* Institute collaboratively developed, unified and consistent standards for auditing provider performance and testing inter-rater reliability of Utilization Management clinician determinations.
- *Structuring Progress Toward Desired Outcomes.* Identify desired service system outcomes and hold providers and the Utilization Management programs accountable for making progress toward those outcomes. As part of this effort, it will be important to monitor the affect of Utilization Management on cost-shifting to other state services.
- *Engaging in Public Outreach and Education.* Establish formal processes for the rapid public dissemination of information about system developments, and a current, consolidated source of information about effective rules, regulations and guidelines, public behavioral health benefits, contact information, anti-stigma, and community integration.
- *Instituting Provider Training.* Develop a full provider training program to improve provider competency in relation to best practices, utilization criteria and proper documentation and billing procedures.

Source: APS report: *Utilization Management for Idaho Medicaid Mental Health and Developmental Disabilities Services*, June 2000.

Response to the Evaluation



State of Idaho
DEPARTMENT OF HEALTH AND WELFARE
Office of the Director

DIHK KEMPTHORNE
Governor

KARL B. KURTZ
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November 15, 2000

Ms. Nancy Van Maren
Office of Performance Evaluations
Idaho State Legislature
P.O. Box 83720
Boise, Idaho 83720-0055

Dear Ms. Van Maren:

Enclosed you will find the Department response to recommendations found in the report Idaho's Medicaid Program: The Department of Health and Welfare Has Many Opportunities for Cost Savings. We have chosen to include an Executive Summary of our response as well as specific responses to the individual recommendations found at the end of each chapter in the report.

We appreciate the thoroughness of the work done by your office, The Lewin Group and Sjoberg Evashenk Consulting, LLC. We look forward to discussion of this report when it is presented to the Joint Legislative Oversight Committee on November 28, 2000.

Sincerely,

Karl Kurtz
Karl Kurtz
Director

Enclosures



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Executive summary of Department of Health and Welfare response to recommendations contained in this report

The recommendations contained in this report provide reassuring confirmation that current efforts already under way will generate cost savings.

Expansion of the Healthy Connections Program falls into this category. However, the infrastructure does not exist today to support a statewide, mandatory expansion. We agree that Healthy Connections should be expanded and will work diligently to lay a groundwork that assures consumer access to primary care providers.

We also agree that conversion of Idaho's three veterans homes to Medicaid will save General Fund dollars. We anticipate conversion of all three homes to be completed by year's end.

The Department has long followed the practice of trying to reduce the use of state General Fund dollars for Medicaid by leveraging available federal funds. The Department will carefully review opportunities to do more in this area while taking suitable precautions to assure the Department claims the appropriate level of federal match for all Medicaid staff positions.

The authors of this report correctly suggest that a reduction in drug dispensing fees and drug acquisition reimbursement can save Medicaid dollars. However, state code requires negotiation with the pharmacy industry before implementing any change in Medicaid reimbursement for pharmaceuticals. With direction from the Governor and Legislature, the Department will seek the changes in pharmacy dispensing fees and reimbursement recommended in this report.

We also agree that a co-payment system and prior authorization for brand name drugs can slow the growth in Medicaid spending. In fact, such systems will be in place shortly. Beginning January 1, 2001, pharmacists may begin collecting and keeping a co-payment from Medicaid consumers. This system was authorized during the last session of the Legislature. Beginning December 15, 2000, the Department will begin requiring prior authorization for brand name drugs that have a generic equivalent. The Department has followed legislative intent in implementing these changes.

The Department also is following legislative intent in developing a utilization management protocol for developmental disability and mental health services provided to Medicaid consumers. March 15, 2001 is the tentative target date for implementing this system of prior authorization and review. Again, we strongly agree that such a system will give the Department an increased ability to manage costs.

Finally, the Department agrees that improvements are needed in our automated system. We're already in process of examining system information/reporting issues. Areas identified in this assessment will be incorporated in a request for proposals for a new AIM operation contract. A new contract will be in place January 1, 2003.

Responses to individual recommendations in Chapter 1

Recommendation:

Expand Healthy Connections program and make the program mandatory in more counties within the state

Department response: We agree with the recommendation. Currently, the Division of Medicaid is exploring the infrastructure that will be required to assure consumer access to primary care providers. Those infrastructure needs include:

- improved claims processing,
- potential reimbursement incentives for providers who take a high percentage of Medicaid clients,
- regional staffing needs,
- physician recruitment,
- automation requirements, and
- training for consumers and providers.

Even with the costs incurred above, we are certain that savings can be found, outcomes improved and consumer and provider satisfaction increased.

Recommendation:

Perform an in-depth cost-benefit analysis associated with its conversion of veterans homes to Medicaid and consider fiscal, program and societal impacts on the state and veterans.

Department response: We agree with this recommendation. The Department is committed to working with the Division of Veterans Services to minimize potential negative impacts on Medicaid and non-Medicaid veterans home residents.

Recommendation:

Leverage federal funds for those case management activities already conducted by regional staff through a targeted case management state plan amendment.

Department response: We agree with this recommendation and will proceed with developing a work plan to implement it. Ongoing assurance of accuracy will be handled through the existing quarterly budget review process. We will verify that we are claiming the appropriate match rate for all positions.

Recommendation:

Capture information systems and skilled medical professional activities and bill them at a higher federal match rate.

Department response: We agree with this recommendation. We will review information system expenditures for appropriateness, to assure that we are developing management information as efficiently as possible. We will review skilled medical position activities to assure we are claiming highest level of federal match possible.

Responses to individual recommendations in Chapter 2

Recommendation:

Lower the pharmaceutical dispensing fees paid to pharmacists by fifty cents from \$4.94 to \$4.54; Alternatively, the department could reduce dispensing fees through a tiered or sliding scale based on volume of prescriptions filled.

And

Recommendation:

Increase its drug acquisition discount paid to pharmacies from 11 percent to at least 12 percent.

Department responses: While the Dept agrees with these two recommendations, any change in reimbursement must be negotiated with the pharmacy industry, as required by state code. With direction from the governor and legislature, we will enter those negotiations in FY2001, asking for changes recommended by this study.

Recommendation:

Implement co-payments for pharmaceuticals ranging from fifty cents to one dollar and provide collections to pharmacies to partially compensate for suggested dispensing and drug product reductions or keep collections to offset growing state Medicaid costs and provide additional benefits to Medicaid beneficiaries.

Department response: Current legislative intent language mandates a co-payment system that provides co-pay collections to pharmacists. The Department is carrying out the intent language as written. The target date for implementation is January 1, 2001. This recommendation describes an alternative approach to pharmaceutical co-pay, one in which the Department collects and keeps co-payments. The Department is willing to redirect its efforts if directed by the governor and legislature.

Recommendation:

Continue with current plans to encourage the use of generic drugs by requiring prior authorizations for brand name pharmaceuticals.

Department response: It is anticipated that this recommendation will be fully implemented by December 15, 2000. On this date, the Department will begin requiring prior authorization for brand name drugs that have a generic equivalent.

Recommendation:

Continue to research opportunities for creating a preferred drug list and consider the feasibility of incorporating it into Idaho's Medicaid program.

Department response: The Department is currently working with the Idaho State University School of Pharmacy to develop a preferred drug list and process for implementation.

Responses to individual recommendations in Chapter 3

Recommendation:

Consider designing a comprehensive utilization management plan that rectifies current weaknesses without giving up benefits inherent in the system.

Department response: We agree with this recommendation. The Department worked intensively with the Legislature's Joint Finance-Appropriations Committee to develop recommendations for utilization management of Medicaid-covered mental health and developmental disability services. The target date for implementation is March 15, 2001. The system will address all of the concerns identified in the text of this report.

Recommendation:

Continue support of long-term care initiatives and regularly monitor success of the techniques instituted.

Department response: The Department will continue with established processes of monitoring long-term care initiatives

Responses to individual recommendations in Chapter 4

Recommendation:

Perform a thorough system-wide assessment, especially involving staff from the regions and key central office program areas, to identify user management data and reporting needs.

Department response: The Department agrees with this recommendation. We're already in process of examining system information/reporting issues. Areas identified in this assessment will be incorporated in a request for proposals for a new AIM operation contract. A new contract will be in place January 1, 2003.

Recommendation:

Overhaul AIM's reporting capabilities to adjust standard and ad hoc reports as necessary, including revamping the flexibility and timeliness of the ad hoc priority process.

Department response: We recognized the problem ourselves and have already moved to improve the situation. In October 2000, the Department installed a new server which shortens the processing time needed to produce ad hoc reports. A committee has been established to review the standard and ad hoc report process. The committee will develop recommendations to improve efficiency, cut duplication, and develop guidelines for prioritizing requests. These recommendations are due to Director Kurtz on January 1, 2001.

In addition:

- The Department will train more people to do ad hoc reports,
- An actuarial study will examine our information needs, review our standard reports, and recommend improvements.

Recommendation:

Consider expanding physical network connections to the regions.

Department response: Following the assessments described above, appropriate decisions will be made to improve AIM's ad hoc reporting process.

Recommendation:

Separate incompatible internal control functions in the fraud unit's billing and collecting activities.

Department response: The legislative auditors previously identified this issue and the correction was made in August 2000.

Recommendation:

Change the fraud unit's organizational reporting structure to provide stronger appearance of independence and reduce potential conflicts of interest between the fraud unit and the Division of Medicaid. Specifically, have the unit report to a difference bureau or to executive management directly.

Department response: This change is being implemented as part of a reorganization of the Division of Medicaid that is currently underway and should be completed by the end of the calendar year. The fraud unit will report to the Division of Management Services, beginning November 13.

Recommendation:

Expand guidelines used for negotiating fraud settlements and consider instituting a "negotiation team" to ensure fair and unbiased negotiations.

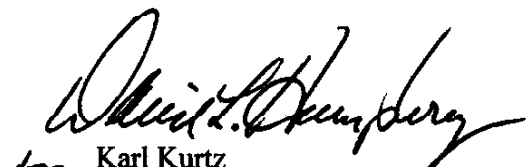
Department response: The Department agrees with this recommendation and has developed some guidelines for administering fraud cases. Specifically, the Department will review the negotiation process to develop more guidelines in this area and will look into the use of a negotiation team.

Recommendation:

Incorporate progressive best practices over fraud activities such as obtaining provider commitments towards detecting and reporting fraudulent and abusive practices and proactively interviewing beneficiaries to determine if care received was appropriate and free of abusive practices.

Department response: We agree with this recommendation. While the Department has implemented many best practices, the Department currently lacks sufficient resources to initiate additional actions. The Department plans to address this problem in a future budget request.

Respectively submitted, November 15, 2000


for Karl Kurtz
Director

Completed Performance Evaluations

<u>Pub. Number</u>	<u>Report Title</u>	<u>Date Released</u>
95-01	State Travel Management	August 1995
95-02	Medicaid Services for Children With Disabilities	November 1995
96-01	Safety Busing in Idaho School Districts	February 1996
96-02	Oversight of Pupil Transportation Contracts	February 1996
96-03	Use of Bus Routing Software in Idaho School Districts	May 1996
96-04	Contracted Versus District-Operated Pupil Transportation Programs: An Analysis of Cost and Program Differences	May 1996
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98-03	Management of State Agency Passenger Vehicles	October 1998
98-04	Management Review of the Idaho Commission for the Blind and Visually Impaired	October 1998
99-01	The State Board of Pharmacy's Regulation of Prescription Controlled Substances	June 1999
99-02	The State Board of Medicine's Resolution of Complaints Against Physicians and Physician Assistants	October 1999
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00-01	A Limited Scope Evaluation of Issues Related to the Department of Fish and Game	March 2000
00-02	The Department of Fish and Game's Automated Licensing System Acquisition and Oversight	June 2000
00-03	Passenger Vehicle Purchase Authority and Practice in Selected State Agencies, Fiscal Years 1999–2000	September 2000
00-04	A Review of Selected Wildlife Programs at the Department of Fish and Game	November 2000
00-05	Idaho's Medicaid Program: The Department of Health and Welfare Has Many Opportunities for Cost Savings	November 2000

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