Idaho's Medicaid Program

Follow-up Review
June 2004

Office of Performance Evaluations
Idaho State Legislature

Report 04-05F

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Office of Performance Evaluations
Idaho State Legislature

Joe R. Williams Building
Lower Level, Suite 10
P.O. Box 83720
Boise, Idaho 83720-0055

Phone (208) 334-3880
Fax (208) 334-3871
www.state.id.us/ope

Rakesh Mohan
Director

June 4, 2004

Members
Joint Legislative Oversight Committee
Idaho State Legislature

At your direction, we have completed our follow-up review of the Department of Health and Welfare's Medicaid Program.

We reviewed the department's implementation of the 18 recommendations in the 2000 report, *Idaho's Medicaid Program: The Department of Health and Welfare Has Many Opportunities for Cost Savings*. The department has addressed all 18 recommendations, fully implementing 14. These recommendations have contributed to cost savings or cost avoidance of over $21 million for the state, and have improved management practices within the Medicaid program.

We appreciate the department's cooperation in providing the information needed to conduct this review. Paul Headlee (team lead) and Brook Smith of the Office of Performance Evaluations completed this follow-up review.

Sincerely,

Rakesh Mohan

Rakesh Mohan

Idaho's Medicaid Program

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Summary

In November 2000, the Office of Performance Evaluations released *Idaho's Medicaid Program: The Department of Health and Welfare Has Many Opportunities for Cost Savings*, an evaluation requested by the Joint Legislative Oversight Committee and the Joint Finance Appropriations Committee. The Idaho Department of Health and Welfare has implemented 14 of the report's 18 recommendations. Implementation of these recommendations has contributed to cost savings and cost avoidance of nearly $52 million to date, including over $21 million to the State of Idaho. Other recommendations have improved data and reporting systems, and fraud and abuse investigations.

Background

The Office of Performance Evaluations released the evaluation report, *Idaho's Medicaid Program: The Department of Health and Welfare Has Many Opportunities for Cost Savings* in November 2000. We contracted with The Lewin Group, a national health care specialist, and Sjoberg Evashenk Consulting, LLC, a government-consulting firm, to conduct the evaluation. The report identified 18 recommendations to reduce costs and improve the management of Idaho's Medicaid program. This follow-up review summarizes efforts to implement each of the recommendations and the resulting outcomes. These recommendations are grouped into five categories: case management, pharmaceuticals, data/reporting, fraud and abuse investigations, and veterans services. Exhibit 1 provides a list of recommendations that have contributed to cost savings or cost avoidance.

The federal Medicaid program provides health related services to needy individuals and families. Services include hospitalization, nursing home care, prescription drugs, and treatment for other medical conditions. Because of federal and state legislation, Medicaid services have expanded in the past ten years. One of the largest expansions occurred in 1999, with the addition of the Children's Health Insurance Program (CHIP).

Exhibit 1: Estimated Cost Savings or Avoidance, November 2000–June 2004

Recommendation	State	Federal	Total Avoidance/ Savings
Expand Healthy Connections program	$6,263,074	$16,877,781	$23,140,855
Design a comprehensive utilization management plan[a]	785,000	n/a	785,000
Increase drug acquisition discount prices from 11% to 12%	805,869	2,018,142	2,824,011
Encourage use of generic drugs through prior authorization of brand name drugs	2,807,581	7,131,523	9,939,104
Research creating a preferred drug list	1,556,061	4,243,939	5,800,000
Overhaul the AIM system's reporting capabilities	185,500	n/a	185,500
Cost-benefit analysis of veterans homes conversion to Medicaid	9,281,980	n/a	9,281,980
TOTAL	$21,685,065	$30,271,385	$51,956,450

[a] The department projects $39 million total cost avoidance for fiscal years 2005–2008.

Source: Office of Performance Evaluations analysis of data from the Idaho Department of Health and Welfare.

In fiscal year 2000, Idaho's Medicaid costs had reached $163 million, about 10 percent of the state general fund. Total funding allocated to Medicaid, including federal funds, was $585 million. At that time, Medicaid served 95,869 clients statewide.[1] A steady and sizeable increase in the Medicaid budget during previous years prompted the Joint Legislative Oversight Committee and the Joint Finance Appropriations Committee to direct us to manage an evaluation of Idaho's Medicaid program with a focus on identifying cost-saving measures.

[1] Medicaid client and budget numbers were reported in the *FY2005 Idaho Legislative Budget Book*, p. 39.

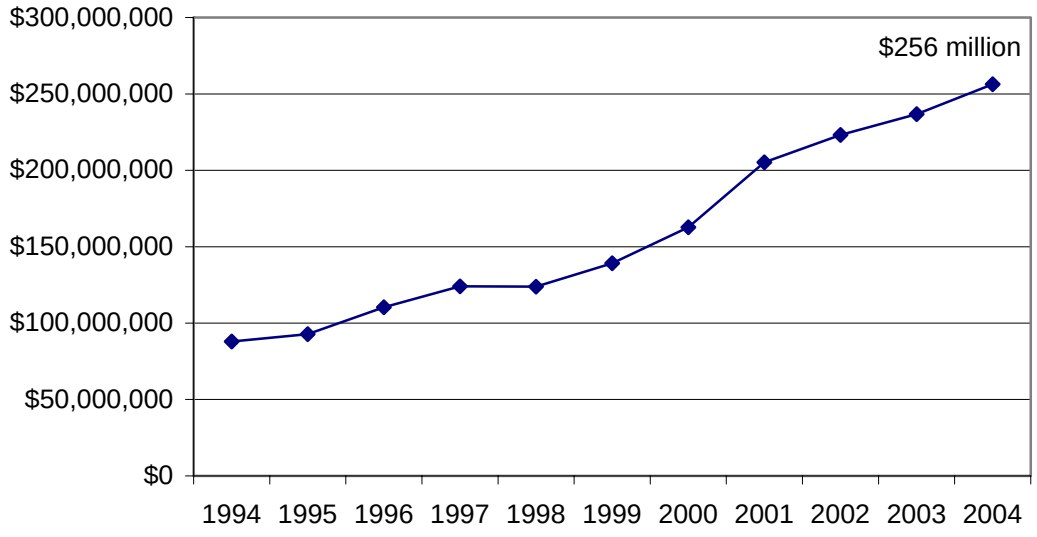
As shown in Exhibit 2, Medicaid costs continue to rise. In fiscal year 2004, the state's share of total Medicaid funding reached $256 million, and approximately 167,000 clients were served statewide.[2] This is a 57 percent increase in funding and more than a 70 percent increase in clients between fiscal years 2000 and 2004. The state's Medicaid budget for fiscal year 2005 is $288 million. When federal, state, and other dedicated funds are combined, Idaho's total Medicaid budget for fiscal year 2005 is over $1 billion.

The large growth in the state Medicaid budget is not unique to Idaho. In 2002, the average growth nationwide in state budgets was 1.2 percent, while the growth in Medicaid costs was 12.8 percent. Budget experts predict that Medicaid costs to states will continue to climb by more than eight percent a year.[3]

[2] The total Medicaid budget for fiscal year 2004 was $920 million, including state, federal, and dedicated funds.

[3] Martha King and Dianna Gordon, "Medicaid: 10 Fixes that Work," *State Legislatures*, National Conference of State Legislatures, March 2004.

Exhibit 2: Idaho's State Funded Medicaid Cost Increase, Fiscal Years 1994–2004



Source: Idaho Legislative Budget and Policy Analysis, *FY2005 Idaho Legislative Budget Book*.

Case Management Recommendations

The 2000 report included five recommendations for cost savings that affected service management for Medicaid clients. As shown in Exhibit 3, these recommendations ranged from promoting a managed-care approach to delivering services to clients, to continued support of home care versus institutionalized care for long-term patients. The department's implementation of these recommendations and follow-through on expanding existing programs has contributed to considerable cost avoidance for the state general fund.

Exhibit 3: Case Management Recommendations

Recommendation	Status	Comment
Expand Healthy Connections program	Implemented	
Leverage federal funds for case management activities	Not Implemented	Current billing methodology is more cost efficient
Capture information to bill skilled professionals' activities at higher rate	Implemented	
Design comprehensive utilization management plan	Implemented	
Continue support of inpatient and long-term care initiatives, monitor success	Implemented	

Source: Office of Performance Evaluations analysis of data from the Idaho Department of Health and Welfare.

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

Status: Implemented.

Healthy Connections is a health care delivery system the department developed and implemented in 1993 to control costs. Healthy Connections operates under a managed care model that organizes and reviews clients' health care and minimizes any duplicative or unnecessary services, in turn, reducing costs. In November 2000, the Healthy Connections program served roughly 30 percent of the total Medicaid clients, and was mandatory in only two counties. As a result, we recommended expansion of this program.

Since the release of our report, the department has taken steps to increase client enrollment in Healthy Connections. A supplemental appropriation approved during the 2001 legislative session allowed the department to hire additional program staff to augment this effort. The department reports that enrollment in Healthy Connections has increased to 126,845 or 76 percent of the total Medicaid clients. Additionally, 43 of 44 counties now participate in Healthy Connections and 35 have mandatory enrollment.[4]

The department reports that after subtracting additional staffing costs associated with implementation of this recommendation, it was able to avoid program costs of over $23 million during fiscal years 2002 through 2004 due to the increased client participation in Healthy Connections. Because the federal match rates ranged from 71 to 73 percent during those years, the cost avoidance to the state has been over $6 million to date.

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

Status: Not implemented.

The 2000 report recommended the department bill the federal Medicaid program for direct services, such as case management, at a higher match rate of 70 percent instead of 50 percent.[5] However, the department researched this recommendation and reports it is more advantageous to bill at the 50 percent rate for several reasons. Specifically, the 70-percent rate is based on a set reimbursement rate per hour, which may not cover the entire cost of the service provided, including the costs to provide administrative support.

The 50-percent match rate allows for reimbursement of employees who provide *direct* and *indirect* services. The department can capture costs for sick leave, vacation time, and holidays not provided for by the 70-percent rate. In addition to the *direct* services, the department is reimbursed for about half of the *indirect* costs for services such as billing, payroll, or clerical staff. The difference in funding between these two methods is illustrated in Exhibit 4. The 50-percent rate results in approximately $2.5 million federal funds annually compared to approximately $1.3 million annually using the 70-percent rate.

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[4] The department reports that Camas County does not participate in Healthy Connections because there are no doctors in that county.

[5] The 70 percent match rate is for direct services. The 50 percent match rate includes *direct* and *indirect* services.

Exhibit 4: Comparison of Federal Match Rates, June 2004

Federal Match under 50% direct and indirect billing	$2,470,300
Federal Match under 70% direct billing	- 1,337,157
NET LOSS if 70% method is used	$1,133,143

Source: Data from the Idaho Department of Health and Welfare.

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

Status: Implemented.

This recommendation addressed the potential for the department to more accurately code and bill skilled medical professionals at the higher 75 percent federal match suggested in the 2000 report, rather than the 50 percent rate. The department has reviewed its billing codes and taken measures to correctly bill the skilled medical professionals at a higher federal match rate. The department reports that these changes have not been tracked long enough to determine cost avoidance.

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

Status: Implemented.

Utilization management involves controlling the costs and quality of client services by using prior authorization and concurrent review.[6,7] On June 30, 2002, the department completed a utilization management pilot program in Region II.[8] The program contracted with Idaho State University as a private independent assessment provider to evaluate and create service plans for adult clients with developmental disabilities. The department reports the average annual cost for participants in the pilot program grew about 6 percent, compared to 16 percent growth for non-participants. The department calculated that, after expenses, the pilot project resulted in a cost-avoidance of $785,000.

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[6] Prior authorization is the advance assessment of a participant's need for services on criteria determined by the department.

[7] Concurrent review assesses on-going treatments for progress toward treatment or service delivery goals and determining whether continued prior authorization is appropriate.

[8] Region II is headquartered in Lewiston, Idaho and consists of Clearwater, Latah, Lewis, and Nez Perce Counties.

The pilot project's success led to legislative authorization for the department to begin a statewide effort to provide managed care to adults with developmental disabilities. The first plans for these clients took effect March 2004. According to the department, all adult developmental disability clients will be part of the program by 2005. The department projects cost avoidance for the program of about $6 million in fiscal year 2005, and about $39 million over the next four years, after expenses.

Implementation of this recommendation also corrected an inherent weakness in the system that allowed case managers to both authorize services *and* directly deliver those authorized services. That previous weakness resulted in a clear conflict of interest for case managers and was contrary to Administrative Code.[9]

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

Status: Implemented.

According to a recent analysis, inpatient hospital care is the highest cost to the state's Medicaid budget, and care provided in a nursing facility is the third highest.[10] The recommendation that the department implement new and monitor existing cost containment measures was intended to result in cost avoidance for these services. The department's implementation of these recommendations includes:

- Prior authorization of hospital stays, reviews of past care, and case management for clients with chronic conditions
- Purchase of specialized medical equipment at nursing homes instead of costly rentals
- Use of the Uniform Assessment Instrument to ensure that services match needs of clients
- Use of waiver services to reduce nursing home costs and utilization

The department found that providing home care through federal service waivers was less expensive than providing long-term care within institutions. Department staff report the number of beneficiaries in home care has increased from 1,380 in fiscal year 2000 to 4,044 in fiscal year 2003.

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[9] IDAHO ADMIN. CODE, October 1, 1994, IDAPA 16.03.09.118.04.e.
[10] Information received from Budget and Policy Analysis, Idaho Legislative Services Office.

Pharmaceutical Recommendations

The five recommendations in this section addressed annual pharmaceutical expenditures within Idaho's Medicaid program and ways to incorporate stronger utilization controls as shown in Exhibit 5. Specifically, the recommendations addressed prescription dispensing fees paid to pharmacists, department drug acquisition discounts, beneficiary co-payments, use of generic drugs, opportunities for a preferred drug list, and stronger drug utilization management techniques.

Exhibit 5: Pharmaceutical Recommendations

Recommendation	Status	Comment
Lower pharmaceutical dispensing fees from $4.94 to $4.54	Not implemented	Recommendation opposed by the pharmacy industry
Increase drug acquisition discount prices from 11% to 12%	Implemented	
Implement co-payments of $0.50 to $1.00	Not implemented	Additional revenues needed to implement
Encourage the use of generic drugs through prior authorization of brand name drugs	Implemented	
Research creating a preferred drug list	Implemented	

Source: Office of Performance Evaluations analysis of data from the Idaho Department of Health and Welfare.

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.

Status: Not implemented.

Idaho pharmacists receive a $4.94 fee for dispensing each prescription to Medicaid beneficiaries. This fee is intended to cover the costs for pharmacist overhead expenses and a reasonable profit. The $4.94 fee was the rate paid as of the November 2000 report release, and was considered to be at the high range of dispensing fees both regionally and nationally. Therefore, the 2000 report concluded that Idaho could reduce its dispensing fees to pharmacists by $0.50 per prescription with little or no impact on the availability of pharmacy services to beneficiaries. The report also offered the option of a tiered method of paying smaller pharmacies the full $4.94 per prescription, while the larger chain drugstores that fill a high volume of prescriptions would receive a lower

payment. It was estimated that uniformly reducing the dispensing fee by $0.50 could save $358,000 annually in federal funds and $153,000 in state funds.

The department reports that it met with representatives from the pharmacy industry several times and was told that lowering the dispensing fee would threaten the existence of many rural pharmacies. In place of lowering the dispensing fee, pharmacists agreed to work with the department to encourage the use of generic and preferred drugs and take a larger role in reviewing the appropriate use of drugs.

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

Status: Implemented.

The department pays pharmacies the average wholesale price (AWP) less an additional discount on the actual pharmaceuticals that are dispensed. Idaho was paying the AWP in addition to receiving an 11 percent discount when the report was released in 2000. Based on studies of nationwide drug acquisition and discount rates, the report recommended the department increase the drug discount it received from pharmacies from 11 percent to 12 percent. The impact of this change was estimated to save the federal government $263,000, and the state $112,000 annually.

The department reports that its officials met with the pharmacy industry to discuss this issue, and although the industry opposed the concept, the department increased the discount rate from 11 percent to 12 percent. The department reports $2.8 million in estimated cost avoidance during the two years since this change has taken effect. Idaho's cost share in this program ranged from 27 to 29 percent, resulting in over $800,000 of cost avoidance.

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.

Status: In-process.

This recommendation centered on the concept of requiring the Medicaid beneficiary to pay a small portion of the pharmaceuticals they receive as a technique to discourage unnecessary utilization. The 2000 report indicated that more than half of the states, including Colorado, Montana, and Wyoming, require some form of cost sharing from their Medicaid beneficiaries. It was estimated that implementing a $0.50 to $1.00 per prescription co-pay could avoid up to $400,000 annually, resulting in nearly $120,000 cost avoidance to the state.

The department previously reported that implementing a co-pay process would require significant and expensive changes to its automated systems. As an alternative, the department is now working on establishing a co-pay process through a different automated system that will be upgraded in the near future. Therefore, this recommendation will require additional time and resources to fully implement.

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

Status: Implemented.

This recommendation endorsed the department's plans to implement a system of requiring providers to request and receive prior authorization when prescribing brand name pharmaceuticals when less expensive generic equivalents are available. The department reports it implemented a pharmaceutical prior authorization system through authority established in administrative rule. It estimated that an additional 25,000 to 26,000 generic prescriptions have been used each quarter since the prior authorization system was implemented. The department reports the cost difference between a prescription of generic over brand name drugs averages about $71 per prescription, and the department's estimated total cost avoidance since the inception of the program has been approximately $10 million. This has resulted in a direct cost avoidance of $2.8 million to the state.

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

Status: Implemented.

When the 2000 report was released, the department was researching the feasibility of incorporating a preferred drug list system into the Medicaid program. Such a system would provide incentive fees to physicians and pharmacists to authorize preferred drugs within specific categories. Use of a preferred drug list is a method that can help reduce overall pharmaceutical costs and help negotiate discounts with manufacturers.

The department reports it implemented a preferred drug list in March 2004. So far, this list includes classes of drugs for arthritis, acid reflux, and migraine headaches. Other drugs will be added as drug class reviews are completed. Although the department projects $5.8 million in cost avoidance for fiscal year 2004, data are not yet available to calculate actual savings. According to the department, much of the savings will be in the form of a supplemental rebate negotiated with manufacturers of the preferred pharmaceuticals.

Data and Reporting Recommendations

The 2000 report found that data systems were not meeting the needs of regional and central office program staff. Regional managers had become frustrated, and three regional offices had created their own "homegrown" automated databases to meet their needs. As shown in Exhibit 6, we recommended the department conduct a thorough, system-wide assessment to identify user needs and formulate a solution to its data challenges, overhauling reporting capabilities, and expanding network connections.

Exhibit 6: Data Reporting Recommendations

Recommendation	Status
Perform a system-wide user management data system assessment of needs	Implemented
Overhaul AIM's reporting capabilities	Implemented
Expand physical network connections to regions	Implemented

Source: Office of Performance Evaluations analysis of data from the Idaho Department of Health and Welfare.

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.

Status: Implemented, see discussion in following 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.

Status: Implemented.

The 2000 report recommended the department address reporting deficiencies in their Advanced Information Management (AIM) system. The department reports implementing the Idaho Data Engine Acquisition (IDEA) in November 2002, a data reporting system that enabled the department to get more accurate and uniform reports. This system has enhanced management capabilities in terms of tracking programs, planning, and making informed decisions. IDEA has more than 500 available reports, and 160 of them are easily accessible by managers and other staff.

The department reports now that it does not have to go through the long and expensive process of creating new reports because it pulls data directly from AIM, the Medicaid billing system. The department reported that now it relies more on IDEA than on EDS to develop ad hoc reports, which saves money. According to the department, 10 Health Insurance Portability and Accountability Act (HIPAA) reports were scheduled for development by EDS last year, but because it could use IDEA, the department saved $185,500. The department also specified that its new system enables it to better identify potential fraud and abuse through improved data reporting capacity.[11]

Consider expanding physical network connections to the regions.

Status: Implemented.

At the time the 2000 report was released, many regional and field offices were not able to access the department's data system because they lacked the needed bandwidth. The department began expanding bandwidth about four years ago, and continues this process today. The annual cost for this expansion is $400,000; the state's cost is $150,000 and the federal government pays the remaining $250,000. As it expands to eastern Idaho, the state's costs are expected to increase to $300,000 annually.

The department reports the benefits of the expansion greatly outweigh the costs. Some of the benefits include:

- Expanded network connections can be used by other state agencies
- Increased security for data transfers
- Lower maintenance costs
- Greater system dependability
- System back-up in case of line failure
- Higher capacity and more room to meet expansion needs

Fraud and Abuse Investigation Recommendations

Concerns about potential fraud and abuse within Medicaid prompted Congress to pass legislation that increased funding to states establishing *external* Medicaid fraud and abuse units. In 1995, Idaho obtained a waiver from the federal Health Care Financing Administration to operate an *internal* fraud unit. The 2000 report found that operating the fraud unit internally, within the department, was actually more cost effective than operating an external fraud unit. However, the report recommended several steps for improvement highlighted in Exhibit 7.

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[11] Electronic Data Systems (EDS) report development costs are higher because the reports are programmed into the data system by engineers at $79 per hour. Department staff are now able to create these same reports in-house for far less costs than EDS.

Exhibit 7: Fraud and Abuse Investigations Recommendations

Recommendation	Status	Comment
Separate incompatible internal control functions in fraud unit's billing and collection activities	Implemented	
Change fraud unit's organizational reporting structure	Implemented	
Expand guidelines for negotiating fraud settlements; consider creating a "negotiation team"	Not Implemented	Determined unnecessary by the department
Incorporate progressive best practices over fraud activities through provider commitments	Implemented	

Source: Office of Performance Evaluations analysis of data from the Idaho Department of Health and Welfare.

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

Status: Implemented.

The first recommendation identified a sound fiscal management practice: separating incompatible internal control functions, such as billing and collection. To address this recommendation, the department reports it established the Central Revenue Unit in Twin Falls to handle collection activities for overpayments. This removed the collection duties from the fraud unit, allowing additional time to support fraud investigations. The fraud unit now only handles fraud investigations, leaving collections with the unit that receives and handles payments. Segregating collection from fraud investigation is common among states.

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.

Status: Implemented.

The 2000 report found the internal fraud unit within the Medicaid division created an inherent conflict of interest. For example, the fraud unit included

advocacy activities, such as encouraging provider participation in Medicaid, while simultaneously performing fraud investigation activities against providers. In November 2000, the fraud unit was moved to the Division of Management Services, which oversees fiscal operations and accountability. There is now a stronger appearance of independence, and potential conflicts of interest have been reduced.

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

Status: Not implemented.

The department reviewed its negotiation process and determined that a negotiation team is unnecessary. The department routinely settles fraud cases, and will continue to work with the Office of the Attorney General on cases in which the collection of Medicaid overpayments is contested by providers. Department officials said that creating a negotiation team would result in an "unnecessary layer" in the process. Such a team would essentially create a formal process in which the department does not have legal authority to negotiate on behalf of the federal government for its share of Medicaid dollars.

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.

Status: Implemented.

The 2000 report recommended the department incorporate best practices in fraud and abuse prevention and investigation. The department reported that it has not developed a formal documented list of best practices, but continues to identify and evaluate best practices and periodically exchange ideas with its counterparts in other states. Recently implemented best practices include:

- Use of a toll-free fraud hotline: 1-866-635-7515
- Use of the *MedicAide Newsletter* to talk about fraud and abuse investigation activities
- Participation in provider training at the statewide health care conference
- Proactive examination of whole programs to determine trends and possible areas of abuse as opposed to targeting single providers

The department began working with other state agencies, such as the Department of Insurance and the Board of Pharmacy, and the federal government to share information about fraud in Medicaid and Medicare. It uses the IDEA database to more easily access data for fraud investigations, and it sends a fraud unit representative to conferences twice a year to learn about innovations in fraud investigation.

Veterans Services Recommendation

At the release of the 2000 report, the department and the Idaho Division of Veterans Services were in the process of converting the three state-operated veterans homes to be Medicaid certified. The following recommendation, summarized in Exhibit 8, was aimed at reducing state costs through additional federal Medicaid reimbursements.

Exhibit 8: Veterans Services Recommendation

Recommendation	Status
Cost-benefit analysis of veterans homes conversion to Medicaid	Implemented

Source: Office of Performance Evaluations analysis of data from the Idaho Division of Veterans Services.

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.

Status: Implemented.

The 2000 report estimated that Medicaid certification of veterans homes would save Idaho approximately $1.6 million annually through federal reimbursements. At that time, the division estimated that approximately 60 percent of the 241 veterans residing in the state-run homes would qualify for Medicaid services. Officials from the Idaho Division of Veterans Services presented cost analysis information on several occasions to a subcommittee of the Joint Finance Appropriations Committee during the 2002 legislative session.

As of January 2004, the division reported that over 62 percent of Idaho veterans home residents were receiving Medicaid benefits, resulting in an additional federal reimbursement of more than $9 million to the state during the past three years. These reimbursements were not available before the conversion to Medicaid.

Conclusion

The department has implemented 14 of the 18 recommendations from the 2000 report. Many of these efforts have contributed to cost savings or cost avoidance, with some exceeding original projections, directly benefiting the state. We calculate the total cost savings and cost avoidance to the state is over $21 million since the report's release in November 2000.

Other implemented recommendations have improved management through more accurate and usable data reporting, and increased regional access to data systems. Department efforts to implement best practices identified in the report have improved the area of fraud and abuse investigations. The department should continue its efforts to reduce Medicaid program costs to the state. Although the state Medicaid budget grew 57 percent during the last four years, the growth rate would have been even higher without the efforts documented in this report.[12]

Further, the department reports taking other Medicaid cost avoidance approaches that were not discussed in the 2000 report. For example, the department now requires 75 percent of a client's prescription drugs to be used before dispensing a refill, is paying *Medicare* rates for physician services, and has standardized client transportation rates statewide. Additional information on these and other Medicaid program initiatives can be obtained directly from the Idaho Department of Health and Welfare, Medicaid Program, Boise, Idaho, (208) 364-1804.

[12] Idaho's portion of the Medicaid budget grew from $162.8 million in fiscal year 2000 to $256.3 million in fiscal year 2004.

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