Indiana Family and Social Services Administration

MEDICAID
Balanced Budget Plan

January 4, 2002

Medicaid: Meeting the Challenge

You probably know someone being helped by Medicaid: Medicaid pays for the care of two-thirds of all Indiana nursing home residents. It provides supports for tens of thousand of people with autism, mental illness or physical disabilities. Hundreds of thousands of children who need immunizations and low-income mothers who need prenatal care also count on Medicaid.

Indiana's Medicaid Program serves more than 700,000 low income and disabled Hoosiers. That's almost one out of every eight residents, and the state share of Medicaid is 12% of the general fund budget.

Here in Indiana, and around the country, budgets are tight. People need help, and Medicaid serves those most in need – people living below the poverty line or with severe disabilities. Indiana is committed to helping its poorest and most vulnerable residents receive basic health care. It's the right thing to do.

As the economy weakened this year, Medicaid enrollment grew. Indiana is also seeing growth in the number of families receiving cash assistance and food stamps.

In Indiana, we have watched state revenues drop and Medicaid costs grow – particularly in the areas of pharmacy costs and nursing home care. This balanced budget plan directly addresses the most significant cost pressures facing Medicaid.

Cost drivers:

Pharmacy – We estimate pharmacy claims will continue to climb sharply. We forecast that pharmacy expenditures will grow more than 50% in the next two years.

From 1996 to 2001, the total number of prescriptions paid for increased 30 percent, from 9.7 million to 12.6 million - an increase of 2.9 million prescriptions.

Compounding the situation: the average price per prescription increased 61 percent, from $26.95 in SFY 1996 to $43.45 in SFY 2001 ($16.50 more per prescription).

Nursing Home Care - This remains the largest Medicaid expenditure, about $858.3 million for SFY 2002, increasing at an annual rate of about 5.5 percent.

The December forecast assumes continued modest decreases in nursing facility bed days but higher overall cost increases due to escalating costs reported by nursing facilities. Examples of rising costs include higher staffing costs due to a nursing shortage and increases in malpractice insurance premiums.

Next Steps

The Family and Social Services Administration is committed to two things – getting quality care to those most in need and getting the most out of the taxpayers' dollars entrusted to us. The forecast of increased demand for services and higher costs sets out a significant challenge in the face of the appropriation established by the legislature. The chart that follows outlines Medicaid expenditures and recipients by category.

Our plan shows we have the ability to meet the needs of those who count on and deserve services – but it is going to take some tough decisions and real partnerships among Medicaid, providers and recipients. Family and Social Services Administration has listened, gathered input and carefully studied the options available to create the balanced budget plan that follows.

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COST CONTAINMENT

Ensure Medicaid is Payer of Last Resort, Not First – *Estimated State Savings $18.5 million*

- **Enforce Medical Support Orders**. The Office of Medicaid Policy and Planning (OMPP) will aggressively recover Medicaid expenditures for children whose non-custodial parents have been ordered to pay for medical support. It is estimated this will save the state $5 million annually.

- **Require Pharmacies to Bill Insurance Companies First.** OMPP will require pharmacies to bill third party insurance carriers before submitting claims to Medicaid. This practice is required of other Medicaid providers. No rule change or state plan amendment is required. It is estimated this will save the state $2 million annually.

- **Require Medicare Certification for Nursing Facilities**. OMPP will require nursing facilities to be Medicare certified in order to participate in the Medicaid program. At least 46 Medicaid nursing facilities are not Medicare certified, with an estimated 868 residents who would likely qualify for Medicare Part A (inpatient) benefits. This will require a rule change and state plan amendment. It is estimated this will save the state $1.5 million annually.

- **Eliminate non-Medicaid Costs in Nursing Facility Rates.** OMPP will no longer consider the indirect costs for ancillary services provided to non-Medicaid nursing facility residents when setting rates. Currently, Medicaid removes the direct cost of providing therapy services to non-Medicaid residents, but not the indirect costs. Examples of indirect costs include administrative and general costs, laundry, housekeeping and plant operations. This will require a rule change and state plan amendment. It is estimated this will save the state $10 million annually.

Close Eligibility Loopholes ~ *Estimated State Savings $5.5 million*

- **Eliminate Asset Shelter – Bonds**. OMPP will count certain bonds purchased after the date of application to Medicaid as assets in determining Medicaid eligibility. Series EE, I and HH bonds purchased after the date of Medicaid application will be counted as assets; such bonds purchased prior to Medicaid application will remain unavailable for 6 months. This will require a rule change and state plan amendment. It is estimated this will save the state $4.5 million annually.

- **Eliminate Asset Shelter – Funeral/Burial Trusts**. OMPP will require that excess funds remaining in a funeral or burial trust held by a Medicaid recipient, must be repaid to Medicaid up to the amount Medicaid expended on that recipient. This will require legislation and possibly a state plan amendment. Data on the amount of funeral/burial trusts held by Medicaid recipients are not available to quantify savings.

- **Tighten Definition of Estate**. OMPP will pursue legislation to adopt the estate recovery standard allowed by federal law, which will add non-probate assets, including life insurance, trusts and annuities, to the definition of estate. This will require legislation and a state plan amendment. Data are not available to quantify an estimate of the savings.

- **Obtain Lien Authority.** OMPP will seek legislation to enhance the State's ability to recoup money spent on behalf of a Medicaid recipient by obtaining the authority to place a lien on a recipient's home. Federal law requires states to make a claim against a Medicaid recipient's estate for the amount of money spent after the recipient was 55, and authorizes states to enforce liens on property owned by recipients who reside in a medical institution and are not expected to return home. Lien authority would not apply if there is a spouse, dependent child, or certain other family members living in the home. The lien would not be enforced until the sale of the property subject to lien, or upon the death of the recipient. This will require legislation, a rule change and a state plan amendment. It is estimated this will save the state $1 million annually.

Enhance System Integrity and Program Effectiveness ~ *Estimated State Savings $30 million*

- **Enhance Fraud and Error Monitoring.** OMPP will contract with a vendor for specialized auditing services to detect erroneous claim payments made to providers due to either fraud or error. It is estimated this will save the state between $1.5 million annually.

- **Increase Use of Restricted Card.** OMPP will identify recipients utilizing multiple pharmacies and prescribing physicians and place recipients on restricted card, requiring them to establish a medical and pharmacy home. This policy, commonly referred to as lock-in, is intended to reduce or eliminate polypharmacy, multiple prescribers, controlled substance drug abuse, drug misutilizations, adverse drug reactions and drug-to-drug interactions. In Phase One, OMPP will target recipients using 10 or more pharmacies and/or prescribers. Future phases will target recipients using 7-9 or 4-6 pharmacies and/or prescribers. This does not require legislation or a rule change. It is estimated that Phase One will save the state $13.5 million annually, with increased savings as future phases are implemented.

- **Implement Hard Prospective Drug Utilization Review (DUR) Edits**. OMPP will implement "hard" edits to the prospective drug utilization point-of-sale system. A hard edit would deny the claim and would not allow the pharmacist to override the edit, without prior authorization. Hard edits would include early and excess refills, therapeutic duplication, Level 1 drug-drug interactions and maximum dosage limitations. This does not require legislation or a rule change to implement. It is estimated this will save the state $7 million annually.

- **Standardize Eligibility Periods**. OMPP will replace the one-year continuous eligibility period applicable to children under age 19 with the prior policy of re-evaluating eligibility based on any changes in the family's financial circumstances. Children will be subject to the same eligibility conditions/time periods as adults. This will require legislation, a rule change and a state plan amendment for both Medicaid and the Children's Health Insurance Program (CHIP). It is estimated this will save the state $8 million in SFY 2003, with greater savings in future years as the policy becomes fully phased in.

- **Implement Disease Management.** OMPP will implement a disease management program for asthma, diabetes, congestive heart failure and HIV/AIDS, serving Medicaid recipients in the primary care case management (PCCM) and fee-for-service (FFS) programs who reside in the 16 most populous counties. The target date for implementation is July 2002. Recipients with one (or more) of these disease states tend to have high Medicaid expenditures; therefore, cost savings from implementing disease management are expected. A savings estimate is difficult to quantify at this time.

- **Implement Case Management.** OMPP will implement a case management program designed to improve health outcomes, monitor utilization and control expenditures for the following high cost Medicaid recipients: aged, blind and disabled recipients and recipients in primary care case management or fee-for-service in the sixteen counties mentioned above with costs in the top 10 percent of per recipient Medicaid expenditures. The target date for implementation is July 2002. Since recipients who will be enrolled in case management are high-cost recipients, OMPP expects cost savings from implementing case management. It is difficult to quantify an estimate of the savings at this time.

- **Solicit Pharmacy Benefit Management Services**. OMPP will contract to provide comprehensive, integrated pharmacy benefit management. Management of a pharmacy benefit could include prescriber profiling, concurrent drug utilization review, prior authorization, rebate administration, effective disease management and technical assistance on a preferred drug list. This does not require legislation or a rule change. Pharmacy benefit management in private sector and managed care health plans has proven to be cost effective; therefore, OMPP expects pharmacy benefit management will result in cost savings, though they are difficult to quantify at this time.

Promote Appropriate and Cost-Effective Drug Utilization ~ *Estimated State Savings $40.6 million*

- **Limit Number of Brand Name Prescriptions.** OMPP will allow recipients to receive up to four brand name prescriptions per month. Recipients requiring more than four brand name prescriptions will continue to have access to additional brand name drugs only with prior authorization. This policy places no limit on generic drugs. This will require a rule change. It is estimated this will save the state $9 million annually.

- **Develop a Preferred Drug List**. OMPP will develop a preferred drug list. Analysis of drugs for appropriate and cost-effective therapies will be conducted in order to develop a list of preferred drugs by therapeutic drug class. Drugs not included on the preferred drug list will be subject to prior authorization. This will require approval by the Drug Utilization Review (DUR) Board and 45-day notice to providers. Cost savings are a function of the number and types of drugs listed on the preferred drug list; however, experience in managed care programs and other states has shown savings potential as great as 15 percent of annual pharmacy expenditures. It is estimated this will result in a state savings of $30 million annually.

- **Expand Indiana Rational Drug Program (IRDP).** OMPP will add additional drug classes to the Rational Drug Program (IRDP). The IRDP applies prior authorization criteria, patterned after evidence-based medicine, to the drug classes within the program. These drugs remain available to Medicaid recipients with prior authorization. Each drug class addition will require approval by the Drug Utilization Review (DUR) Board and 45-day notice to providers. It is estimated that Phase Two, scheduled for DUR Board approval in January 2002, will save the state $1 million.

- **Expand the Over-the-Counter (OTC) Drug Formulary**. OMPP will expand the over-the-counter drug formulary, currently comprised of OTC drugs produced by manufacturers participating in the federal drug rebate program. The major therapeutic categories of OTC drugs (e.g., analgesics, antacids, cough and cold products, etc.) are currently included on the formulary. OMPP proposes to add additional products and/or categories so that more OTC alternatives would be covered, promoting the use of less expensive, equally appropriate products over more expensive legend drugs. This would not require legislation or a rule change. Savings will be a function of the number of OTC drugs to be added.

- **Limit Days Supply**. OMPP will limit prescriptions to a 34 day supply for all medications, except certain maintenance drugs such as high blood pressure and heart disease medications. This policy change augments OMPP's efforts to decrease prescription waste and/or abuse. It is estimated this will save the state $0.6 million annually.

- **Develop a Prescriber Education/Notification Program**. OMPP will work with the Drug Utilization Review (DUR) Board to develop a prescriber education and notification program to contact physicians prescribing single-source, highly expensive, innovative treatments when less expensive drugs considered to be "best practice" are available. This policy would encourage prescribers to use costly therapies only when first-line therapies have failed to achieve desired treatment outcomes. This does not require legislation or a rule change. This policy will result in cost savings to the state; however, it is not possible to quantify a savings estimate.

- **Establish a Pharmacy and Therapeutics (P&T) Committee**. OMPP will establish a State P&T Committee to develop policy and educate providers regarding the therapeutic use of drugs. The P&T Committee would perform unbiased systematic review and scientific evaluations of pharmaceuticals to maximize utilization of the right drug for the right condition. This will benefit the overall management of the pharmacy program, including the development of a preferred drug list, as well as the disease management program and will therefore produce indirect cost savings to the state.

Reform Reimbursement Methodologies ~ *Estimated State Savings $18.2 million*

- **Modify Profit Add-On Payment for Nursing Facilities**. OMPP will eliminate the profit add-on for the direct care component of nursing facility reimbursement. Currently, the case mix methodology recognizes a provider's allowable costs and provides a profit add-on payment when the facility's case-mix adjusted allowable costs are less than the median costs. For direct care, facilities at less than 105 percent of the median costs receive a profit add-on that is 52 percent of the difference; this policy removes that profit add-on. This will require a rule change and state plan amendment. It is estimated this will save the state $10.6 million annually.

- **Establish a Minimum Occupancy Requirement for Reimbursement of Nursing Facilities.** OMPP will establish a 60 percent minimum occupancy standard for the direct care, indirect care and administrative rate components of nursing facility reimbursement. If a nursing facility has occupancy below the 60 percent minimum standard, then for purposes of determining the facility's per diem costs, number of patient days will be imputed at the minimum occupancy standard. OMPP envisions beginning with a 60 percent standard and increasing it to 70 percent in a phased approach. This will require a rule change and state plan amendment. It is estimated this will save the state $3 million annually, with greater savings as the standard moves to 70 percent.

- **Recalculate Nursing Facility Rates Every Two Years**. OMPP will recalculate nursing facility rates every other year rather than annually. The rate for year one will be calculated based on the latest nursing facility cost report; the rate for year two will be updated using the Health Care Financing Administration/Skilled Nursing Facility (HCFA/SNF) Index. This change will make nursing facility rate setting consistent with hospital rate setting, which follows a two-year schedule. This will require a rule change and state plan amendment. It is estimated this will save the state $3.3 million annually.

- **Recalculate ICF/MR and CRF/DD Rates Every Two Years**. OMPP will recalculate Intermediate Care Facility for the Mentally Retarded (ICF/MR) and Community Residential Facility for the Developmentally Disabled (CRF/DD) rates every other year rather than annually. The rate for year one will be calculated based on the latest ICF/MR or CRF/DD cost report; the rate for year two will be updated using HCFA/SNFI. This will require a rule change and state plan amendment. It is estimated this will save the state $2 million annually.

Modify Optional Services ~ *Estimated State Savings $10.6 million*

- **Impose Annual Cap on Adult Dental Services**. OMPP will limit expenditures on dental services for adult recipients to $600 per year, which is the average annual adult dental expenditure. An annual cap will allow adults to choose which services they receive without eliminating any covered services or reducing dental provider rates. This will require a rule change and state plan amendment. It is estimated this will save the state $10 million annually.

- **Limit Chiropractic Services**. OMPP will limit chiropractic services for adults to spinal manipulations and x-rays, consistent with Medicare, and eliminate chiropractic services for children. This will require legislation, a rule change and a state plan amendment. It is estimated this will save the state $0.6 million annually.

REVENUE ENHANCEMENT ~ Estimated Revenue $44 million

- **Maximize Federal Medicaid Funding.** OMPP will make additional payments to non-state government owned nursing facilities up to their Medicare Upper Payment Limit (UPL). Senate Enrolled Act 309 gave OMPP the authority to make such payments, subject to the availability of state matching funds. OMPP filed the required state plan amendment with CMS, which approved the plan recently. It is estimated that the net gain to the state is $8 million annually.

- **Adjust Disproportionate Share Payments**. OMPP will leverage additional federal monies by correcting the calculation of prior year disproportionate share payments. The state match required to leverage these additional payments will be generated via intergovernmental transfer. It is estimated that the one-time net gain to the state will be approximately $15 million.

- **Implement Temporary Nursing Facility Provider Fee**. OMPP will seek a temporary fee on nursing facilities in the amount of $2 per resident per day. The fee will be imposed for a period of two years to provide relief to the current Medicaid deficit. The assessment will be an allowable cost for Medicaid certified nursing facilities. This will require legislation, a rule change and a state plan amendment. It is estimated this will provide $21 million net revenue to the state annually.

Reinvesting Long Term Care Savings to Serve Recipients – ***Long Term Care Transition Fund -*** OMPP will create a Long Term Care Transition Fund, using 25% of the realized Phase Two program savings in long term care expenditures. The funds will help Medicaid recipients, including those facing nursing home closure, transition to appropriate community and home-based programs, waiver slots, or other institutional settings. It is estimated that this will cost the state $12 million to fund this effort.

Note: The estimated savings are estimated annual state savings assuming implementation occurs at the beginning of a year.

NET TOTAL STATE SAVINGS: $155.4 Million