2012 Medicaid Cost Reductions – House Bill (HB) 260
Frequently Asked Questions

Question	Answer
PRICING CHANGES	
1) What provider types will have reimbursement inflators removed from statute?	Nursing homes, intermediate care facilities, personal care services, physicians, and dentists.
2) How will these provider types get increases in reimbursement?	During the annual budget process, Idaho Medicaid will include a line item requesting adjustments to provider rates. All changes to provider payment rates will be subject to the legislature's approval by appropriation.
3) How much money will Medicaid save by removing reimbursement inflators from statute?	It is estimated that this will save approximately $4.7 million in state general funds. Of this $4.7 million, $500 thousand is savings related to non-primary care code rates being reduced to 90% of Medicare rates.
4) What provider types will have reimbursement methodology removed from statute?	Nursing homes, intermediate care facilities, personal care services, physicians, and dentists.
5) Will new agency rules have to be written to outline the reimbursement methodology?	No. Reimbursement methodology for these provider types is already outlined in agency rules. A thorough review will be conducted to ensure that everything in statute is reflected in rule.
6) Can reimbursement methodology be changed in agency rules?	Yes. Agency rules can be changed through the rule promulgation process as defined by the Department of Administration. However, Medicaid has no plans to make changes to existing reimbursement methodology at this time. Future changes will only be made in response to legislative direction or through negotiated rulemaking with the industry.

Question	Answer
7) What changes are being made to pharmacy service reimbursement?	Currently, pharmacies are reimbursed based on average wholesale price less 12% for single-source drugs and state maximum allowable cost for multi-source drugs. The change in reimbursement will set a reimbursement rate for both single-source and multi-source drugs based on estimated acquisition cost which is defined as the average acquisition cost (AAC) of the drug. When no AAC is available, reimbursement will be wholesale acquisition cost.
8) Will pharmacy dispensing fee reimbursement be affected?	Yes. Reimbursement will be set on a tiered dispensing fee payment. The payment rate will be based on survey data from pharmacies.
9) When will this pharmacy pricing change begin?	Once Idaho Medicaid collects survey data for both drug acquisition cost and dispensing fees, we will calculate the AAC and structure a tiered dispensing fee reimbursement system. After discussions and negotiation with the Idaho pharmacy profession, the new pharmacy reimbursement methodology will be announced in the MedicAide newsletter along with an implementation time line.
10) How much money will changing pharmacy pricing save Medicaid?	It is estimated that this will save approximately $2 million in state general funds and $4.6 million in federal funds, for a total of $6.6 million.
11) Why is the affiliated agency reference being removed from Idaho Code section 56-118?	Because Idaho Medicaid has awarded a contract, payment for services will be set through a procurement contract instead of through the Medicaid trustee and benefit payment process. Therefore, there is no need for this language in statute.
12) Why is the reimbursement methodology for private businesses providing DD and MH services being deleted from statute?	The department has worked with businesses over the last several years to arrive at a methodology agreeable to all stakeholders. This methodology was approved by this year's legislature in rule. The statute now refers to the methodology as described in rule.

Question	Answer
13) Why are the adult individual therapy and group developmental therapy rates being combined?	Idaho Medicaid asked for provider and stakeholder comments about cost saving measures for SFY 2011. During this process Idaho Medicaid received requests to blend the individual and group developmental therapy rates.
14) When will the adult individual therapy and group developmental therapy combined rates begin?	Beginning dates of service July 1, 2011, Idaho Medicaid will implement the following procedure code and rate changes: • The rate on file for all existing prior authorizations for procedure codes 97537 HQ and 97537 will be updated to reflect the new rate. • The rate on file for all existing prior authorizations for procedure codes H2032 and H2032 HQ will be updated to reflect the new rate. • Providers will use existing PAs through the end of the plan year until the PA is end dated or exhausted. No addendums are required to reflect this change. More specific information about submitting claims for DT is available in the **instructional document**. • New or annual plans will not request services using modifiers • There are no rule changes related to this change.
15) Will providers still use modifiers when submitting claims for adult developmental therapy services?	Providers will continue to use their existing prior authorizations for developmental therapy including those with group modifiers, until the prior authorization (PA) is exhausted or scheduled to end before the plan's end date. New or annual services plans submitted after July 1, 2011, will not request DT services with modifiers. For service specific provider claims instructions please refer to the **instructional document**.

Question	Answer
16) How much money will combining group and DD therapy rates save Medicaid?	It is estimated that this will save approximately $1.1 million in state general funds and $2.5 million in federal funds, for a total of $3.6 million.
17) Why are non-primary care code rates being reduced to 90% of Medicare rates?	As part of HB 260's legislative direction, Idaho Medicaid is matching the reimbursement rates at 90% of Medicare rates.
18) Are services paid by revenue codes going to be aligned with Medicare pricing as well?	No.
19) When will the new non-primary care code rates begin?	On July 1, 2011, Idaho Medicaid will implement this rate change.
20) How much money will this save Medicaid?	It is estimated that this will save approximately $1.5 million in state general funds and $3.5 million in federal funds, for a total of $5 million.
21) How is Medicaid changing the way it pays for outpatient hospital physical, occupational, and speech therapy services?	Medicaid will pay based on 90% of the Medicare fee schedule for these services. Outpatient hospital therapy services will require reporting CPT codes. Hospital interim reimbursement for those services will be based on CPT codes.
22) How much money will this save Medicaid?	It is estimated that this will save approximately $300 thousand in state general funds and $696 thousand in federal funds, for a total of $996 thousand.
BENEFIT CHANGES	
23) Who will pay for the costs associated with getting national accreditation?	The owners of Medicaid-reimbursed mental health agencies are responsible to cover the costs associated with achieving and maintaining the national accreditation.

Question	Answer
24) What are an agency's choices about which accreditation to pursue?	Agencies are free to choose any national accreditation that exists in the United States.
25) What is the deadline to meet the accreditation requirement?	The department will work with providers on a process to implement this new requirement.
26) If an agency has already achieved Medicaid mental health (MH) credentialing, does it also have to obtain a national accreditation?	Yes. Idaho code, section 31-873 does not provide for any exceptions that would allow an agency to forgo national accreditation.
27) How will the department implement effective management tools for psychosocial rehabilitation (PSR) services?	Currently, the department uses prior authorization processes, service limitations, and quality assurance reviews to manage the use of PSR services. The department is exploring the use of clinical decision support tools that support evidence-based decision such as the Level of Care Utilization System (LOCUS), the Child and Adolescent Level of Care Utilization System (CALOCUS), and InterQual Criteria products.
28) What is the new weekly benefit for adults who need PSR services?	Effective July 1, 2011, adult weekly service limits will be reduced from five hours per week to four hours per week. This reduction applies to adults who are eligible for Medicaid Enhanced Plan benefits and are 21 years of age or older. Eligible adults may receive up to four hours of PSR services per week if they have been diagnosed with a severe and persistent mental illness and meet the criteria for medical necessity to obtain this service.
29) Does the PSR weekly service limit reduction also affect children?	No. The policy for PSR service limitations is not changing for children. Eligible children must meet the criteria of serious emotional disorder (SED), experience a substantial impairment in functioning, and meet the criteria for medical necessity to obtain this service. When participants reach the age of 18, they must meet the diagnostic criteria for Serious and Persistent Mental Illness (SPMI) in order to continue to be eligible for PSR services.

Question	Answer
30) Does this service limit reduction affect the PSR crisis service benefit?	No. Community crisis service policies have not changed. PSR crisis hours must be prior authorized by the Office of Mental Health and Substance Abuse at Medicaid.
31) How much money will reducing PSR benefits for adults save Medicaid?	This reduction is expected to save approximately $2.3 million in state general funds and $5.3 million in federal funds, for a total of $7.6 million.
32) How many Medicaid participants will reducing PSR benefits affect?	It is estimated this change will affect 2,937 adult participants.
33) When you change the adult individual budget methodology will my DD budget change?	Yes. It is likely that your budget will change. However, the department will assign your new budget based on all of the data we have collected regarding your assessed needs. It is the department's goal to provide you with the budget necessary to address your health and safety needs and your ability to live in the community.
34) When will I know what my new DD budget is?	The department will begin working immediately on developing the new budget methodology. This may take several months or longer. Part of this process will include developing a transition plan, which we will communicate with stakeholders prior to making any changes and well before participants are expected to make this change. You will be informed of your budget during a re-determination process, before your transition.
35) Will the rules regarding individual DD budget modification requests change before the new budget methodology is implemented?	Yes. The department has been directed through HB 260 to review individual budget modification requests for DD services only when health and safety issues are indentified and meet the criteria in rule.
36) How will Medicaid therapy coverage be aligned with Medicare?	Physical and speech therapy for adults will be capped at $1,870 per year. Occupational therapy for adults will have a separate cap of the same amount. These changes will take effect January 1, 2012.
37) Will this apply to all therapy services?	This will apply to outpatient therapy services.

Question	Answer
38) How much money will putting a price cap on therapy services save Medicaid?	This reduction is expected to save approximately $200 thousand in state general funds and $464 thousand in federal funds, for a total of $664 thousand.
39) Why can there be differences between what services adults and children receive when HB 260 doesn't specify?	Children are always entitled to receive the Medicaid benefits that are medically necessary for them to maintain their health and safety. For example, if Medicaid imposes a cap on therapy services for adults, the same cap could apply to children. However, if children need additional therapy services to maintain their health and safety above the capped amount, they will receive the services they need.
40) What are family-directed services?	The family-directed services option is a new option for families that is being made available as part of the Children's System Redesign. This option allows families to use a child's budget to identify and purchase services and supports from persons and businesses of their choice. The family-directed services option is very similar to the self-directed services option currently available for adults.
41) What are the advantages of family-directed services?	By choosing family-directed services, families can: • Hire people they know and decide the qualifications they want to require. • Supervise and direct their children's support workers. • Decide when and where they get the services and supports that meet the needs of their children. • Decide the types of services and supports they will purchase. • Decide the amount of services and supports they will purchase. • Manage an individual budget based on their children's assessed needs.
42) Do families have to choose family-directed services to access the new children's DD benefits?	No. Families will have the choice of selecting the traditional option or family-directed services option for their children's DD benefits.

Question	Answer
43) Are family-directed services part of the cost reductions?	No. The family-directed services option is not being added to reduce costs but rather is being added to align with changes under the children's system redesign. The children's system redesign is intended to be cost neutral which means the spending in the redesign cannot be more than previous spending.
44) How will DD services be delivered to children and adults according to their level of needs?	Children and adults requesting DD services will be evaluated by the department's independent assessment provider who will identify assessed needs and assign the budget for each person. A participant's needs will be assessed according to a measurement of the participant's functional abilities, behavioral limitations, medical needs, and other individual factors related to the participant's disability. The budget setting methodology will correlate a participant's characteristics with the participant's budget amount so that those with higher needs will be assigned a higher budget amount.
45) What is the fiscal impact of the changes being made to the adult DD budgets?	This change will reduce the total annual DD Waiver expenditures by $2 million. (Idaho's expenditures for DD Waiver services were $77 million dollars based on the most recent federal reporting period for 2008-2009. Using this data as an example, implementing this reduction would reduce the spending from $77 Million to $75 Million estimated annual DD Waiver expenditures.)
46) What dental services are being reduced?	Dental benefits for adults ages 21 and over will be limited to emergency dental care only. Emergency dental treatment may include medically necessary oral surgery, extractions, exams, anesthesia, and x-rays to support those services. Some palliative care will also be covered.
47) Will reducing dental services affect all adults?	No. Pregnant women will have additional coverage beyond these services.

Question	Answer
48) How much money will reducing adult dental services save Medicaid?	This will save approximately $1.7 million in state general funds and $3.9 million in federal funds, for a total of $5.6 million.
49) How many Medicaid participants will this affect?	It is estimated this change will affect 42,159 adult participants.
50) What changes are being made to chiropractic services?	Participants will be limited to no more than 6 chiropractic visits per calendar year instead of 24.
51) Since this limit starts half way through the year, how will the visits be counted?	Medicaid will allow 6 visits from July 1, 2011, through December 31, 2011. Participants may receive up to 6 medically necessary visits each year after that.
52) How much money will limiting chiropractic services save Medicaid?	This will save approximately $200 thousand in state general funds and $464 thousand in federal funds for a total of $664 thousand.
53) How many Medicaid participants will this affect?	It is estimated this change will affect 1,206 adult participants.
54) What changes are being made to podiatry and optometry services?	Adults with chronic conditions such as diabetes will continue to have access to the same podiatry and optometry benefits. Children's podiatry and optometry benefits will not be affected. Podiatry and optometry benefits will be eliminated for all other adults.
55) Are podiatry services covered for other chronic conditions besides diabetes?	Podiatry services for adults age 21 and older will be covered when they are necessary to treat a chronic condition that impacts the foot or with the potential to seriously compromise the participant's health. Examples of such conditions include: • Diabetes • Peripheral neuropathy • Peripheral vascular disease • Rheumatoid arthritis

Question	Answer
	• Degenerative Joint disease • Other chronic conditions that require regular podiatric care for the purpose of preventing recurrent wounds pressure ulcers, amputation, or to avoid other serious or irreversible compromise to the participant's overall health.
56) Are podiatry services covered for acute needs at all?	Treatment for acute conditions that would result in permanent or chronic damage to the foot, calf, or ankle if left untreated will continue to be covered.
57) What changes are being made to childrens' podiatry benefits?	Due to federal requirements for childrens' services, coverage for participants under age 21 is not affected by these changes.
58) What changes are being made to vision services?	Effective July 1, 2011, vision services for adults will be limited to services that are necessary to treat or monitor a chronic condition.
59) Why are these changes being made?	In HB 260 the legislature directed the Idaho Medicaid to make these changes to vision benefits.
60) What chronic conditions will be covered?	Chronic conditions that can affect the eye are covered. These conditions include: • Diabetes • Macular Degeneration • Sarcoidosis • Glaucoma • Cataracts • Multiple Sclerosis This is not an all-inclusive list. If there are other chronic conditions that can affect the eye, the provider may contact the department or send in a prior authorization request.

Question	Answer
61) Are eyeglasses covered?	Eyeglasses will no longer be covered for adults age 21 and over. If eyeglasses or contacts are necessary to treat a chronic condition or post cataract surgery, they may be prior authorized. Eyeglasses or contacts for the purposes of routine vision correction are not covered.
62) Are acute conditions or injury covered?	If an acute condition, left untreated, could result in permanent or chronic damage to the eye, then the services will be covered.
63) Can a participant receive more services if they are on the Medicaid Enhanced Plan?	No. These changes apply to all adults age 21 and older.
64) Does this change affect benefits for children under age 21?	No. Benefits for participants under age 21 remain the same.
65) How much money will Medicaid save by eliminating podiatry and optometry benefits for some adults?	It is estimated that this will save approximately $800 thousand in state general funds and $1.8 million in federal funds, for a total of $2.6 million.
66) How many Medicaid participants will this change affect?	It is estimated that this change will affect 6,531 adult participants.
67) What changes are happening in the Certified Family Home (CFH) Program?	The legislature has directed the department to implement changes to the CFH Program to: • Create approval criteria and a process for approving new CFHs. • Recertify current CFHs. • Develop applicant and licensure fees to cover certifying and recertifying costs.

Question	Answer
68) What new criteria for CFHs have been adopted and where can I review the criteria?	The department's current criteria is posted on the department's Web site at http://www.cfh.dhw.idaho.gov. The links under the Certification Application Tools heading outline the certification process and explain pre-orientation activities, certification/ orientation activities, and home inspection activities/ documentation. The section of Idaho Administrative Procedures Act which requires each item is also referenced. The department will review current criteria to determine whether further changes are needed.
69) How will the certification process for CFH providers change?	The department will review existing processes to determine where there are opportunities to improve efficiencies.
70) What new fees will there be in the CFH Program?	The department will implement two new fees related to CFHs: • A new one-time CFH application fee of $150 to cover orientation, training, consulting, and on-site survey of the CFH. • A monthly assessment fee of $25 per CFH to cover recertification costs. This amount will be invoiced and collected by the department on a quarterly basis.
71) How will Medicaid manage the transition from institutional care to community-based services?	The Money Follows the Person (MFP) Rebalancing Demonstration (known in Idaho as Idaho Home Choice) is a Centers for Medicare and Medicaid Services (CMS) Demonstration grant designed to help states try new ways of delivering Medicaid services. The demonstration is designed to help people move, also called "transition", from an institution into home and community-based (HCBS) living settings, such as a home or an apartment. The goals of the demonstration are: • Increase the use of HCBS and reduce the use of institutionally-based services. • Eliminate barriers and mechanisms in state law, state Medicaid

Question	Answer
	plans, or state budgets that prevent or restrict the flexible use of Medicaid funds to enable Medicaid-eligible individuals to receive long-term care in the settings of their choice. • Strengthen the ability of Medicaid programs to ensure continued provision of HCBS to those individuals who choose to transition from institutions. • Ensure that procedures are in place to provide quality assurance and continuous quality improvement of HCBS.
72) Who will transition from institutional care to community-based settings?	The target populations selected for transition include individuals residing in a qualified institutional setting for a minimum of 90 consecutive days past their short-term rehabilitation stay and who are eligible for Medicaid at least one day before to the transition. In addition, these individuals must meet the financial and level-of-care eligibility for Idaho's existing Aged and Disabled or Developmental Disability HCBS Waivers. Therefore, the elderly and those with a physical or mental disability will comprise the target population. Idaho Home Choice will be a statewide demonstration.
73) How long will Idaho Home Choice last?	Idaho Home Choice will run from April 1, 2011, through March 31, 2016.
74) How many participants will transition from institutional settings to community-based settings?	Thirty five participants will transition by the end of fiscal year 2012.
75) How much money will Medicaid save by transitioning participants from institutional settings to community-based settings?	It is estimated that this will save approximately $1.3 million in state general funds and $3 million in federal funds, for a total of $4.3 million.

Question	Answer
CO-PAYS	
76) What is cost-sharing?	Cost-sharing is out-of-pocket costs for health care coverage. The three common types of cost-sharing are deductibles, co-pays, and premiums.
77) What Medicaid services currently require cost-sharing?	Idaho Medicaid currently has seven programs that require cost-sharing. They are: • Premiums for individuals eligible for Children's Health Insurance Program coverage. • Voluntary premiums for families with children eligible for the Home Care for Certain Disabled Children Program. • Premiums for individuals eligible for Workers with Disabilities coverage. • Share of cost requirements for individuals eligible for long-term care services including nursing homes and Home and Community-Based Waiver services. • Co-pays for non-emergent use of emergency transportation. • Co-pays for non-emergent use of the emergency room. • Co-pays for missed appointments depending upon provider practice policies.
78) Why is Medicaid requiring participants to pay a co-pay for services?	In HB260 the department is directed to "establish enforceable cost sharing in order to increase the awareness and responsibility of Medicaid participants for the cost of their health care and to encourage use of cost-effective care in the most appropriate setting."
79) What additional services will require a co-pay?	Some of the services that might be considered for co-pays are: • Physician Visits • Chiropractic Visits • Optometrist Visits • Podiatrist Visits • Non-Hospital Physical & Occupational Therapy • Non-Hospital Speech Therapy • Outpatient Hospital Services

Question	Answer
80) How much will the co-pay be?	The co-pay will not exceed the current nominal amount allowed by the federal government which currently is $3.65/visit. Most Medicaid co-payments are limited. Most participants will have an annual cost-sharing limit of no more than 5% of their family income, but it will typically be less.
81) Does everyone have to pay a co-pay for these services?	No. By law Idaho Medicaid can't charge some participants a co-pay. Idaho Medicaid will notify you if you are expected to pay a co-pay.
82) How will Medicaid eliminate duplicative practices that result in unnecessary use and cost?	Idaho is incorporating National Correct Coding Initiatives (NCCI) into its claims system to ensure payments are subject to proper edits and audits. In addition, the Department's Program Integrity Office will help review claims, initiate investigations into program compliance issues, and take the necessary steps to recover overpayments.
83) What is the National Correct Coding Initiative (NCCI)?	The CMS originally developed the NCCI to promote national correct coding methodologies and to control improper coding leading to inappropriate payments in Medicare Part B claims. The Patient Protection and Affordable Care Act (H.R. 3590) Section 6507, requires state Medicaid programs to incorporate NCCI methodologies in their claims processing systems. The CMS has reviewed all of the Medicare edits and determined which were applicable to state Medicaid programs. Most of the 1.3 million edits were already in place for Idaho Medicaid, but additional work has been done to ensure that all required edits are in place.
84) How much money will adopting all the NCCI edits save Medicaid?	This will save approximately $50 thousand in state general funds and $116 thousand in federal funds, for a total of $166 thousand.

Question	Answer
MANAGED CARE	
85) What is Managed Care?	Medicaid managed care is an approach to delivering and financing health care aimed at improving access and quality, and providing more predictable costs. Cost savings can result by improving the coordination of care, implementing case management approaches for high-cost individuals, and providing incentives for preventive care.
86) What types of managed care approaches have been implemented by state Medicaid programs?	There are various approaches implemented across the country: • Some states have contracted with managed care organizations (typically commercial health plans) that cover comprehensive inpatient and outpatient services through established provider networks. The state Medicaid programs pay a per member, per month amount (capitation fee) to the managed care organization. The managed care organization is "at risk" for these set payments. This means that if they end up paying more than the capitation amount, they assume the loss whereas if they end up paying less than the capitation amount, they assume more of a profit. Managed care organizations determine the reimbursement methodology they use in their contracts with providers. Idaho Medicaid does not have any contracts under this approach. • Almost all state Medicaid programs have primary care case management programs. These programs pay primary care providers a case management fee to coordinate services of enrollees assigned to their practice. Idaho's primary care case management program is called Healthy Connections. It is a requirement that most enrollees have a "medical home" with a primary care provider.

Question	Answer
	• Some state Medicaid programs have prepaid inpatient health plans that provide less than comprehensive services but include inpatient hospital or institutional care and are at-risk. Idaho does not have any prepaid inpatient health plans in its Medicaid program. • Some state Medicaid programs have prepaid ambulatory health plans that provide less than comprehensive services and exclude any inpatient services and are at-risk. Idaho has two programs in place that meet this definition: o Medicare/Medicaid Coordinated Plans (through United Health and Blue Cross). o Idaho Smiles (dental coverage through Blue Cross and Dentaquest).
87) What is selective contracting?	Contracts with service providers are typically accomplished through provider agreements and are open to all providers who meet defined qualifications. Under this approach, Medicaid identifies provider qualifications, a scope of work, sometimes a price per member, and procures the services through a contract process. In Idaho, a selective contract approach was used to procure its transportation broker. State Medicaid programs can determine how many contracts to issue and have some flexibility to define the scope as statewide, regional, or smaller areas. Idaho's transportation broker is based on a fixed per member, per month and is an at-risk contract.
88) What might we expect to see related to improved coordination of care through primary care medical homes?	The Governor established a Medical Home Collaborative to develop multi-payer medical homes in an effort to begin improving the health care delivery system. Physician and medical practice representatives have been working with the health plans on reimbursement and practice changes to provide incentives leading to improved quality of care. Idaho Medicaid is considering applying

Question	Answer
	for "Health Home" funding as a State Plan amendment to focus on improved care coordination for individuals with chronic health conditions.
89) What types of approaches would be considered to improve coordination and provide case management for high-risk, high-cost disabled individuals; reduce costs; and improve health outcomes?	Idaho Medicaid has applied for planning grant funds to begin reviewing ways to implement and improve care for its dual eligibles (individuals with Medicare and Medicaid). With stakeholder input, Medicaid is hoping to explore ways to improve its existing Medicare/Medicaid Coordinated Plan (special needs plans) and review other local options such as the program for the All-Inclusive Care for the Elderly.
90) What approach will be pursued for developing managed care contracts to pay for behavioral health benefits?	Relying on work accomplished by the Governor's Behavioral Health Transformation Group, Medicaid will first develop a Request For Information. A Request For Proposal will follow and include requirements for a statewide standardized assessment and evidenced-based benefits that can be provided by businesses that meet national accreditation standards. It will be the responsibility of the managed care organization to develop provider networks.
91) What does it mean to establish contracts based on gain sharing, risk-sharing, or a capitated basis?	These approaches are alternatives to fee-for-service which pays based on the amount of service delivered: • Gain-sharing is a method of incentive compensation given for measurable performance. • Risk-sharing takes into account the consequential costs and benefits and distributes among the parties based on a pre-determined formula. • A capitation payment is a fixed amount (usually a per member, per month payment) for a defined set of services.

Question	Answer
PROVIDER ASSESSMENTS	
92) What will happen now that non-state government hospitals are added to the Hospital Assessment Act, but private physician specialty hospitals and state hospitals remain exempt?	This means that county hospital providers will be assessed provider taxes along with the private hospital providers. The provider taxes will be assessed on the disproportionate share hospital payments, federal upper payment limit payments, and a percentage of net patient revenues limited by the Medicaid trustee and benefit expenditure shortfall for the state fiscal year.
93) When will the county hospitals be assessed?	The assessments will occur between the fall and spring of the state fiscal year.
94) How much money will assessing county hospitals save Medicaid?	It is estimated that this will save approximately $3.5 million in state general funds.
95) Why is the department adding a new assessment for intermediate care facilities?	The department is issuing an assessment in order to maximize the financial resources eligible and available for the Medicaid Program. The department will establish a fund in order to receive intermediate care facility assessments to use in securing federal matching funds under the federally prescribed programs that are available through the Idaho Medicaid plan.
96) How much money will adding new assessments for intermediate care facilities save Medicaid?	It is estimated that this will save approximately $500 thousand in state general funds.
97) Why is the department standardizing assessment language for hospitals, nursing homes, and intermediate care facilities?	For hospitals, nursing facilities, and intermediate care facilities, the assessment language specifies that: • All providers in each category are subject to the assessment with the exception of state owned facilities. • The assessment will be used to provide state matching funds for the Idaho Medicaid trustee and benefit expenditures to the extent that a general fund shortfall exists.

Question	Answer
98) Why is Medicaid making technical changes to processing payments with nursing homes and allowing maximum assessment under federal law?	For nursing facilities, the assessment language represents consistent application of the assessment, how the assessment is collected, and what penalties occur if the assessment isn't paid on time.
99) How much money will Medicaid save by making changes to the nursing home payment process?	It is estimated that this will save approximately $3.5 million in state general funds.
PROGRAM INTEGRITY	
100) What will the Medicaid Program Integrity Unit do to increase the recovery of Medicaid overpayments?	The Program Integrity Unit will take actions to generate additional general fund recovery by: • Continuing to expand the use of civil monetary penalties to all of the audits that are subject to the penalty. • Implementing data analysis for identifying overpaid claims on a systematic basis. • Hiring additional staff to increase the amount of general fund recovery.
101) When will these changes begin?	The Program Integrity Unit will begin expanding the use of civil monetary penalties and will use data analysis immediately. The increase in staff would occur over the first four months of the next fiscal year.
102) How are these changes different from what we are doing now?	• Expand civil monetary penalties: Although we began expanding the use of civil monetary penalties at the beginning of the current fiscal year, the full realization of their benefit will not be felt until next fiscal year because there is a lag in time to implement the penalties and collect them. One year ago, we collected about $25 thousand in penalties. This year we expect to collect nearly $200 thousand.

Question	Answer
	• Implement data analysis: We have been developing some analysis to identify overpayments this year and expect this new tool could increase our productivity by 20% or more. The analysis we have done has proven to provide a very efficient means to identify overpaid claims. • Increase number of analysts: Currently, we estimate that each analyst will return between three and four times their costs in general fund receipts. By increasing the number of analysts, we can increase the total return to the general fund.
103) Who will these changes affect?	These changes will affect the providers who bill Medicaid for services that are not reimbursable under the current rules.
104) How much money will hiring additional staff in the Program Integrity Unit to help reduce fraudulent payment save Medicaid?	It is estimated that this will save approximately $1.1 million in state general funds and $2.5 million in federal funds, for a total of $3.6 million.