STATE OF IOWA DEPARTMENT OF

Health AND Human

SERVICES

IOWA MEDICAID QIO SERVICES SFY23 ANNUAL FINANCIAL MANAGEMENT REPORT

October 2023

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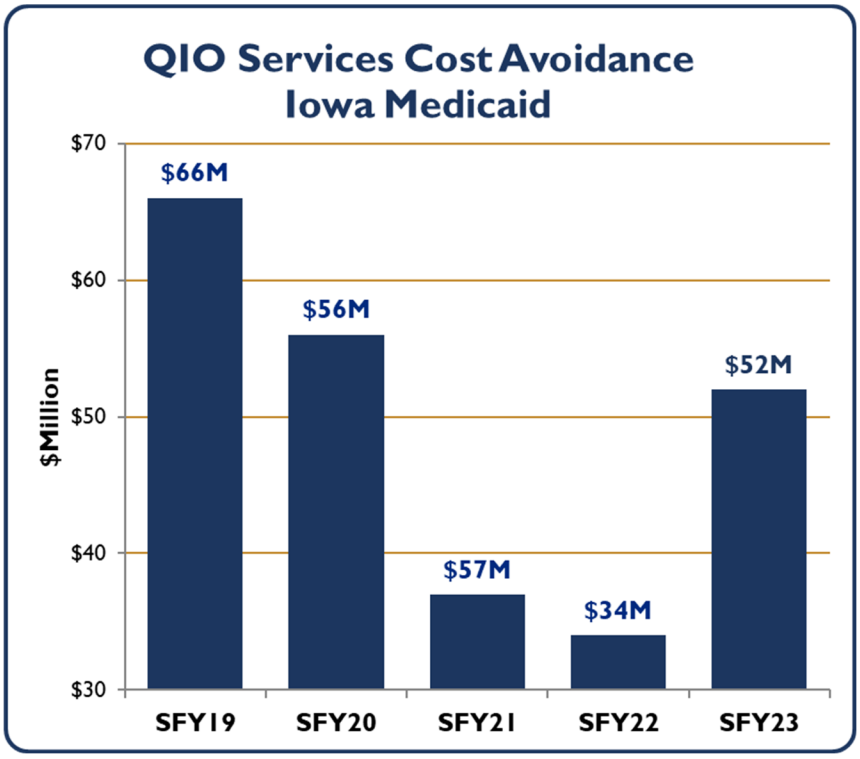
REPORT OVERVIEW

Solid financial and population health management are critical to the long term sustainability of the Medicaid program. Telligen delivers leading-edge solutions to improving quality and utilization management to Iowa Medicaid and the Iowa Department of Health and Human Services (HHS).

The Quality Improvement Organization (QIO) Services unit provides focused and innovative planning and management to serve Iowa's Medicaid members. QIO Services identifies and promotes best practices that result in measurable cost avoidance to the State of Iowa. The total cost avoidance amount in SFY23 was just over $52 million. State cost avoidance in SFY22 was $34 million, SFY21 was $37 million, SFY20 was $56 million, and SFY19 was $66 million. This cost avoidance represents more than $245 million over the last five State fiscal years.



Cost avoidance is calculated from admission and continued stay reviews (CSR), as well as other utilization management activities involving care provided to Medicaid members in the following categories:

- claims pre-pay review for medical necessity,
- HCBS waiver programs,
- institutional services, and
- prior authorization.

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Total cost avoidance is displayed below for Iowa Medicaid QIO Services programs.

Table 1
All Program Cost Avoidance

Claims Prepay Review for Medical Necessity	$148,919
Home and Community Based Services	$143,446,925
IoWANS Service Plan Reviews	$35,130
Institutional Services	$3,868,634
Prior Authorizations	$405,196
Total Cost Avoidance	**$147,904,804**

Total program costs for SFY23 were $9,553,200 which includes all monies paid to Telligen to perform the QIO Services contract, including all administrative functions where no cost avoidance can be realized (e.g., Clinical Advisory Committees, International Classification of Diseases-10th Revision, and exceptions to policy).

Telligen applied the Federal financial participation (FFP) rate of 63 percent to determine the impact on State dollars.

Telligen applied the 75 percent contribution from the Federal government (available for services provided by a QIO) to determine the State dollars that funded the QIO Services unit.

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Table 2
Overall Cost Avoidance

	Avoidance
Total Avoidance	$147,904,804
63% FFP	$93,180,027
Total State Avoidance (total minus 63% FFP)	$54,724,777
Telligen Review Costs	$9,553,200
75% Federal Match	$7,164,900
State Cost (review costs minus 75%)	$2,388,300
State Avoidance	$54,724,777
State Cost	$2,388,300
Total Avoidance (State avoidance minus State cost)	**$52,336,477**

The return on investment ratio for combined Federal and State dollars, and State dollars only was calculated. For each state dollar spent on QIO Services in SFY23, HHS saved $22.91, for just under a 23:1 ratio.

Table 3
Total Cost Avoidance

Federal and State Dollars				
Total Avoidance		Total Costs		Dollars Avoided per Dollar Spent
$147,904,804	÷	$9,553,200	=	$15.48
State Dollars Only				
State Avoidance		State Costs		Dollars Avoided per Dollar Spent
$54,724,777	÷	$2,388,300	=	$22.91

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CLAIMS PREPAY REVIEW

QIO Services reviews suspended provider claims that require a medical necessity determination or manual pricing. Only those claims denied with a specific set of denial reasons are included as cost avoidance. Denial reasons include any medical necessity denial, services not meeting Medicaid guidelines, and concurrent care denials. Cost avoidance was calculated by multiplying the fee schedule for each procedure code by the number of denied units. Only claims denied during this fiscal year and not later paid during this same fiscal year were included in cost avoidance calculations.

Cost avoidance not included in this report includes denied services that did not utilize a specific fee schedule, such as services paid by provider report, or were manually priced using a pricing reduction methodology performed by QIO Services. When a provider bills multiple surgical procedures on the same date of service, multiple surgery reduction pricing applies. Typically, the highest paying procedure is paid at the full fee schedule with each additional procedure being paid at 50 percent of the fee schedule.

Due to the volume of claims reviewed that do not have fee schedules or are for multiple surgical procedures, Iowa Medicaid has significant additional cost avoidance, but specific dollar amounts cannot be calculated.

Administrative or technical denials for claims that did not include the necessary documentation to review to make a medical necessity judgment were not included as cost avoidance.

Table 4
Claims Cost Avoidance

Claims Avoidance	**$148,919**

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HCBS WAIVER LEVEL OF CARE

Admission and CSRs are conducted by determining level of care (LOC) from medical information submitted by the attending provider and/or case manager. Peer reviewers make medical necessity determinations when LOC cannot be approved based on the established criteria. If a peer reviewer determines the member's functional impairments would not result in the member qualifying for facility placement in accordance with criteria, a denial is issued. Cases initially denied and later reversed through the appeal process are excluded from the cost avoidance calculations.

In order to calculate cost avoidance for care reimbursed on a per diem basis, the average length of stay (ALOS) from the IoWANS database and reimbursement information from Medicaid B-1 reports for SFY23 were utilized using a 12-month average.

The numbers of upheld denials were multiplied by the ALOS and the average cost per member for each waiver category. Members who transition to other waiver programs were not included in cost avoidance calculations.

The HCBS waiver programs reviewed include the AIDS/HIV waiver, Brain Injury (BI) waiver, Children's Mental Health (CMH) waiver, Elderly waiver, Health and Disability (HD) waiver, Intellectual Disability (ID) waiver, and Physical Disability (PD) waiver. Targeted case management (TCM) service costs are also avoided by admission and CSR denials in the BI, CMH, and ID waivers. Habilitation (HAB) services are also included in these cost savings.

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Table 5
HCBS Waiver Level of Care Cost Avoidance by Waiver/Review Type

Waiver	Upheld Denials		ALOS* (in months)		Average Cost per Member per Month**		Cost Avoidance
AIDS/HIV Admit	3	X	85.2	X	$1,276.85	=	$326,363
AIDS/HIV CSR†	3	X	0.00	X	$1,276.85	=	$0
BI Admit	28	X	123.76	X	$3,367.63	=	$11,669,781
BI CSR†	0	X	101.16	X	$3,367.63	=	$0
BI TCM+ Admit	28	X	123.76	X	$455.08	=	$1,576,980
BI TCM+ CSR†	0	X	101.16	X	$455.08	=	$0
CMH Admit	48	X	37.77	X	$825.80	=	$1,497,142
CMH CSR†	3	X	0.00	X	$825.80	=	$0
CMH TCM+ Admit	48	X	37.77	X	$0	=	$0
CMH TCM+ CSR†	3	X	0.00	X	$0	=	$0
Elderly Admit	817	X	54.31	X	$1,264.79	=	$56,120,339
Elderly CSR†	71	X	33.97	X	$1,264.79	=	$3,050,509
HAB Admit	3	X	78.13	X	$3,661.71	=	$858,268
HAB CSR†	1	X	56.00	X	$3,661.71	=	$205,056
HD Admit	3	X	102.94	X	$2,140.58	=	$661,054
HD CSR†	11	X	49.36	X	$2,140.58	=	$1,162,249
ID Admit	48	X	187.33	X	$3,472.78	=	$31,226,682
ID CSR†	10	X	118.19	X	$3,472.78	=	$4,104,479
ID TCM+ Admit	48	X	187.33	X	$186.81	=	$1,679,766
ID TCM+ CSR†	10	X	118.19	X	$186.81	=	$220,791
PD Admit	156	X	62.46	X	$2,825.23	=	$27,528,363
PD CSR†	13	X	42.45	X	$2,825.23	=	$1,559,103
						Total Cost Avoidance	**$143,446,925**

* ALOS calculated by IOWANS.

** Average cost per member from SFY B-1 reports, averaged over 12 months (July 1 through June 30).

\+ Avoided TCM payments based on denied cases.

† ALOS between denial and admission ALOS. Any CSR denials beyond the admission ALOS were not included.

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Table 6
HCBS Waiver Level of Care Cost Avoidance

	Avoidance
AIDS/HIV	$326,363
BI	$13,246,761
CMH	$1,497,142
Elderly	$59,170,848
HAB	$1,063,324
HD	$1,823,303
ID	$37,231,718
PD	$29,087,466
Total Avoidance	**$ 143,446,925**

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IoWANS SERVICE PLAN REVIEW

Milestones initiated in IoWANS occurs when the case manager enters the annual service plan or makes a change to an existing service plan. When an IoWANS workflow has been started for a member, a milestone will be sent to the review coordinator (RC). The RC will review each service that is entered into the plan to ensure that the service plans are in compliance with Iowa Administrative Code (IAC) and Waiver program rules. An error in the plan results in a modification. The RC will contact the case manager to correct the error, resulting in a modification and potential cost savings.

Table 7
IoWANS Service Plan Review Cost Avoidance

IoWANS Service Plan Avoidance	**$35,130**

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INSTITUTIONAL SERVICES

Admission and CSR reviews are conducted for intermediate care facilities for the intellectually disabled, nursing facilities (NFs), and nursing facilities for the mentally ill, as well as Program of All-Inclusive Care for the Elderly (PACE) by determining LOC from medical information submitted by the attending provider. Peer reviewers are consulted for medical necessity determinations when LOC cannot be approved based on criteria. If a peer reviewer determines that the member's functional abilities do not require facility placement, a denial is issued. Cases initially denied and later reversed through appeal or upon receipt of additional information are excluded from the cost avoidance calculations.

In order to calculate cost avoidance for care reimbursed on a per diem basis, ALOS information from the IoWANS database and reimbursement information from Medicaid B-1 reports for SFY23 were utilized using a 12-month average. The numbers of upheld denials were multiplied by the ALOS and the average cost per member per month for each institutional category.

Table 8
Institutional Services Cost Avoidance

Waiver	Upheld Denials		ALOS* (in months)		Average Cost per Member per Month**		Cost Avoidance
NF Admit	8	X	28.94	X	$10,549.12	=	$2,442,332
PACE Admit	8	X	42.34	X	$4,210.86	=	$1,426,302
					Total Cost Avoidance		**$3,868,634**

* ALOS calculated by IoWANS.
** Average cost per member from SFY B-1 reports, averaged over 12 months (July 1 through June 30).

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PRIOR AUTHORIZATIONS FOR VARIOUS QIO SERVICE

Denied prior authorizations (PAs) are determined by identifying all items with a medically related denial reason in a year-to-date report from Data Warehouse. The number of denied units is multiplied by the appropriate fee schedule for each procedure code.

Modified PAs were determined by identifying year-to-date requests by procedure code. The difference between what was requested and what was approved was multiplied by the appropriate fee schedule for each procedure code modified. All non-medical denials such as non-covered benefit or information not being submitted (i.e., technical denials) were not included in cost avoidance.

Cost avoidance for pre-procedure was calculated by the combined avoidance of gastric procedures and transplant authorization denials multiplied by the average cost of the procedures.

Waiver prior authorization cost avoidance was similarly calculated by obtaining all members with a denied or modified prior authorization in the SFY.

Table 9
Prior Authorization Cost Avoidance

	Avoidance
Denied PAs	$275,774
Modified PAs	$53,725
Pre-procedure	$0
Waiver Prior Authorization	$75,697
Total Avoidance	**$405,196**

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ADDITIONAL QIO SERVICES HIGHLIGHTS

HEALTH INFORMATION TECHNOLOGY

QIO provides HIT support as needed to Policy. The HIT coordinator reviews and provides information regarding HIT rules when they are proposed or finalized. The HIT coordinator attends several meetings and monitors websites and listservs, to stay apprised of HIT activities. Activities related to HIT have included:

- Attended national Centers for Medicare & Medicaid Services (CMS) Systems Technical Advisory Group (S-TAG) and S-TAG Interoperability Workgroup calls.
- Reviewed Notice of Proposed Rule Making, final rules, and State Medicaid Director letters which may impact Medicaid HIT and interoperability strategies.
- Kept Policy informed on CMS, Office of the National Coordinator HIT, and interoperability strategies.

PATIENT PROTECTION AND AFFORDABLE CARE ACT SECTION 2703: CHRONIC CONDITION AND INTEGRATED HEALTH HOMES

Iowa has two approved State Plan Amendments (SPAs) for Section 2703 identified as IA-21-0005 Chronic Condition Health Home and IA-21-0003 Serious Persistent Mental Illness Health Home. QIO Services manages these State Plan Amendments and provides technical assistance and program oversight. Activities have included:

- Submitted a decision document to end the Chronic Condition Health Home SPA.
- Facilitated project plan to end the Chronic Condition Health Home SPA.
- Completed onboarding for two new Integrated Health Homes.
- Worked in collaboration with the managed care organizations (MCOs) to update the following tools and templates (annual process):
  - Comprehensive assessment and social history template.
  - Person-centered service plan template.
  - Updated chart review workbook with additional guidance.
  - Notification form.
  - Health Home Self-Assessment tool.
- Contributed to the development of Informational Letters and policy clarifications.
- Gathered and submitted data for the CY22 CMS Health Home core measures via the Medicaid and Children's Health Insurance Program portal.
- Updated HHS website content.
- Reviewed materials submitted by MCOs for clarity and accuracy.
- Facilitated and tracked attendance for the monthly Health Home Learning Collaboratives.
- Conducted weekly Learning Collaborative workgroup meetings with the MCOs that included the following activities:
  - Created and implemented the Learning Collaborative plan for CY21, including virtual and face-to-face meetings.
  - Collected, shared, discussed, and provided follow up for the Learning Collaborative survey results.

    - Created a tracking tool for future learning topics gathered from the Health Home Learning Collaborative survey feedback.
    - Coordinated and conducted MCO presentation materials review.
- Provided registration reports weekly to the Learning Collaborative workgroup.
- Improved oversight of the Health Home program through an updated chart review.
- Continued improved program analysis by creating a process to review the program on an annual basis according to the Donabedian model to identify if improvements made a positive impact on the program.
- Annual collaboration with the MCOs to develop performance measures for incentives to improve outcomes for members enrolled in the Health Home program.
- Provided subject matter expertise and outreach to assist resolving provider and member issues across multiple areas including Health Homes, HAB services, IMPA, IoWANS, MCO contracts, and claims.
- Addressed questions and concerns from providers regarding the Health Home programs.
- Supported Provider Services with subject matter expertise when providers expressed interest in enrollment as a new Health Home.
- Collected and reported monthly member enrollment numbers by MCO and fee-for-service (FFS).
- Facilitated a reimbursement workgroup consisting of Health Homes to identify areas of improvement in the program. This workgroup met February through June 2023.
- Facilitated a quarterly director's meeting to allow sharing of best practices and to provide updates that are important for directors.
- Continued development of a dashboard and key performance indicators including rosters and enrollment (staffing ratio), Learning Collaborative attendance, chart review scores, success story submissions, and expansion.
- Attended biweekly MCO Open Office Hours calls.
- Conducted monthly Open Office Hours calls with Health Home providers.

QUALITY COMMITTEE FACILITATION

Iowa Medicaid has quality activities required by Federal code outlined in Code of Federal Regulation §457.1240, §438.340, and §438.6. Telligen facilitates the quality committee and activities have included:

- Provided quality oversight of the Medicaid Quality Strategy.
- Kept current and advised Iowa Medicaid leadership regarding innovative best practices.
- Oversight on performance indicators to identify areas of improvement.
- Oversight of managed care health equity plans.
- Updated monthly leadership document that outlines all Quality Committee activities.
- Developed a Quality Strategy dashboard to become data driven focused.
- Provided support to the MCO Bureau on managed care and primary care case management performance measures.
- Ensured alignment between Medicaid Strategic plan and the work of the Quality Committee.
- Created a project plan to update the Medicaid Quality Strategy for 2024.

- Facilitate quarterly meetings with NCQA to ensure our work is in alignment with Health Plan Expectations for accreditations.
- Supported the update of the Dental Quality Strategy.
- Supported pre-print evaluations including:
  - Provided leadership with updates.
  - Supported ad hoc quality issues.

OUTPATIENT HOSPITAL CERTIFICATIONS

Oversight certification is completed for new outpatient programs by reviewing submitted documentation to ensure the facility has met published criteria in the Iowa Medicaid Provider Manual. QIO Services received two requests for outpatient hospital certifications for pulmonary rehabilitation during this SFY.

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Table 10
Annual Medicaid Claims Analysis
(excludes crossover, capitation, and encounter claims)

Claim Type Children (0-18)	Members Served	Claims	Reimbursement	Cost per Member
Dental	608	837	$22,436	$37
Inpatient	1,101	1,147	$5,069,775	$4,605
Medical	11,772	334,826	$47,978,512	$4,076
Outpatient	2,358	5,633	$1,873,768	$795
Pharmacy	2,215	19,214	$1,720,837	$777
Waiver	86	1,046	$1,472,388	$17,121
Total	12,663	362,834	$59,132,402	$4,670
Adults (19-64)				
Dental	515	753	$108,041	$210
Inpatient	2,720	3,162	$23,751,988	$8,732
Medical	13,026	94,893	$15,412,129	$1,183
Outpatient	6,996	20,699	$10,196,433	$1,457
Pharmacy	5,306	69,091	$8,434,397	$1,590
Waiver	12	188	$607,839	$50,653
Total	15,029	188,906	$59,224,967	$3,941
Aged (65+)				
Dental	3	4	$840	$280
Inpatient	49	67	$930,422	$18,988
Medical	147	1,283	$162,195	$1,103
Outpatient	98	249	$420,131	$4,287
Pharmacy	29	210	$10,813	$373
Waiver	27	754	$339,475	$12,573
Total	229	2,573	$2,002,467	$8,744
Disabled				
Dental	345	577	$37,585	$109
Inpatient	178	237	$1,565,514	$8,795
Medical	5,277	392,955	$76,400,482	$14,478
Outpatient	1,113	9,144	$9,588,574	$8,615
Pharmacy	1,317	41,125	$4,061,432	$3,084
Waiver	1,366	22,016	$54,412,104	$39,833
Total	5,623	466,169	$148,614,525	$26,430

*Members Served Total is the unduplicated total of members served.
Data includes FFS claims only for paid dates in the SFY; does not include encounter claims.

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Table 11
Analysis of Acute Care Hospital Inpatient Claims (paid basis)

	Analysis of SFY18 Acute Care Hospital Inpatient Claim (Paid Basis)	< 19 Years Old			Between 19 and 64			> 64 Years Old			Disabled			Total		
		Reimb	Recip	Avg	Reimb	Recip	Avg	Reimb	Recip	Avg	Reimb	Recip	Avg	Reimb	Recip	Avg
1	Nervous System	$51,629	8	$6,454	$1,023,278	67	$15,272.80	$45,053	4	$11,263	$100,730	24	$4,197	$1,220,689	103	$11,851
2	Eye	$1,572	1	$1,572	$21,892	4	$5,473.00	-	-	-	-	-	-	$23,464	5	$4,693
3	Ear, Nose, Mouth And Throat	$4,055	1	$4,055	$80,886	10	$8,088.64				$10,408	2	$5,204	$95,349	13	$7,335
4	Respiratory System	$235,846	25	$9,434	$877,842	92	$9,541.76	$70,378	7	$10,054	$79,923	24	$3,330	$1,263,989	148	$8,540
5	Circulatory System	$53,142	7	$7,592	$1,197,966.51	105	$11,409.20	$157,810	11	$14,346	$118,884	9	$13,209	$1,527,804	132	$11,574
6	Digestive System	$124,442	16	$7,778	$1,791,906	115	$15,581.79	$130,793	10	$13,079	$69,767	12	$5,814	$2,116,908	153	$13,836
7	Hepatobiliary System And Pancreas	$15,073	3	$5,024	$847,475	101	$8,390.85	$24,888	2	$12,444	$46,739	8	$5,842	$934,175	114	$8,195
8	Musculoskeletal System & Connective Tissue	$16,419	3	$5,473	$984,679	64	$15,385.60	$88,631	4	$22,158	$60,097	9	$6,677	$1,149,825	80	$14,373
9	Skin, Subcutaneous Tissue and Breast	$5,907	2	$2,953	$304,462	36	$8,457.28	$6,107	1	$6,107	$9,746	3	$3,249	$326,222	42	$7,767
10	Endocrine, Nutritional and Metabolic System	$20,202	5	$4,040	$576,258	77	$7,483.87	$56,984	6	$9,497	$67,553	9	$7,506	$720,998	97	$7,433
11	Kidney And Urinary Tract	$6,567	2	$3,283	$598,950	53	$11,300.94	$88,510	5	$17,702	$109,950	10	$10,995	$803,976	70	$11,485
12	Male Reproductive System	-	-	-	$74,357	6	$12,392.87	-	-	-	$0	1	$0	$74,357	7	$10,622
13	Female Reproductive System	-	-	-	$106,444	11	$9,676.70	-	-	-	-	-	-	$106,444	11	$9,677
14	Pregnancy, Childbirth and Puerperium	$27,112	6	$4,519	$263,627	62	$4,252.04	-	-	-	$3,107	1	$3,107	$293,845	69	$4,259
15	Newborn & Other Neonates (Perinatal Period)	$3,372,136	910	$3,706	$251	3	$83.52	-	-	-	$224,118	25	$8,965	$3,596,505	938	$3,834
16	Blood and Blood Forming Organs and Immunological Disorders	$19,209	3	$6,403	$62,221	9	$6,913.45	-	-	-	$0	1	$0	$81,430	13	$6,264
17	Myeloproliferative DDs (Poorly Differentiated Neoplasms)	$51,471	4	$12,868	$110,754	8	$13,844.21	-	-	-	$46,732	1	$46,732	$208,957	13	$16,074
18	Infectious and Parasitic DDs	$45,267	5	$9,053	$1,809,793	136	$13,307.30	$97,314	9	$10,813	$143,334	14	$10,238	$2,095,708	164	$12,779
19	Mental Diseases and Disorders	$203,624	46	$4,427	$1,802,257	320	$5,632.05	$17,052	1	$17,052	$229,712	36	$6,381	$2,252,646	403	$5,590
20	Alcohol/Drug Use/Induced Mental Disorders	-	-	-	$882,953	152	$5,808.90	-	-	-	$17,226	4	$4,306	$900,179	156	$5,770
21	Injuries, Poison and Toxic Effect of Drugs	$14,823	5	$2,965	$461,804	67	$6,892.59	-	-	-	$3,675	1	$3,675	$480,302	73	$6,579
22	Burns	-	-	-	$61,438	5	$12,287.61	-	-	-	-	-	-	$61,438	5	$12,288
23	Factors Influencing Health Status	-	-	-	$24,868	14	$1,776.25	-	-	-	$4,895	2	$2,447	$29,763	16	$1,860
24	Multiple Significant Trauma	$120,113	3	$40,038	$417,639	15	$27,842.60	-	-	-	-	-	-	$537,752	18	$29,875
25	Human Immunodeficiency Virus Infection	-	-	-	$21,953	2	$10,976.41	-	-	-	$14,324	1	$14,324	$36,276	3	$12,092
	Totals	$4,388,610	1,055	$4,160$	$14,405,952	1534	$9,391	$783,519	60	$13,059	$1,360,921	197	$6,908	$20,939,001	2846	$7,357

Data includes only FFS claims for paid dates in the SFY; data does not include encounter claims.

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ACRONYMS

ALOS	average length of stay
BI	Brain Injury (waiver)
CMH	Children's Mental Health (waiver)
CMS	Centers for Medicare & Medicaid Services
CSR	continued stay review
FFP	Federal financial participation
FFS	fee-for-service
HAB	Habilitation services
HD	Health and Disability (waiver)
HCBS	Home and Community-Based Services
HHS	Department of Health and Human Services
HIT	health Information technology
IAC	Iowa Administrative Code
ID	Intellectual Disability (waiver)
IMPA	Iowa Medicaid Porta Access (system)
LOC	level of care
MCO	managed care organization
NF	nursing facility
PA	prior authorization
PACE	Program of All-Inclusive Care for the Elderly
PD	Physical Disability (waiver)
RC	review coordinator
QIO	Quality Improvement Organization
SPA	State Plan Amendment
S-TAG	Systems Technical Advisory Group
TCM	targeted case management