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$30M Savings in Program Integrity Exceeds Goal for Iowa Medicaid

DES MOINES, Iowa – An aggressive program integrity initiative for Iowa Medicaid saved taxpayers nearly $30 million in cost avoidance or recoveries in its second year of operation, far exceeding expectations.

"Combined with first-year savings of more than $23 million, we have now saved or recovered more than $50 million without trimming essential healthcare services for 400,000 Iowans or reducing provider rates," said Medicaid Director Jennifer Vermeer.

The savings were achieved through a three-year $14 million program integrity contract that was awarded to Optum of Eden Prairie, Minn.

Vermeer said the savings – which exceeded the contracted goal by about $7.5 million for the first two years – result from analyses of claims submitted by major Medicaid providers, with most savings or recoveries due to claiming errors.

For example, one strategy screens claims for inadvertent errors that would make Medicaid pay for a more expensive procedure than was actually performed. Another strategy makes sure that Medicaid is reimbursed when a non-government insurer eventually pays for the same hospital visit or procedure.

Vermeer said hundreds of thousands of dollars have also been saved or recovered when analysts discovered fraudulent claims. She said Medicaid has referred dozens of providers to the fraud investigation unit of the Department of Inspections and Appeals.

Most of the savings come from analysis of paid claims. Examples include:

- **Hospital readmissions**. Most claims for hospital stays are paid in a lump sum that depends on the condition of the patient. Hospitals can save money if they can quickly discharge the patient, but premature discharge sometimes leads to another admission for the same issue in a few days. In these cases, Medicaid now pays for a less-costly continuation of the first admission rather than for an expensive new admission.
- **Credit balance reviews**. More than $6.5 million was recovered in each of the first two years of the contract by making sure that Medicaid is reimbursed when another insurer eventually pays for the same visit or procedure. Hospitals process thousands of transactions daily and many have limited staff to detect credit balance overpayments that must revert to Medicaid. Duplicate payments occur due to the timing of reimbursements by insurance companies, a provider's financial reconciliation schedule, or administrative error.
- **Upcoding.** Providers sometimes inadvertently claim reimbursement for a more expensive service than was actually delivered. It was learned, for example, that some providers claimed in error to treat "respiratory distress syndrome" in newborns while in fact the service was to assist the child with less serious breathing problems.
- **Billing Errors**. For example, analysts discovered a misplaced decimal on a claim by an ambulance provider. The bill was for a 712-mile ambulance ride rather than a 71.2-mile ride. Analysts also have developed a method for reviewing paper claims. Most Medicaid

claims are filed electronically but there are still thousands of claims filed by paper every week. These claims have a higher potential for keying and scanning errors.

- **Questionable dental claims.** Analysts discovered claims for root canals on teeth that had been pulled months or years earlier. They also discovered claims for partial dentures for people who had received full dentures previously in the same area of the mouth, a highly unlikely scenario. Some questionable claims are the result of errors, such as labeling the wrong tooth. When the error causes an improper payment, Medicaid seeks reimbursement. One case was referred to the fraud unit.
- **Questionable chore claims.** People who are eligible for Medicaid-paid nursing home care can sometimes remain in their homes with the help of various services, including chores such as lawn mowing and snow removal. Program integrity analysts discovered that some chore providers billed for snow removal on days that it did not snow, or billed excessively for mild snowfall.

"The Iowa Medicaid program has become a model in the area of program integrity and shares our philosophy that when it comes to payment accuracy, every taxpayer dollar must be properly spent and every provider must be properly paid for the critical work they do," said Shelby Solomon, president of Optum Government Solutions.

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About Iowa Medicaid Enterprise (IME)

IME, a combination of state employees and commercial vendors, is responsible for managing a Medicaid program that covers nearly 450,000 beneficiaries and 38,000 care providers. IME unites state staff and "best of breed" contractors into a performance-based model for administration of the Medicaid program.

About Optum

Optum (www.optum.com) is a leading information and technology-enabled health services business dedicated to helping make the health system work better for everyone. Optum comprises three companies – OptumHealth, OptumInsight and OptumRx – representing more than 35,000 employees worldwide who collaborate to deliver integrated, intelligent solutions that work to modernize the health system and improve overall population health.

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